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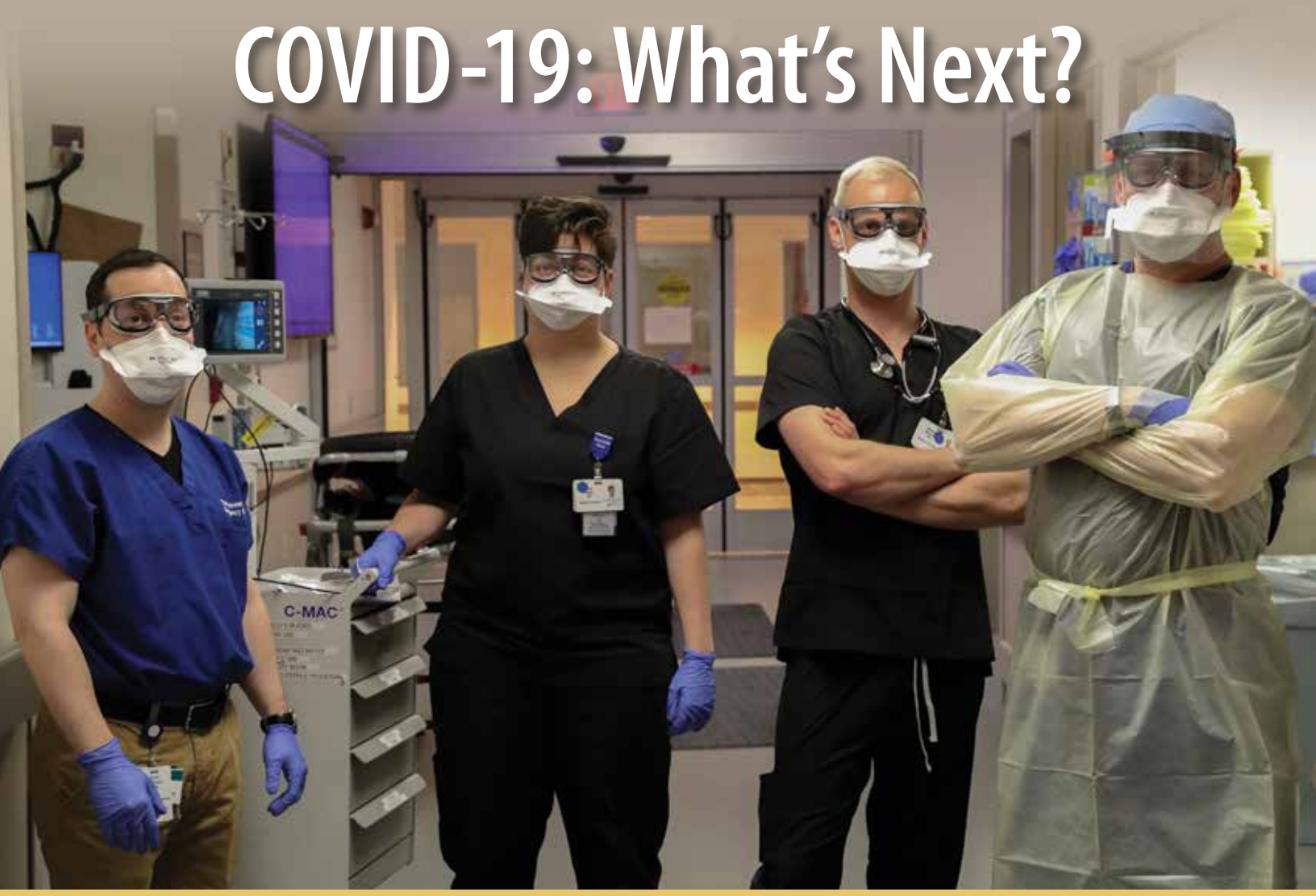
COVID-19: What's Next?



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ON THE COVER: Physicians in the emergency department at Barnes-Jewish Hospital in between treating patients including those with COVID-19: From left, Evan Schwarz, MD; Emily Grass, MD; Weston McCarron, MD; and Sanford Sineff, MD. *Photo credit: Erin Jones, Barnes-Jewish Hospital.*

Moving Forward

Steps to safely reopen society

By Jason Skyles, MD, President, St. Louis Metropolitan Medical Society 2020

Jason Skyles, MD

This will likely mean decreased patient volumes for the foreseeable future. It also means setting up procedures for screening staff and patients for symptoms, ensuring adequate supply of personal protective equipment and developing sanitation protocols.

The COVID-19 situation continues to upend our lives and practices. As I write this column in late April, much may have changed by the time you read this.

All Americans, including most physicians, have learned more about viral epidemiology and flattening the curve than they ever wanted to know. With social distancing plus state and local lockdowns, we have begun to slow the spread of the virus and saved countless lives. Every day that we aren't working, shopping or attending school, we help to flatten the curve and save lives.

We are beginning to see the frightening economic cost of these measures. Entire industries—hospitality, restaurants, tourism and more—have shut down almost completely. By June, we will be well into the more difficult process of lifting quarantines safely and getting Americans back to work. We must remember, though, that reopening society does not mean returning to "normal." With the prospect of a vaccine at least a year away and no proven treatment as of yet, we will have to get used to a new normal.

As we navigate these challenging times, it is important to move forward in a way that minimizes the risks to public health. This will likely require a phased approach and will undoubtedly happen slower than we all would hope for. Some of the measures may well involve a trade-off between public health and safety and that of civil liberties and privacy.

We have the benefit of learning from other countries that are several weeks ahead of the U.S. in their virus response, such as China, Italy, Hong Kong and South Korea. From these countries, we can evaluate what has worked and what has not. From these countries, we can see that there are three basic steps needed to safely open the economy:

1. Mass testing (both those with symptoms as well as randomized testing)
2. Contact tracking
3. Isolation process

Mass Testing Essential

I believe that the most important thing to end lockdowns remains mass testing. There is no substitute for a widespread testing process. This will require testing both symptomatic and asymptomatic individuals. One of the biggest challenges with COVID-19 is the number of people who are asymptomatic carriers. We have made substantial progress in this direction, including expanding testing capabilities and shortening turnaround times, but more progress needs to be made. As of late April, we are currently testing between 150,000 to 200,000 persons per day. Some reports suggest that we need to see testing grow to 20 million tests a day. Manufacturing and distributing this many tests would be a daunting task.

As we navigate these challenging times, it is important to move forward in a way that minimizes the risks to public health.

Another important factor is developing a method that allows extensive social tracing. This includes both manual contact tracing and use of digital tracing with the use of smart phone technology. Manual tracing can alert those who are close contacts, while the smart phone or digital tracing can alert those you do not know who were in close contact with you. This will require significant manpower and will raise important privacy considerations. Several countries have begun using this data

to trace contacts or to ensure that quarantined individuals maintain quarantine. Both Google and Apple have announced a partnership to further proximity-based contact tracing.

Temperature checks will likely become more commonplace even though it is an imperfect screening method. A *New England Journal of Medicine* article reported that among hospitalized patients in China, only 44% had presented at time of admission with a fever.

Masks are another essential component of mitigation. The hard science behind the widespread use of facemasks is lacking. I think it will become clear that they offer some containment benefit.

Social distancing is unlikely to end completely until a majority of the population has immunity. This immunity will either be from a vaccine or from widespread infection/recovery.

On a more personal note, I know we are all anxious to start our practices up again not only for ourselves but for our staff and our patients. As the lockdowns wind down, we should be putting some serious thought into how our practices will begin the slow process of ramping up to provide the "non-essential" care that has been delayed for the last month or two. The threat of the virus may be diminished during the summer, but it is not absent.

As the patient volumes begin to increase, we still need to have reasonable social distancing policies in place in our offices and imaging centers. This will likely mean decreased patient volumes for the foreseeable future. It also means setting up procedures for screening staff and patients for symptoms, ensuring adequate supply of personal protective equipment and developing sanitation protocols.

If all goes well, these policies will help prevent a major resurgence, but should the data show a resurgence, it is likely we must be ready to responsibly scale back down our practices. While this has been challenging and stressful for many reasons, please also remember to try to enjoy the increased "off" time. This experience will likely lead many to re-evaluate their work and life priorities. Only time will tell how this plays out. We need to remember to take care of ourselves during this time as well, so we can be there for our patients when the time arises.

Jason Skyles, MD, is a diagnostic radiologist with West County Radiology at Mercy Hospital St. Louis.

Nominate a Colleague for SLMMS Annual Awards

Nominations are now open for the 2020 special awards to be given by the St. Louis Metropolitan Medical Society. The award recipients will be recognized at the Society's Annual Meeting and Installation Dinner on Saturday, January 30, 2021. The SLMMS Council invites the membership to nominate a physician colleague for one of the following awards:

Robert E. Schlueter Leadership Award

The Schlueter Award is given, when appropriate, to a member who it is determined has met the following criteria: demonstrated leadership in organized medicine; demonstrated scientific attitude through excellent clinical practice; has been an advocate for patients on social, economic and political matters; and involved in community service on behalf of the medical profession. This is the highest honor bestowed by the Medical Society, and it has only been presented 21 times previously.

Award of Merit

The Award of Merit is given, when appropriate, to recognize outstanding and distinguished contributions to scientific medicine in the St. Louis community. The nominee must be a physician; preference will be given to current or former SLMMS members, but the nominee need not be a member of SLMMS.

President's Award

The President's Award is for outstanding service to the medical profession by a member of the St. Louis Metropolitan Medical Society.

To submit a nomination for any of the three awards, provide a brief narrative (two or three paragraphs) explaining why the nominee should be recognized; if possible, include the nominee's biographical sketch or curriculum vitae. SLMMS members may submit more than one nomination for each award. Include contact information of the person submitting the nomination, and forward all materials to Dave Nowak, executive vice president, in the SLMMS office or email dnowak@slmms.org.

The deadline for nominations is Wednesday, July 1, 2020. All nominations will be reviewed by the SLMMS Nominating Committee in July, with a recommendation subject to final approval by the SLMMS Council in September. No materials will be returned, and the award recipients will be notified this fall.

Lessons Learned for Life in the "New Normal"

By David M. Nowak, Medical Society Executive Vice President

David M. Nowak

But we have been able to challenge the myths that telemedicine is "too hard, ineffective, and no payment model exists for it,"[2] as well as recognize that medicine can be flexible in times of crisis.

I believe it is safe to say that very few people could have predicted what we've experienced as a society over the last 90 days dealing with the COVID-19 global pandemic. I think it's also safe to assume that no one can predict what things will look like six months from now—there are still too many unknowns. But what we can focus on is what have we learned from it, and how well we will adjust and adapt to what many are referring to as "the new normal."

Much has been written in recent weeks about the new normal and the modifications to health care delivery necessary to exist in a post COVID-19 world. One of the most interesting articles appeared in the *NEJM Catalyst* newsletter, examining the transition from reimagining to recreating health care. The authors maintain that before the COVID-19 pandemic, our health care system was struggling with "trying to align incentives between payers and providers to accommodate patients who were beginning to view health care as consumer commodity. Policy makers and leaders from both the care delivery side and payer side were busy reimagining health care. Suddenly that ended. Instantly we had to begin recreating."[1]

One of the biggest adjustments has come in the area of telemedicine and converting to a "virtual practice." The federal government loosened restrictions on telehealth and getting paid for it at breakneck speed. Something that would have taken years to achieve, mainly due to bureaucratic "red tape," happened in just a few short weeks in response to the pandemic.

Until recently, there were several barriers preventing the widespread adoption of telemedicine. Providers, health systems and payers were slow to embrace change, and they were only coming to realize that telemedicine is not a new type of medicine, but rather a care delivery mechanism that can be utilized with some patients, some of the time, to provide high-quality care.[1]

But COVID-19 changed all that, driving a rapid and radical transformation from in-person care to telehealth in many practices. Changes that would typically encompass months of planning, pilot testing, and education have been compressed into days.[2] And while many barriers still exist to overcome, patient care has been able to continue, providing much needed relief in extraordinarily stressful times.

By no means has everything come together perfectly, and there are still many lessons to learn. But we have been able to challenge the myths that telemedicine is "too hard, ineffective, and no payment model exists for it,"[2] as well as recognize that medicine can be flexible in times of crisis.

Two physicians from Saint Louis University School of Medicine, Jin Wang, MD, and Sharon Frey, MD, contributed a compelling piece to the March/April 2020 issue of *Missouri Medicine*, discussing the hard lessons taught by COVID-19. What will we learn from this pandemic? They concluded that "crises teach societies hard lessons but from these challenges come ingenuity, growth and a renewed sense of kindness toward each other. We will learn more efficient and less costly ways to provide health care; new innovations will occur with development of drugs, vaccines and diagnostics. There will be innovations in education and changes in models for conducting business … hopefully, there will be a renewed appreciation of life and good will towards others."[3]

So much can be accomplished, but my hope is that we use what we have learned from the COVID-19 pandemic and move forward in a new normal that allows for optimism, creativity and the ability to transform

So much can be accomplished, but my hope is that we use what we have learned from the COVID-19 pandemic and move forward in a new normal that allows for optimism, creativity and the ability to transform medicine for the good of patient care.

medicine for the good of patient care. Stay healthy and safe so that as a Medical Society, and organized medicine as a whole, we can do that together.

Closing Thoughts

Usually I dedicate this column in the June magazine each year to summarizing the resolutions and happenings at the Missouri State Medical Association's Annual Convention held each spring. Of course, COVID-19 forced a quick cancellation of this year's meeting, but our colleagues at MSMA were able to pivot quickly and organize a modified House of Delegates via conference call, and in turn create a forum for reviewing and commenting on 2020 resolutions online. SLMMS sponsored two resolutions this year, both authored by medical student members: Ensuring Affordable Insulin and Non-Medical Exemptions for Immunizations. All resolutions will be referred to the MSMA Council, with consideration to the comments received during the online comment period. Keep an eye on the MSMA website for updates on all resolutions, and I will summarize outcomes of the SLMMS-sponsored resolutions in a future publication.

Also during the Annual Convention conference call, SLMMS member George Hruza, MD, MBA, was installed as the 2020-21 president of MSMA (for more, see page 25). While we were unable to hold the inauguration ceremony and celebrate Dr. Hruza's presidency in the manner we had wished, we move forward knowing that our state medical association is in good hands thanks to his wisdom and guidance. On behalf of SLMMS, we wish you a successful year.

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3. Wang, Jin, MD and Frey, Sharon, MD, "COVID-19 Teaches Hard Lessons", *Missouri Medicine*, March/April 2020, 117-2, p. 84-85.

Representing the Profession of Medicine

Interested in serving your fellow physicians while contributing to the practice of medicine? Consider serving in a leadership role with the St. Louis Metropolitan Medical Society.

SLMMS invites all potential leaders from within the membership to serve. The Nominating Committee will meet later this summer to consider candidates for terms beginning in 2021. We need nominees from all specialties and practice settings to serve as SLMMS councilors, delegates to the Missouri State Medical Association annual meeting, and appointees to SLMMS committees.

Your Medical Society knows that the time commitment is a concern for many physicians. SLMMS is committed to keeping meetings to a minimum, and to meet via email or conference call when possible. We also ask that you consider the social and networking opportunities that also come with SLMMS leadership. Organized medicine benefits you, your profession, your practice and your patients.

To be considered as a potential nominee or a committee role, please contact Ravi Johar, MD, chair of the Nominating Committee, at rkjohar@att.net or David Nowak, executive vice president, at the SLMMS office at 314-786-5473, ext. 105 or email dnowak@slmms.org no later than Wednesday, July 1. If you wish to nominate another member for a leadership position, please speak with them first to confirm their willingness to serve. All recommendations will be considered.

Per the Society's bylaws, the Nominating Committee will present its slate of officers and councilors at a General Society meeting on Tuesday, September 15, at 6:00 p.m. to be held in the conference room of the West County Radiology Group office at 11475 Olde Cabin Road, Suite 200. All members are welcome to attend this meeting.

Candidates for office will be profiled in the October/November issue of *St. Louis Metropolitan Medicine*, and the annual election will take place online during the month of November. This is a great opportunity to positively influence the future of medical practice. Thank you to those who are willing to serve and represent your profession.

Leader of Pandemic Task Force Brings Wide-Ranging Experience

Q&A with Alexander Garza, MD

By Jim Braibish, St. Louis Metropolitan Medicine

From helping manage H1N1 response in Washington … to being a paramedic in Kansas City … to rebuilding the health system in Iraq, Alexander Garza, MD, comes well-prepared for his role as incident commander for the St. Louis Metropolitan Pandemic Task Force.

Dr. Alexander Garza

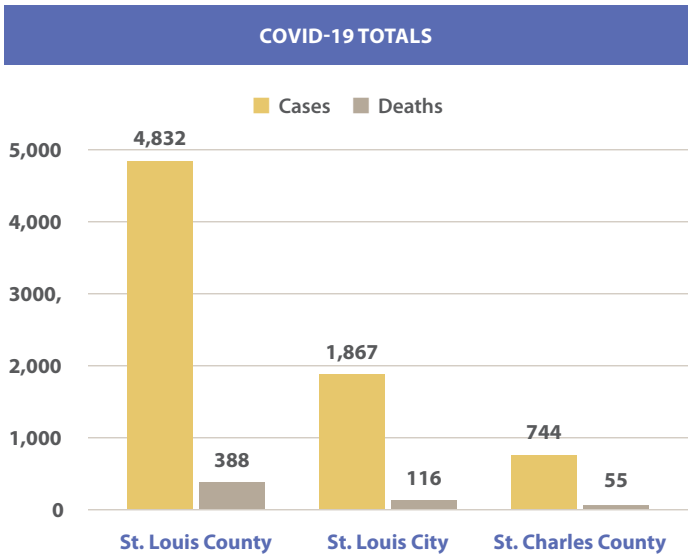
The Task Force is a collaboration between SSM Health, BJC Healthcare, Mercy and St. Luke's, along with public health departments, elected officials and state and federal agencies. Dr. Garza, a member of SLMMS, is the public face of the Task Force in its regular media briefings.

Dr. Garza is chief medical officer for SSM Health. He joined SSM in 2016 as chief medical officer for the St. Louis region and assumed responsibility for the system in 2018.

Originally from St. Louis, Dr. Garza worked as a paramedic in Kansas City for two years after earning his undergraduate degree from the University of Missouri-Kansas City. He obtained his medical degree from the University of Missouri-Columbia in 1996 and then completed his emergency medicine residency at Truman Medical Center and the University of Missouri-Kansas City. He became an assistant professor of emergency medicine at UMKC and was associate medical director then medical director of the Kansas City EMS.

Dr. Garza joined the U.S. Army Reserves in 1997 and served as a battalion surgeon and public health team chief for the 418th Civil Affairs Battalion. Deployed to Iraq in 2003, he was in charge of rebuilding Iraq's health sector after the fall of Saddam Hussein. Following a year on the faculty at the University of New Mexico, he joined the Washington Hospital Center in Washington, D.C., in 2007 as an emergency physician.

In 2009, he was appointed by President Barack Obama as the assistant secretary for health affairs and chief medical officer for the U.S. Department of Homeland Security. During his four years there, he was the principal health advisor to the Secretary of Homeland Security and the administrator of FEMA, and oversaw an office of over 200 health, science and security professionals.



Source: Local health departments as of May 27, 2020

Dr. Garza returned to St. Louis in 2013 to become associate dean of the Saint Louis University College for Public Health and Social Justice. He moved to SSM Health in 2016 but remains on the faculty at SLU. At SSM, he leads patient safety and quality, infection prevention, risk and regulatory, data and analytics and employee health across four states and 24 hospitals.

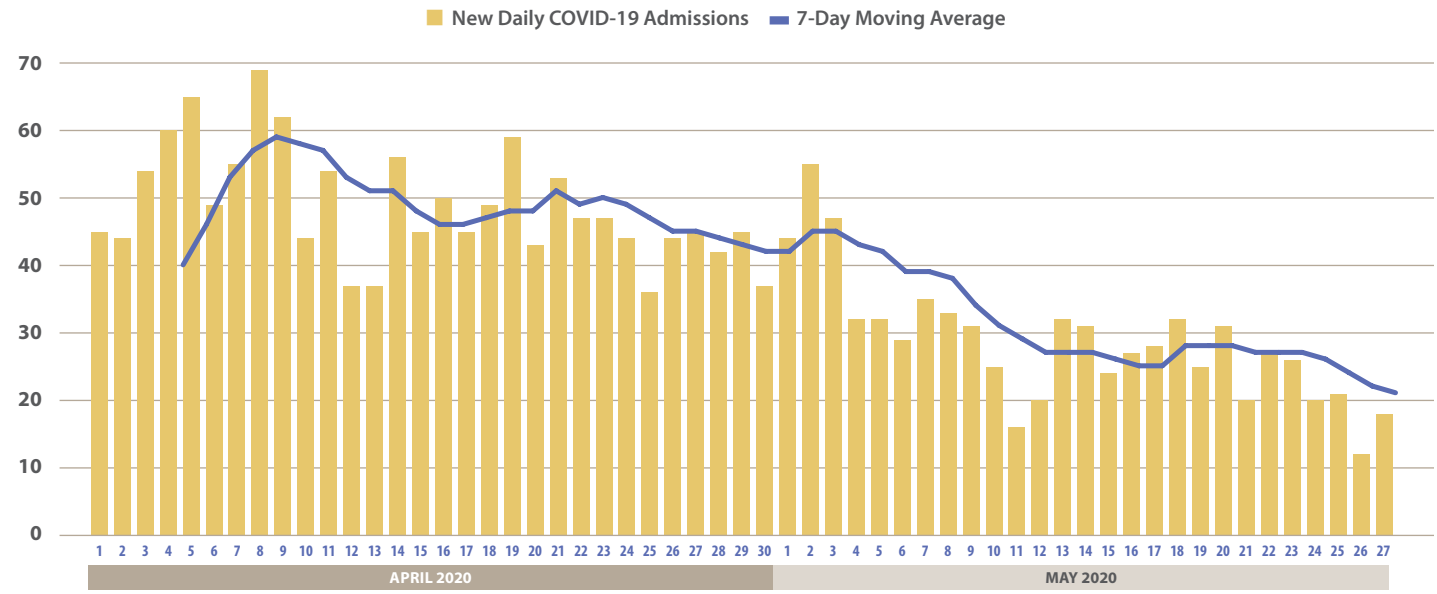
He shared his thoughts on the Task Force and COVID-19 with *St. Louis Metropolitan Medicine*.

How did collaboration and the Task Force originate?

In January, Dr. Clay Dunagan (BJC HealthCare senior vice president and chief clinical officer) emailed me and our counterpart, Dr. Keith Starke, at Mercy, asking our thoughts on COVID-19. As cases mounted around the nation, those discussions accelerated. We wanted to make sure we were developing policies and acting together on matters such as visitor policies and PPE as a metropolitan area rather than separate health care systems.

We also combined our analytic capabilities to land on a single model for disease burden and health care impact within the St. Louis metropolitan area. Based on these models, we held planning sessions about how to develop more capacity as a

MOVING AVERAGE: NEW COVID-19 HOSPITALIZATIONS IN THE ST. LOUIS AREA



Source: St. Louis Metropolitan Pandemic Task Force

region, including ICU capacity, supplies such as ventilators, staffing and PPE. Because we knew we need to act as a single body and not as individual systems, the decision was made to form the Pandemic Task Force. We also brought in our partners with the federally qualified health centers (FQHCs) as well as civic and business groups.

We also soon realized this process had to include not just the health care systems but the entire region. We reached out and began working with the local public health departments, elected leaders and state and federal agencies. This whole process came together quickly because they had been thinking the same way.

What have been the results?

In the St. Louis area, we have been able to avert what could have been a very challenging surge in patients. I give a lot of credit to our elected officials for acting decisively to issue shelter-in-place orders. From the task force side, we have been able to inform area officials as to the capacity of the health care system and what we expected to see as well as what our data and infectious disease experts were telling us.

Work groups within the Task Force provided guidance on such issues as infection protection measures for health care workers, when to stop elective surgeries, sharing best practices for COVID treatment, and developing criteria for testing. It was very beneficial to have everyone involved so we were all doing the same things.

What is your role as head of the task force?

To be the spokesperson and to help lead the collaborative effort. I also interface with public health and elected officials and other community groups.

What are your thoughts on the disproportionate number of COVID-19 cases among African Americans?

The virus itself does not affect African Americans differently. A disproportionate amount of disease is concentrated in socioeconomically disadvantaged populations and among those with chronic health conditions. This is because their overall health is determined by such factors as dense living conditions, a lack of access to healthy foods and poverty. So it is not surprising that the disproportionate burden would fall on those communities. President Obama would say, "Disasters have a way of pulling back the curtain to reveal the festering problems that have always been there," and I believe this is true for COVID.

What type of outreach efforts are occurring to these communities?

There have been a number of efforts to improve testing in at-risk populations, particularly through federally qualified health centers. PrepareSTL and other organizations have provided communication and education. Since we all have been challenged by the testing supply chain, any effort to focus on at-risk communities will be beneficial. In addition we have helped supply PPE and other protective measures to at-risk populations.

How has care for COVID patients improved since March?

One of the benefits of living in the Midwest is to observe what has happened in places like New York and learn from their experience. Prone positioning techniques and plasma therapy are among what we've learned. As we look at some of our data

continued

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at SSM, we've seen a significant drop in the share of COVID patients going to the ICU and being put on a ventilator since March because of improvements in care. Clinicians are learning more and more every day.

How likely is it we will see a second wave of infections as society reopens?

Any time you relax a shelter-in-place order, you increase the probability of transmission. However, it helps that we will have a gradual reopening of the economy, not jump right back to the way things were pre-COVID. Secondly, all of the policies and procedures we have put in place—wearing a mask, staying six feet apart, hand washing—all contribute to a lower transmission rate. Thirdly, we will be able to identify specific segments where transmission is higher, and target our interventions there. We will continue watching for flare-ups and doing suppression strategies until a vaccine is available or herd immunity is achieved.

Have the hospitals found instance of people delaying or forgoing seeking emergency treatment for chest pains, etc., out of fear of catching the virus at the hospital?

The census in our stroke and cardiac care units has been up to 50% of normal. However, people have not stopped having strokes and heart attacks because of COVID. It's logical to think that people have foregone coming to the hospital, especially if they were having more subtle signs of heart attack and stroke. We are now emphasizing that it is safe to come to the hospital. Many safety protocols have been implemented to protect our patients from being exposed to COVID.

As a physician and considering your wide-ranging background, what has this experience been like for you?

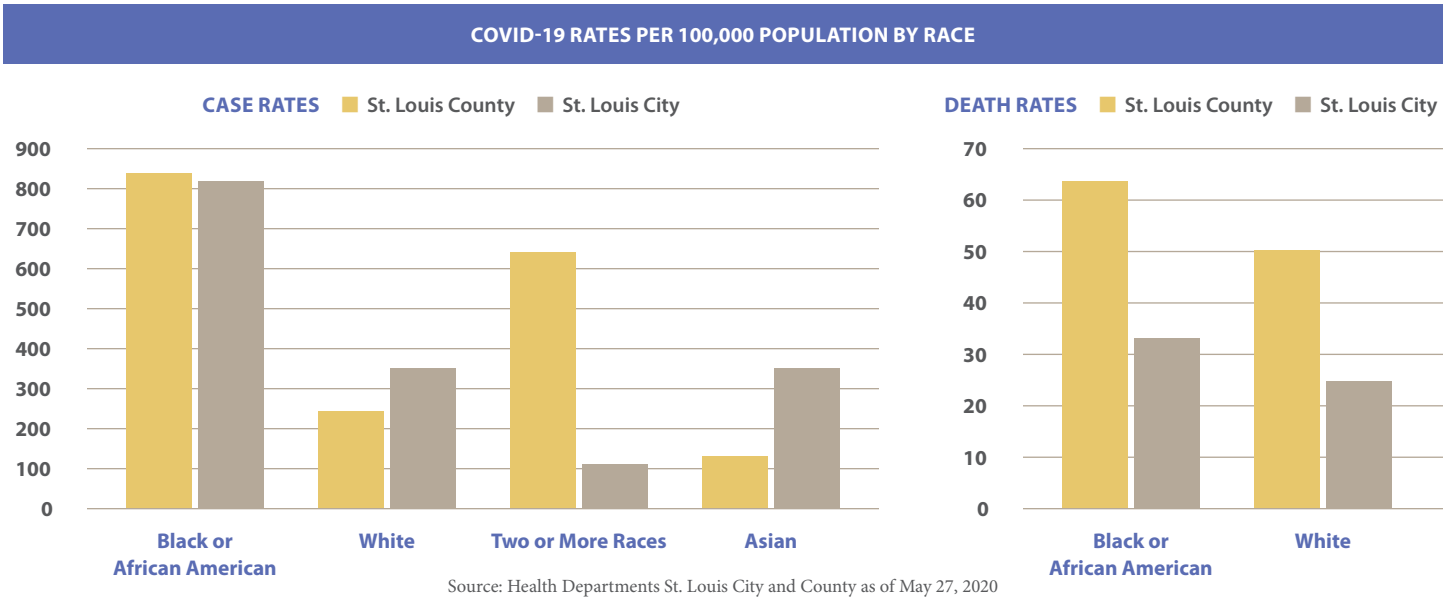
It's been like everything rolled into one. When I was in the Obama administration, H1N1 was going on and I worked with the CDC and others on developing strategy. I also likened developing our COVID strategy to a war strategy. In the military, you use a deliberative decision-making process that brings order. It worked here and continues to work. In a way this has been like war. We knew the enemy was coming, so we had a preparation phase. Then there is the shaping phase when we organize the people and supplies. Next is the kinetic phase, when you're in the battle. Now, we are entering the stability phase. We are starting to bring society back to normal while still being wary of the enemy. So it's been interesting to draw from prior experiences in this pandemic.

Is there anything else you would like to add?

The thing I routinely tell people is this is going to be a long war. This has been just the first battle. We will have ongoing battles until we get a vaccine or immunity. We are constantly going to have to flex and change and maneuver and adapt.

African Americans Hit Hardest by COVID-19

Data for St. Louis City and County shows the disproportionate impact that African Americans are incurring from COVID-19. Experts attribute this to social determinants of health including lower incomes, less access to healthy food, greater prevalence of chronic conditions and more. A ZIP code map of cases in St. Louis County shows the highest concentrations in north county.



Source: Health Departments St. Louis City and County as of May 27, 2020

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Q&A With St. Louis County Executive Sam Page, MD

Physician leads county through COVID-19 crisis

Sam L. Page, MD, was appointed St. Louis County Executive on April 29, 2019. He had barely been in office for 10 months when the pandemic struck. Already tasked with a full agenda, the coronavirus brought new challenges. Important and far-reaching decisions had to be made about restrictions on public activity, testing and more. Dr. Page, a longtime SLMMS member and board-certified anesthesiologist, took a few minutes to share his thoughts on the past 60 days and COVID-19 with *St. Louis Metropolitan Medicine*.

What have your days been like?

This crisis is the first thing on my mind when I wake up and the last thing on my mind when I go to bed at night. This is a historic challenge to our community that affects us across the spectrum, from public health to economic stability.

First and foremost, as county executive, my job is to protect the health and welfare of the residents of St. Louis County. I listen to the advice of our public health experts and work cooperatively with our health care systems.

We have three crises: a public health crisis, a humanitarian crisis and an economic crisis.

What do you do to keep strength and focus?

I try and keep all of this in perspective. This is a long-term challenge for our community. Things won't be back to normal until we have a vaccine. Keeping perspective means knowing where we are and where we must go. You set goals, follow public health principles and listen to very diverse opinions in the community. We always stay focused on our public health goals.

When I can peel away and have some free time, I like to go on bike rides with my family.

How have Dr. Jenny Page and the family been supportive?

Jenny and I have been married for 27 years. We talk about the complicated issues. She has been a good advisor and teammate through all my elected offices and understands the medical side of things and the political challenges of elected office.

How has having a physician's mindset aided your ability to lead the county through this difficult time?

I understand how a virus can spread in a community—like a brush fire. I understand the vocabulary of public health and the necessity of making decisions when you don't have all the information you'd like to have. The lack of a robust testing environment limits our available data; we must depend on hospitalizations and ICU admissions as data points.

More robust testing would provide better data to guide us. As a physician, you learn to make clinical decisions when you don't always have the test that you want. The stay at home order, in absence of strong testing data, was, in part, a clinical decision.

This crisis is the first thing on my mind when I wake up and the last thing on my mind when I go to bed at night. This is a historic challenge to our community that affects us across the spectrum, from public health to economic stability.

You have brought on some very well-qualified and respected volunteer advisors. How did that come about? What are they doing?

This is a complex crisis that lays on top of the normal structure and function and obligations of county government. We needed some extra bandwidth to process complicated questions like how to put stimulus funds to work in the community—in public health, humanitarian relief and economic relief.

We worked to identify volunteers who have extensive history in dealing with complex issues, who have reputations of being responsible, thoughtful and effective and who have deep relationships in the community with groups who will be delivering a lot of these services and will be helping us make our decisions.

Cindy Brinkley, a former president of AT&T Missouri, has corporate leadership experience and is putting together the decision-making structure and helping us with the compliance piece of the federal grant process to make sure these funds are spent in a way that complies with federal law and brings the most benefit to our community.

Deborah Patterson, former president of the Monsanto Fund and former CEO of the American Red Cross St. Louis Chapter, has extensive relationships with nonprofits who will be delivering some of the humanitarian aid. We recognize some communities are disproportionately affected when dealing with a public health crisis.

We know as we ease our restrictions on social mixing, we will expect an increase in COVID infections in the community. It's important we can manage it with traditional public health resources like testing, contact tracing, isolation and quarantine.

With the state and the county beginning a partial reopening and partial easing of restrictions, how likely is it we will see a second wave of infection? When might that come?

We know as we ease our restrictions on social mixing, we will expect an increase in COVID infections in the community. It's important we can manage it with traditional public health resources like testing, contact tracing, isolation and quarantine.

We will plan to manage COVID-19 in the existing health care system as more of a bump in infections rather than a wave. A lot of this depends on public acceptance of the new normal of social distancing, wearing a mask, and limiting crowd sizes until we have adequate medical therapies and a vaccine.

St. Louis has seen this type of challenge before, 100 years ago, and we know we can get through this if we work together and follow good public health practices. This is certainly a serious threat to our community. We have a comprehensive plan working with health care systems, our public health department and elected officials.

COVID-19 Mental Health Resources for Physicians

The COVID-19 pandemic has brought much added stress for physicians, residents and medical students—whether it be from caring for patients on the frontlines, or from the disruption of their practices or educations. Here are several mental health resources:

- The **Missouri Physicians Health Program**, www.themphp.org, 314-578-9574, offers free, confidential consultation. There is no commitment, monitoring, referral or group presentation required. Virtual appointments are available. "The MPHP is fully committed to doing everything we can to help physicians, residents and medical students stay healthy during this very difficult time," the organization said.
- **Physician Support Line**, 888-409-0141, offers free and confidential peer support to American physicians by creating a safe space to discuss immediate life stressors with volunteer psychiatrist colleagues. This service was launched in March 2020 to help physicians cope with the stress of COVID-19.
- The **American Medical Association** offers mental health tips for physicians, patients and staff, on its website, https://bit.ly/ama-mental-health.

HARRY'S HOMILIES©

Harry L.S. Knopf, MD

ON COVID-19

"April is the cruelest month, breeding lilacs out of the dead land, mixing memory and desire, stirring dull roots with spring rain."

– T.S. Eliot, The Waste Land

Currently we are recovering from the "cruelest April" in memory. Our country has suffered from unimaginable losses of life, liberty and wealth. But we were not alone: The world has suffered too. Too many deaths. Too much sadness. Then spring arrived, and the sun came out. The land bloomed again. Hope returned, and suppressed the fear. Didn't it? Being the eternal optimist that I am, I am certain we will be better next spring. Until this is fact, though, I and all of us need to carry on.

Dr. Knopf is editor of Harry's Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

Commentary

Off the Wards, But on Duty to Serve

By Dominic DeMarco and Parth Joshi

It was two weeks into our final clerkships of our third year of medical school. We were finally starting to feel like real physicians. The knowledge we gained had finally been coming to use. We could actually feel ourselves starting to truly assist our attending physicians in providing care to our patients. It had been a long year, but it was finally starting to pay off.

The third year was equal parts the best and worst year of medical school. Best in the sense that we finally get the chance to get out on to the wards, interact with patients, and test the knowledge that we had diligently and feverishly spent the previous two years acquiring. Worst in the sense that it was the busiest, most mentally and physically taxing year yet. Either way, by the end of this long and arduous year, the white coats seemed less of a costume and more of a uniform—it was real now. We were going to be doctors.

So, we did what medical students do best and found ways to contribute despite our inability to participate in rotations.

As all of this was playing out in our lives, a crisis was materializing in the background. As good medical students should, we kept up on the looming panic abroad as a new virus began spreading. Little news was breaking at first, but the stories quickly became more frequent and more serious. Nevertheless, we trudged on forward, keeping our minds on our patients during the day and our noses in the books at night. In free moments, we discussed how we thought this would play out, wondering if the past crises we learned about in classes would ever become a reality.

Dominic DeMarco

Parth Joshi

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Being in St. Louis, the news we heard from other parts of the country was still distant to our immediate lives. The first case in St. Louis changed that. All of a sudden, it was real now. The worry was palpable throughout the hospital, but we still did our work, our duty for our patients trumping our own fears. This is what we signed up for. This is what we are training for. Although our role was small, it was still significant. We would continue to help however we could.

And then the email came. *"All medical schools are to pull students from clinical rotations. Please gather your belongings and head home now."* And just like that, we were gone.

The world around us was becoming more and more unstable every day. Cases were increasing exponentially. People were dying. Loved ones with coughs, fatigue or fevers began fearing the worst. The word "pandemic" was finally being used seriously. And meanwhile, like most people, we were stuck in our homes, armed with knowledge and a desire to help but powerless to do anything about it. A mixture of frustration, fear and guilt poured over us. All of our training, that last year of intense work and study behind us. Yet the right thing to do during this crisis was to stand on the sidelines.

The first few weeks for most of us were categorized by stagnation, somewhat paralyzed by the abrupt changes in our world. We were fortunate to have the opportunity to continue our courses online, but many of us were not content just sitting at home staring at our computer screens. We wanted a way to help our attendings, residents and, most importantly, our patients. So, we did what medical students do best and found ways to contribute despite our inability to participate in rotations.

Not just third years, but across all four classes, we thought critically throughout about the ways we could make a difference. We looked at the world, not only as future doctors, but as people. The ways we could help soon became obvious. Everybody's lives had been upended by this crisis, leaving things we normally take for granted now hard to handle. Simple activities such as sending the kids to school, grocery shopping, walking the dog, were now difficult. Finding ways to cope in light of social restrictions seemed impossible. But we saw a way for our class to support the health care professionals we previously were working alongside. Our class has taken it upon

ourselves in large numbers to set up volunteer programs to make their lives easier and assist them with these problems. It may not be medicine, but they need all the help they can get. And we can help.

During this unprecedented time, we feel fortunate to be able to help those in our profession who are putting their health, safety, and well-being on the line to confront this health crisis.

From our view, we have been heartened by the outpouring of support we have seen from our classmates. Personally, we have contributed in our own ways as well. Parth has signed up for a program that provides companionship to seniors living in nursing homes. Dominic has spent this time as part of a team at Saint Louis University Medical School developing a wellness website for health care workers to find resources to cope with the increased anxiety and stress, while they become connected to social resources for support. We have also spent time reaching out to our fellow students on an online support system for those whose mental health has been affected. Although we may be on the sidelines of health care, as people we can still make a difference.

During this unprecedented time, we feel fortunate to be able to help those in our profession who are putting their health, safety, and well-being on the line to confront this health crisis. As students, we are not yet fully prepared to practice as physicians, but we are doing our part in whatever way we can.

WU Medical Students Initiate Volunteer Projects

Like their counterparts at Saint Louis University, students at Washington University School of Medicine have launched volunteer projects during the COVID-19 pandemic. The projects enable them to contribute while they are unable to care directly for patients. Among their activities:

- Preparing daily summaries of new research relevant to COVID-19 for practicing physicians at the university.
- Establishing student-run child-care services for health care workers.
- Assisting the St. Louis County Department of Public Health with contact tracing of persons infected with the virus that causes COVID-19.
- Staffing an email information service on COVID-19 for School of Medicine students and employees.
- Delivering food to people isolated with COVID-19 or at high risk of infection.

COVID-19 Clinical Trials in the St. Louis Area

Several clinical trials of treatments and vaccines for COVID-19 are underway in the St. Louis area:

- The antidepressant fluvoxamine is being evaluated at Washington University School of Medicine to help prevent patients with mild COVID-19 symptoms from advancing to the 'cytokine storm' phase that brings a life-threatening overreaction of the immune system.
- Washington University is part of a global study testing whether the antimalarial drug chloroquine might prevent or reduce the severity of COVID-19 infections in health care workers.
- The safety and effectiveness of remdesivir, an investigational intravenous anti-viral medication, in treating COVID-19 is being studied in a trial at Saint Louis University School of Medicine.
- The Vaccine Treatment and Evaluation Unit at Saint Louis University, one of nine in the nation, is involved in a multi-site COVID-19 treatment trial that includes all nine VTEU sites plus other domestic and international "protocol-specific sites." A COVID-19 vaccine trial began in Seattle the week of March 16.
- The St. Louis facility of Pfizer is part of national trials of four RNA vaccine candidates.
- Mercy and Mercy Research are participating in the U.S. Food and Drug Administration's investigation into the use of plasma from recovered COVID-19 patients to treat current patients. Washington University also has been involved in this work.

Telemedicine Ramps Up as Area Practices Adapt to COVID-19

Growth of telemedicine likely to be permanent

By Jim Braibish, St. Louis Metropolitan Medicine

As COVID-19 protective measures went into place in March and limited patient access to physician offices, practices quickly turned to telemedicine—the use of video or phone visits—to continue patient care.

Area health systems report that they have jumped from minimal telemedicine visits to as many as thousands each day. Experts say growth of telemedicine—aided by the temporary easing of regulations and payment restrictions by Medicare, private insurers and states—is here to stay.

"Over the past year we had begun introducing telemedicine in our outreach specialty clinics. But when COVID-19 came along, we quickly expanded to primary care clinics and now all of our providers are doing video visits," said Michele Thomas, MD, FAAFP, BJC Medical Group chief medical information officer. Between mid-March and mid-May, BJC Medical Group providers completed more than 20,000 video visits.

Setting up telemedicine in a medical practice requires more than just learning how to hold a Zoom meeting.

"We had to build out the process and workflow in the EHR which our team turned around very quickly," Dr. Thomas said. "We selected the platforms we would use for video such as Zoom, FaceTime, etc. Medical assistants were trained on how to room a patient for a video visit, asking for example if the patient has a blood pressure cuff at home."

She added that the clinics called all patients with scheduled appointments to determine whether a video visit or an in-office visit was most appropriate, and to screen for COVID-19. If there were COVID-19 concerns, the patient could be directed to one of BJC's dedicated COVID respiratory clinics. The screening protocol has remained in place for all new callers.

Conditions Most Suited

SSM Health put together a list of conditions best suited for in-person versus video visits, said Tim Johnson, MD, system vice president of medical group and population health operations. Video visits work well for chronic medical conditions such as high blood pressure and high cholesterol as well as minor acute issues like a skin rash or allergies. They can also be used for annual wellness visits. Examples of necessary in-person visits include relatively simple things like diabetic foot exams and pediatric immunizations, in addition to the more serious issues like shortness of breath or severe pain.

"The specialty that has really jumped on this is behavioral health," he said. "Behavioral health is perfect for telemedicine; they generally don't have to do a physical exam. Now (as of mid-May), 93% of our behavioral health visits are done via televideo."

At St. Luke's Hospital, a similar process was implemented to screen for COVID-19 and to determine whether to offer a virtual visit, said Jim Snider, vice president of St. Luke's physician network.

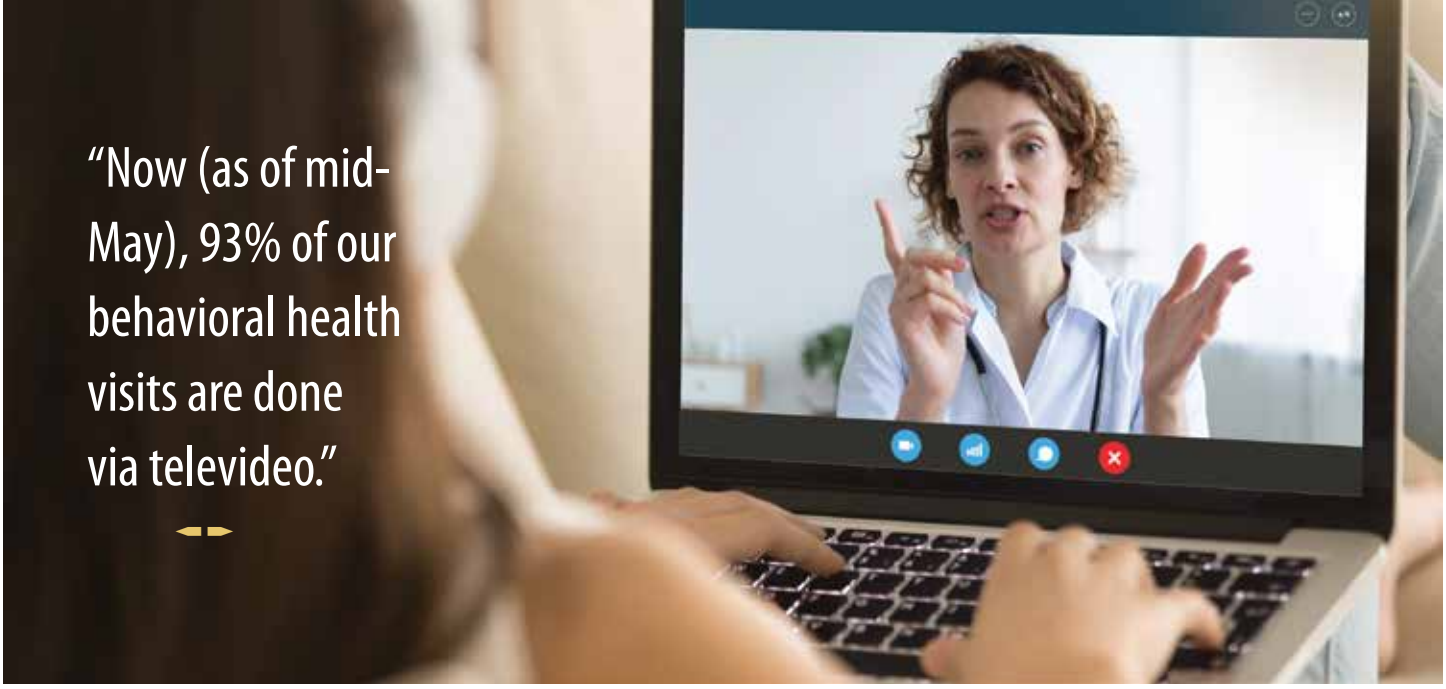
"Physicians, nurse practitioners, physician assistants and clinical support staff each received specific hands-on training as well as printed guidelines. Physician leaders were deeply engaged with operational and information technology team members to ensure the workflow process is designed efficiently and effectively for patient care," Snider said.

Each of the systems had pilot programs in telemedicine. Mercy had the benefit of its large Mercy Virtual operation that since 2006 has provided remote physician services to hospitals along with monitoring of patients with chronic conditions and much more, though this capacity was not being utilized in Mercy Clinic practices.

"Mercy was able to expand our existing technology and infrastructure to support all of our physicians with virtual visits for both primary care and specialty consults," said Gavin Helton, MD, president of Mercy Virtual and Mercy senior vice president of population health.

"Additionally, Mercy developed digital tools to enable triage and integrate the ability to seamlessly connect patients with the most appropriate follow-up care where needed," he added.

At Washington University Physicians, Jennifer Schmidt, MD, published a paper in April in *NEJM Catalyst* on her experience in ramping up telemedicine the Complete Care Center which she directs. The paper contains charts for triage, COVID-19 screening, appointment scheduling and more.



Here to Stay

The systems agree that expanded telemedicine is here to stay.

"It's a win for our patients," said Dr. Johnson at SSM Health. "We've seen strong interest among younger patients as well as older patients. Also, providers who have been skeptical of video visits in the past are now realizing that they can still give high quality care even if it isn't through an in-person visit."

Added Snider of St. Luke's, "Patients have quickly adapted to this form of care, and I presume many would prefer to have some form of virtual patient care continue in the future. Besides routine patient care, virtual care offers many additional possibilities such as expert monitoring of chronic patient conditions, physician-to-physician patient consulting, patient medication monitoring and post-hospital virtual visits."

Commented Dr. Helton of Mercy: "Using a breadth of integrated offerings—digital, virtual and physical—allows our care teams to provide the appropriate level of care for each individual to ensure the best outcome. Patients have truly been able to see the value, convenience and personalization that is not only a part of this interaction but is actually multiplied."

For more information on current regulations and payment guidelines on telemedicine during COVID-19, see *Telehealth Guidance During COVID-19: Expanded Access to Services* produced by the law firm Lashly & Baer, https://bit.ly/telehealth-guidance.

KEY CONSIDERATIONS WHEN DESIGNING A TELEHEALTH WORKFLOW

The AMA in its *Telehealth Implementation Playbook* offers these questions to consider when building a telehealth-inclusive workflow:

- How will the telehealth technology integrate with the EHR if it isn't through your existing EHR setup?
- How will clinicians document telehealth visits?
- How will telehealth visits fit into the clinic/clinician schedule?
- Where will telehealth visits take place in the clinic (e.g., administrative office, specific exam room)?
- How do patients first hear about telehealth? (e.g., from health care practitioner (HCP) during appointment, read in waiting room, read on website, email announcement)
- How do patients learn more about telehealth? (e.g., designated staff, website, email)
- How do patients register for telehealth?
- What reimbursement model makes most sense for your practice (e.g., bill insurance, flat fee for patient)?
- Who will keep track of developing reimbursement policies?
- Are the appropriate codes available in the EHR system?
- Do the care team members know what documentation is required for telehealth billing?

To view the *Telehealth Implementation Playbook*, visit https://bit.ly/ama-telehealth.

Commentary

The State of Medicaid Expansion . . . And its Future

Expansion measure to be on August 4 Missouri ballot

By Elie Azrak, MD, MHA, FACC, FSCAI

To this day, public opinion in the U.S. remains narrowly divided about the Patient Protection and Affordable Care Act (PPACA, ACA in short – Public Law 111-148), enacted during the Obama Administration in 2010. Ironically, by 2019 the law was more popular than ever, particularly provisions related to pre-existing conditions and elimination of lifetime coverage limits.

On the other hand, the state Medicaid programs—the subject of significant change in the ACA—met with a different fate: two Supreme Court challenges to the law have weakened the provisions related to Medicaid. More recently Missouri has joined a challenge to the Affordable Care Act in the Texas vs. U.S. case, in which a lower court invalidated the ACA, and a federal appeals court agreed.[1] The effect was a reinforcement of the partisan nature of support—or lack thereof—for the Medicaid program.

Over two thirds of the U.S. population has some connection to Medicaid, and some 70 million individuals are directly covered by the program.

Background

Enacted in 1965 as America's health care program for the poor, Medicaid has expanded in significant ways over the past 50 years: it now covers people with disabilities—including mental illness—and most recently under the ACA those with substance use disorder. What is more, unlike Medicare, Medicaid covers long-term care, and as such is the largest payer for nursing home services. Over two thirds of the U.S. population has some connection to Medicaid.

Elie Azrak, MD

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Unlike Medicare and Social Security, which enjoy widespread support and positive perception among the public, the stigma associated with Medicaid historically has hurt its public perception.

Ostensibly, Medicaid remains associated with significant stigma, both experienced (relationship with providers) and internalized (being poor and financially "needy"), although recent research disputes these findings.[2,3] Furthermore, Medicaid's historical attachment to Temporary Assistance for Needy Families (TANF) welfare cash assistance (phased out with State Children's Health Insurance Program, SCHIP, adopted in 1997) has made it a target to partisan attacks and shaming. At the time of this writing, all Democrat-controlled states have adopted expansion under the ACA, while all 14 non-expansion states are controlled by Republicans, Missouri among them.

Unlike Medicare and Social Security, which enjoy widespread support and positive perception among the public, the stigma associated with Medicaid historically has hurt its public perception. Medicaid enrollees might be subject to shaming for their moral "failings," are less likely to participate in political activity, and may have a worse experience in receiving health care than privately insured or Medicare patients.[2,3]

One additional driver of the poor perception about Medicaid is the low reimbursement for Medicaid services: the Medicaid-to-Medicare fee index for primary care in Missouri is 0.55 (Medicaid pays 55% of the Medicare fee), and for specialty care is 0.79, with an average of 0.60. Many physicians place limits on the number of Medicaid patients they can see, therefore restricting access for this patient population.[4]

Overall, Medicaid and CHIP provide health and long-term care coverage to more than 70 million low-income children, pregnant women, adults, seniors, and people with disabilities across the U.S.[3]

The Situation in Missouri

In Missouri, total Medicaid and CHIP enrollment was 833,900 in November 2019. Total Medicaid spending in fiscal year 2018 was $10,086,608,700 in Missouri; the federal government paid 64.7% of these Medicaid costs.[5]

The eligibility criteria for Medicaid in Missouri vary in relation to the federal poverty level (FPL). Pregnant women and children are eligible up to 305% of FPL, while seniors and the disabled are eligible only up to 87% of FPL. On the other hand, parents of eligible children can qualify only up to 21% of FPL, and other adults are not covered. Our state heretofore has elected not to expand Medicaid under the ACA to cover nearly all nonelderly adults under 138% of FPL. According to Kaiser Family Foundation estimates, an additional 205,000 uninsured adults would have been eligible for Medicaid in 2018 if the state had elected this expansion in Missouri.[5]

Notwithstanding all the challenges to the ACA in general—and to Medicaid in particular—the Missouri Medicaid expansion initiative is gaining momentum, both in support and in funding!

Expansion will be placed before Missouri voters in the August 4 election as an initiated constitutional amendment, the result of 350,000 petition signatures collected by the pro-expansion group Healthcare for Missouri. The ballot measure would require the state government to provide Medicaid for persons whose income is 133% of the FPL or below and who are not eligible for other state insurance coverage. This would effectively increase the coverage level to 138% of FPL under the provisions of the Affordable Care Act.

Two political action committees, Healthcare for Missouri and Missourians for Healthcare, are registered to support the measure. As of January 15, 2020, the committees had raised $3 million, with Missourians for Healthcare receiving the bulk of the contributions.[6]

The proposed ballot language reads as follows:

"Do you want to amend the Missouri Constitution to:

- *adopt Medicaid Expansion for persons 19 to 64 years old with an income level at or below 133% of the federal poverty level, as outlined in the Affordable Care Act*
- *prohibit placing greater or additional burdens on eligibility or enrollment standards, methodologies or practices on persons covered under Medicaid Expansion than on any other population eligible for Medicaid; and*
- *require state agencies to take all actions necessary to maximize federal financial participation in funding medical assistance under Medicaid Expansion?"*

Proponents of Medicaid expansion cite protection of rural hospitals, improving access to primary care services, and reduction in emergency interventions as potential benefits.

According to BallotPedia, the state government is estimated to have a one-time cost of approximately $6.4 million. The fiscal impact to the state is unknown, ranging from costs over $200 million to savings of $1 billion through 2026. Local governments expect costs to decrease by an unknown amount.[7]

Proponents of Medicaid expansion cite protection of rural hospitals, improving access to primary care services, and reduction in emergency interventions as potential benefits. Opponents, on the other hand, argue that access will not improve with Medicaid expansion given low provider reimbursement.[7]

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Commentary: For

Better Health for All, Economic Efficiency

By Ed Weisbart, MD

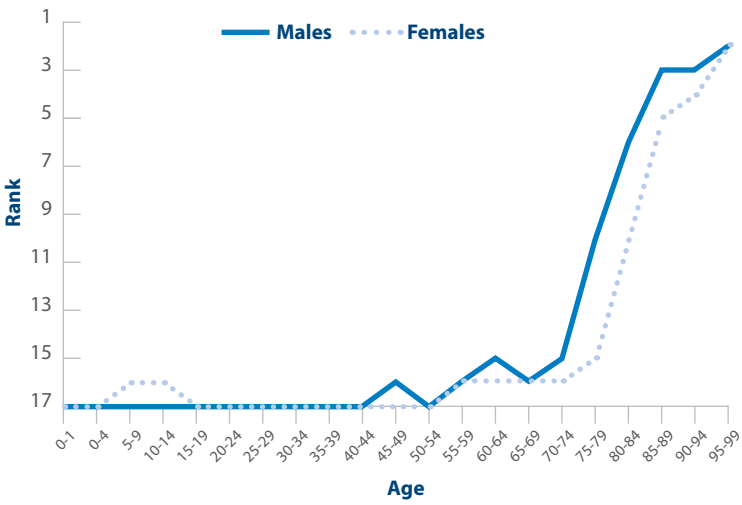
In the 1940s, Winston Churchill is rumored to have said "Never let a good crisis go to waste."[1] If he did say this, he was referring to the unlikely trio of himself, Stalin and Roosevelt creating opportunities in the midst of a global crisis. The world was changed by their combined capacity to imagine a better way forward.

Another global crisis is upon us, and once again we need to imagine a better way forward.

The pandemic has unmasked the hazards of linking health insurance to employment, along with our health care system's long-standing inefficiencies, poor outcomes and injustices and disparities.

FIGURE 1

Ranking of U.S. mortality rates, by age group, among 17 peer countries, 2006–2008 *(Top of chart is highest rank)*



Source: Woolf SH, Aron L. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. National Research Council (US); Institute of Medicine (US). Washington (DC): National Academies Press. 2013.

Ed Weisbart, MD

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The same war that drove Churchill to seek such unusual bedfellows also drove American businesses to attract and reward employees with access to lifesaving medical care through employer-sponsored health insurance. Decades later, we are still locked into a failing system of job-based coverage. For many workers, losing that job for any reason—your own underperformance, your own entrepreneurship or a major change in the economy—jeopardizes your continued access to health care.

Our strategies to address COVID-19 must also address these systemic faults with our system. Let us do that by building on the successes of Medicare, improving its obvious shortcomings, and providing that to all of us.

Why Base a Solution on Medicare?

Medicare is far from perfect, but even in its present state it brings tremendous value.

Medicare patients may worry about surviving the pandemic, but they have the peace of mind that their health insurance will be there even in the worst of times. If Medicare already covered all Americans, the pandemic would not require emergency legislation to ensure access to affordable screening, prophylaxis and treatment for coronavirus. Even in the most desperate days of Italy's catastrophe, Italians were not afraid to seek treatment due to cost, or worried about personal bankruptcy from medical bills.[2] Universal health care is not a panacea and certainly did not shield Italy from the coronavirus, but it did shield Italians from some of the worst economic consequences.

Traditional Medicare offers a national network including virtually every hospital and 93% of non-pediatric primary care physicians.[3] I know octogenarian Floridians on Medicare who have flown to St. Louis for world-class subspecialty care, never having to ask for permission from their insurance company. Every American should have the freedom to choose their own health care.

Improved Health

Even outside of a pandemic, Medicare has a favorable impact on Americans' health. After worst-in-class mortality rates for the first 65 years of our lives, American mortality rates quickly improve to the best in the world upon reaching the age of Medicare eligibility. (Fig.1) This should make us enormously

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Commentary: Against

Nirvana or Trojan Horse?

By George J. Hruza, MD, MBA

An 8-year-old boy with enlarged adenoids that were interfering with his breathing went with his mother to the hospital to have them removed. He was brought to the operating room and assured that he would be given a medicine so that he would sleep, and it would not hurt. Lying down on the operating room table, he said that he is not feeling sleepy. The next thing he remembers was the searing pain of his adenoids being scraped out—without ANY anesthesia.

You might ask, what physician would operate in such a barbaric manner? Well, the boy was me living in Czechoslovakia, the socialist "paradise," with health care for all paid for by the government.

When the government has a monopoly on any part of economic activity, but especially in health care, it results in dramatic market distortions with unintended consequences. The concept of Medicare for All is, on the surface, very attractive: universal health care, reduced administrative hassles and reduced costs of administration. The problem is that these potential gains come at unacceptable costs to society and the individual.

Higher Costs and Rationing of Care

Currently, Medicare has to compete with the private health insurance market for physicians and other providers to participate and see Medicare patients. If competition is removed, there is no limit to what the well-meaning regulators would come up with. As the cost of promising unlimited care to everyone would be unaffordable, there would, inevitably, be drastic reimbursement cuts, mandatory physician participation in this Medicare for All program, no private contracting, and when that does not control costs sufficiently, various forms of rationing (like my no-anesthesia example).

George Hruza, MD

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The biggest casualty would be to the physician-patient relationship. If you don't like prior authorization, just wait, Medicare for All would bring prior authorization on steroids in order to contain ballooning costs.

Examples of these problems are available throughout the world. In the Organization for Economic Cooperation and Development (OECD), costs have recently been rising at a similar rate (2.8% vs. 2.6% 2000–2016 U.S. vs. OECD)[1] to health care costs in the U.S. (albeit starting at a much lower level of GDP), leading to many attempts to contain costs. One is to have bureaucrats deciding who gets access to certain cancer treatments, with resultant higher cancer mortality in the United Kingdom than other OECD countries.[2] Rationing has been tried in Oregon for Medicaid.[3] You only got coverage above the line of a list of conditions and treatments. The government bureaucrats decided what is best for the patient, not the doctor with the patient.

If you don't like prior authorization, just wait, Medicare for All would bring prior authorization on steroids in order to contain ballooning costs.

The vaunted Canadian Medicare for All system also has experienced rapidly increasing costs. Their approach to controlling costs has been through reimbursement freezes for decades and limiting how much work physicians can do in a given year (in some provinces) by capping their billings to the system. This has resulted in huge waits for "elective" procedures such as hip replacement or even getting diagnostic procedures done.[4] Canadians living close to the U.S. border are fortunate as the Canadian government sends patients across the border to have their care rendered in the U.S. Medicare for All in the U.S. would likely shut off that avenue, as the low reimbursement rates that would follow can be expected to result in drastic reduction in hospital capacity in the U.S.

In both Canada and the United Kingdom, the challenge to provide free care, which results in unlimited demand with its associated costs, has led to the development of a two-tier system (edging back toward the U.S. system) by allowing physicians to privately contract with patients, and for patients to get some health care services outside the government monopoly.

continued

Nirvana or Trojan Horse?… *continued from page 19*

Free Enterprise and Innovation

The U.S. drives innovation in medicines and in medical devices as well as novel surgical techniques. The driving force behind such entrepreneurial innovation is rooted in the American free enterprise system. Americans underwrite such innovation for the rest of the world to share in through our higher health care costs. Think about a cure for Hepatitis C, breakthrough melanoma treatment, cyber knife, etc. With a single-payer system and its inevitable price controls and regulations, this innovation would disappear. Government bureaucrats are notoriously bad at picking winners—think the former eastern bloc: USSR, Cuba, North Korea, Venezuela. Innovation by our European allies is mostly driven by the hope to sell their device or medication in the more open U.S. market.

The cost of moving to Medicare for All is projected to be about $34 trillion of additional federal spending during its first decade (Congressional Budget Office projection). As these estimates for other government entitlements have always ended up being far lower than actual costs, I would consider the $34 trillion to be a very conservative estimate. That is a number more than double the projected individual and corporate taxes expected to be collected during that time period. Think about having your taxes doubled or tripled to pay for this program. Is that realistic? And those of us more fortunate would probably see a much higher tax increase to pay for it. Think huge wealth taxes and federal income tax marginal rates in the 90+% range as existed in the 1950s (what prompted Ronald Reagan to go into politics and ultimately become president). It is simply not affordable.

With a single-payer system and its inevitable price controls and regulations, this innovation would disappear.

Currently, on average, Medicare pays hospitals about 53% of what private insurers pay (Congressional Budget Office, April 2017). Imagine hospitals now receiving that amount on all their patients. How many hospitals would be able to stay in business? Many hospitals outside of metropolitan areas are already struggling with margins hovering near zero for many and, even for the most successful ones, they are in the single digits. There would be an inevitable wholesale closure of hospitals and many practices, with loss of access to care for the most vulnerable populations. Consolidation in health care would pick up steam with only massive conglomerates of vertically integrated health care systems surviving. The physician and patient would become a tiny cog in the massive health care-industrial complex. Rationing of one kind or another would inevitably follow.

Congress should repeal the antitrust exemptions, mandate price transparency and ban "rebates," just as physicians are not allowed to get rebates for patient referrals.

Fixing Current Challenges

The U.S. health care system has many challenges: key among them are high costs and limited access to care for some. There must be a better way that harnesses the free market, entrepreneurism and American ingenuity. Drug costs are the fastest rising component of health care costs due to a classic market failure. A lot can be traced back to the government giving group purchasing organizations (GPOs) and later, by derivation, pharmacy benefit mangers (PBMs) antitrust exemption and allowing "rebates" (in layman's terms, kickbacks). For some drugs, like insulin, 80% of the retail price of the drug is used as a rebate that is divvied up between the insurance company and the PBM. Even crazier, the full retail price is counted toward the insurance company's patient care expense, and the rebate goes straight to the bottom line not subject to the 20% limit on administrative costs and profit (mandated by the ACA). Many hospital GPOs operate similarly to PBMs, raising the cost of supplies and equipment.

Congress should repeal the antitrust exemptions, mandate price transparency and ban "rebates," just as physicians are not allowed to get rebates for patient referrals. Access to less costly generics is hampered by various anti-competitive shenanigans by branded drug companies and FDA roadblocks to get generics to market quickly. Recently there has been some legislative action in this area. Reimportation of medications would also help to reduce medication costs.

Hospitals are the most expensive component of health care. They represent another example of market failure. There is a huge differential in the cost of care in the outpatient department of a hospital vs. the physician office. An MRI in a St. Louis-area hospital-affiliated imaging center costs the insurance company about $2,500. Getting it at a free-standing imaging center, the cost is about $500. I recently went to my physical therapist to get my knee worked on. The cost had been $35/visit. When I showed up for my next appointment, there was a new sign on

the door, but everything else was unchanged, including the physical therapist. The charge for the identical visit was now $135. No wonder hospitals have snapped up most imaging centers and other practices in recent years. There should be price transparency and site-of-service price neutrality to put an end to such rent-seeking behavior.

ACOs can save money, if run by physicians. The St. Louis Physician Alliance has been able to save the Medicare system tens of millions of dollars over the last few years, saving money every year of its existence, while none of the hospital-based systems in the area have been able to do so. Letting physicians with their patients make the decisions about care not only provides optimal care, but also can save money.

Insurance companies have been vertically integrating including owning pharmacies, PBMs and physician practices (UnitedHealthcare owns the most physician practices of any organization). In many states, insurers have near monopoly power. Some Blue Cross and Blue Shield plans have more than 80% market share in some states (AMA, 2019 *Competition in Health Insurance*). This is another case of market failure, with monopolistic and oligopolistic behavior following with increasing costs and associated rent-seeking behavior. Effective anti-trust enforcement is lacking and sorely needed. Large insurers should be broken up and vertical integration should not be permitted. (Think of the incredible innovation, improved service and reduced costs the breakup of AT&T unleashed.)

Large integrated hospital systems also raise costs when their market share in a given market gets too large, resulting in excessive leverage with insurers which increases costs. In Massachusetts, the state attorney general has been active in blocking acquisitions and limiting the price differential between what the conglomerates charge and what the community physicians get from insurers. Anti-trust enforcement is needed here as well.

Effective anti-trust enforcement is lacking and sorely needed. Large insurers should be broken up and vertical integration should not be permitted.

Positive Steps

Consumer-driven health care couples price transparency with making sure that patients have some "skin" in the game. That allows patients to become good consumers. Just like we search on the internet for the best price of an item, we should be able to search for the best price, with quality, i.e. value, when purchasing health care. The current administration has made some push for price transparency, but entrenched interests have resisted those efforts every step of the way. Congress should step in and help out.

We should reward patients and physicians for wellness activities and preventive care that improve quality of life and reduce costs. Some insurers and employers are making tentative steps in this direction. A lot more can be done. Outcomes research using the many EHR-linked registries promise to save money and improve care through development of best practices. Unfortunately, there is resistance to sharing data by the largest EHR vendors. The 21st Century Cures Act, passed in 2016, prohibits data-blocking, yet we are still waiting for such anticompetitive behaviors to stop in practice. In dermatology, we were able to change behavior and save money for the system, simply by showing members how they stood on a bell-shaped curve on doing Mohs surgery. In subsequent years, the outliers moved closer to the mean, saving millions of dollars for the system. There are huge opportunities for savings in many specialties by sharing best practices.

Insurance costs can be addressed by allowing competition across state lines, association health plans and government subsidized high-risk pools to make sure that everyone has access to affordable health insurance.

These are just some of the steps, using free-market principles, that we can take to reduce costs, improve access, preserve quality of care and maintain the physician and patient at the center of health care decisions without bringing us into a statist, overregulated government monopoly.[5]

My attorney uncle developed renal failure at age 51 and died from it at age 52, because, in socialist Czechoslovakia, renal dialysis was not available for anyone over age 50. Government bureaucrats should never be permitted to make such decisions on behalf of patients.

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Better Health for All… *continued from page 18*

proud; it's only possible because we have many of the world's best physicians, nurses, pharmacists, hospitals and the rest of the delivery system. We just don't let everyone in until age 65.

Medicare also reverses racial disparities in life expectancy. In Missouri, African-American lives are 3.3 years shorter than those of whites.[4] Nationally, 86% of the causes of these premature deaths are from conditions amenable to medical prevention and treatment.[5] That suggests that part of the life expectancy gap is related to the fact that African-American Missourians are 40% more likely to be uninsured than are white Missourians (14% vs 10%)[6] along with a broadly different mix of insurance products.

We have clear evidence that Medicare coverage reduces and even reverses racial health disparities. For example, every American who needs dialysis can enroll in Medicare regardless of age. Once on dialysis, African-Americans enjoy the same insurance as all other Americans and survive longer than whites on an age-matched cohort.[7]

One argument in favor of our private insurance industry is the proposition that it makes health care more affordable. But private health insurance has shown an unimpressive track record of controlling costs. Over the past decade, the cumulative growth in per-enrollee spending in Medicare has increased 21.5%; the comparable figure for private health insurers is 52.6%,[8] a relative difference of 244%. (Fig. 2)

Medicare has provided American seniors with decades of success, more individual freedom, better health outcomes and greater economic efficiencies. Each of these attributes of Medicare could be available to all of us.

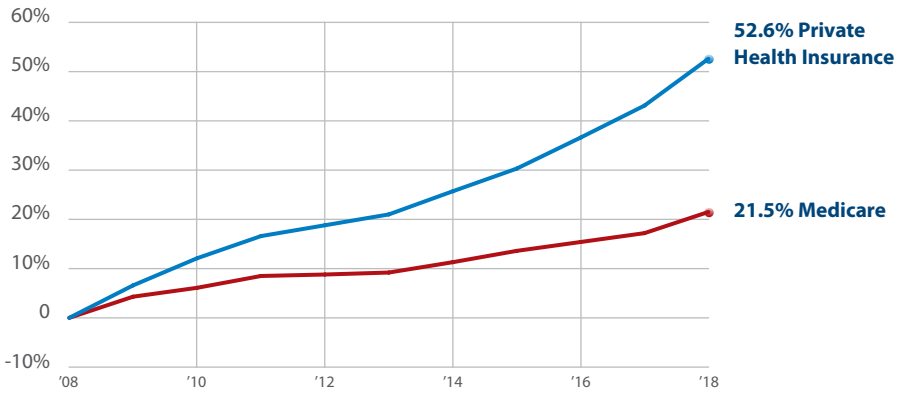
Improved Medicare for All is a public-private partnership without the waste of today's corporate insurance middlemen. Proposed legislation, HR1384 and S1129, would improve the flaws with traditional Medicare and provide that to Americans of every age. With such robust universal insurance, the niche for commercial insurers virtually disappears, simplifying both the patient experience and independent medical practice.

Medicare for All would:

- **Provide first-dollar coverage** of all medically necessary care, funded by an equitable tax model;
- **Include all essential benefits** like dentistry, optometry, audiology, pharmacy and long-term care;
- **Transition hospitals to global budgets** instead of today's complex schemes, reducing their operating overhead and aligning their business interests with the public health imperatives of their communities;
- **Streamline physician reimbursements** with fee-for-service, salary or capitation. Every physician and medical group would be free to select the model they prefer. Rather than having to accept employment in a large system, physicians would find the business of running a practice far less onerous and be more able to retain their independence if that were their preference;
- Adopt **one clinically based formulary** with ready access to evidence-based medical exceptions;
- Include many more features as defined by the Working Group on Single-Payer Program Design.[9]

FIGURE 2

Cumulative growth in per-enrollee spending, 2008-2018



Kaiser Family Foundation data presented at Axios

Medicare has provided American seniors with decades of success, more individual freedom, better health outcomes and greater economic efficiencies. Each of these attributes of Medicare could be available to all of us.

Economic Savings

Despite all of these benefits for patients and physicians, I would not be on board with Medicare for All were I not convinced that it is the most prudent strategy. Hundreds of independent economists,[10] including dozens of the most prestigious,[11] all came to the same conclusion: the U.S. would either break even or, more likely, have considerable economic savings by switching to Medicare for All. These studies do not even account for the indirect benefits, such as savings on workers' comp, improved health or increased productivity.

Perhaps the most telling and quantifiable measure of the impact of single payer on medical practice comes from an analysis of the average number of characters per ambulatory progress note in electronic medical records.

The two strategies that drive the economics of Improved Medicare for All are the same two strategies employed by most successful businesses: structural efficiency and meaningful price negotiations.

Medicare operates with an overhead of 2.3%, as compared to the 12-18% overhead of commercial insurers.[12] Medicare achieves these low levels of overhead because—unlike private insurance companies—it does not need legions of staff for sales, advertising, account management, aggressive utilization management, redundant information systems, eight-figure executive salaries and shareholder profits.

Some critics claim that Medicare for All would hurt physicians and hospitals financially. However, neither Medicare for All bill proposes using the current Medicare fee schedule. Instead, the bills establish a "physician practice review board to assure ... fair reimbursements for physician-delivered items and services."[13] These boards would be regionally representative and also bear responsibility for quality assurance and cost effectiveness.

Three recent studies (Mercatus, 2018; Rand, 2019; and Urban Institute, 2016) projected payments to physicians would remain close to the current $688 billion; their estimates under Medicare for All were $681 billion, $673 billion and $774 billion respectively.

In fact, Medicare for All would provide hospitals with tremendous savings. Today, hospitals in the United States spend 25% of their total budget on administration and billing, more than double what is required at comparable institutions in single-payer nations.[14]

Similar excesses exist in American physician office overhead; U.S. physicians spend two to three times as much as our Canadian colleagues on billing.[15] The overall average Canadian clinical payment per physician in 2018 was $344,978; in family medicine $280,763; psychiatry was $278,069; dermatology was $384,786; ob-gyn was $391,743; ophthalmology was $768,958.[16]

Malpractice insurance costs are far less onerous in Canada. The Canadian Medical Protective Association reports that 2019 malpractice premiums for family medicine in Quebec were $1,583; in British Columbia and Alberta, the rates were $3,420.[17] The 2019 average internal medicine premium in Missouri the same year was $13,425.[18]

Perhaps the most telling and quantifiable measure of the impact of single payer on medical practice comes from an analysis of the average number of characters per ambulatory progress note in electronic medical records. Epic, one of the world's most common EMRs, is implemented differently in every institution around the world. Epic carefully optimizes each unique installation in every institution, optimizing the software to meet the particular needs of the specific setting. In 12 other modern nations, these notes average 1,000 characters. In the United States, the average is 4,000 characters.[19] Here, our charting is structured to optimize reimbursement and protect against malpractice claims. Elsewhere, it is primarily focused on meeting the clinical requirements of a medical record.

When faced with an opportunity to relieve many of the pressures on medical practice, let's ensure that every American can get all medically necessary care, and reduce the economic drain that has taken over our national economy. The imperative to move forward with Medicare for All is clear.

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PARTING SHOTS

I'm Back

By Richard J. Gimpelson, MD

I know that many of you have been wondering, "What happened to Rich Gimpelson?" Well, I'm not dead yet. Actually, I had to take some time off because of family interests and my unexpected surgery. However, now I am back and ready to resume my "Parting Shots."

Unfortunately COVID-19 has put a significant crimp in all of our plans, but for someone like me with no filter in my frontal lobe combined with ADD, I have been able to make the most of this unique period in all of our lives. I will relate some of my thoughts and observations as well as a sacrifice that I made for my family.

Before beginning my column, I want to express my condolences to all who have lost loved ones and friends to COVID-19. My condolences also to families of first responders, physicians, nurses and all other hospital workers, who have died from COVID-19 while working long hours taking care of patients with COVID-19. Thanks to all involved in the care of COVID-19 patients.

Now some of my thoughts and observations:

1. Joe Biden must not have a filter in his frontal lobe, similar to me, but there is a difference between him and me. He is a groper, grabber, and sniffer. I just see life in a humorous manner and speak out or write about it. No groping, grabbing or sniffing by me. Maybe being a gynecologist is what differentiates me from Joe Biden.
2. I was disappointed when hydroxychloroquine was reported to not be very effective as a treatment for COVID-19 infection. However, remdesivir has shown promise. I hope some of the other treatments being studied can give us more promising results. The best hope will be a vaccine.
3. I wear a mask whenever I go somewhere. It probably does not protect me, but it may make others feel safer, and it gets me into stores so I can buy medicine, food, and toilet tissue (more on this later).
4. I get to spend hours bonding with my wife and son. In fact, we bond so much that they have run out of bonds.
5. I have read nearly all of Bill O'Reilly's *Killing* books and several other books that interest me. I am now only donating to political candidates that will send me a signed copy of a book that they wrote.
6. I have begun to enjoy Shirley Temple movies (what a talented singer and dancer). I'm learning to appreciate black and white classic films. I do enjoy watching documentaries showing Hitler's army suffer the same fate as Napoleon's army during the Russian winter. Obviously neither Hitler nor Napoleon played the board game "Risk," thank heavens.

At this point, I will relate the "Tale of the Toilet Tissue," since there is no better place for toilet tissue than in the end. Through the end of April, the shelves in many stores were void of toilet tissue or had a limit on how much could be purchased. My family likes Charmin, which was impossible to find. I bought four rolls of an off-brand tissue in very small rolls as backup to our stock of Charmin. At the beginning of the quarantine and the toilet tissue embargo, I bought a box containing six rolls of Monarch industrial toilet tissue. All three types of tissue are two-ply, all are soft and not sandpaper, but the big difference is in the size of the rolls. There are 168 feet of tissue in each roll of Charmin in a six-roll pack. There is no length given in the off-brand tissue and each roll is packaged individually. The Monarch (an apropos name) has 900 feet per roll in the six-roll pack totaling 5,400 feet. I'm letting my wife and son enjoy the Charmin while I will continue to use the Monarch until it is gone, at which time I hope the quarantine and embargo are over.

My slogan: "I'll wipe a mile in my bathroom for my family."

Since I still do not have a frontal lobe filter, I will return with more relevant information in the next issue of *St. Louis Metropolitan Medicine*.


Dr. Richard J. Gimpelson

Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. He shares his opinions here to stimulate thought and discussion, but these do not necessarily represent the opinion of the Medical Society. Your comments on this column are most welcome and may be sent to editor@slmms.org.

George Hruza, MD, Installed as MSMA President

George J. Hruza, MD

SLMMS past president **George J. Hruza, MD, MBA, FAAD, FACMS**, was installed as 2020-2021 president of the Missouri State Medical Association at their virtual House of Delegates meeting on April 4.

Dr. Hruza is medical director of the Laser and Dermatologic Surgery Center in Chesterfield, and is adjunct professor of dermatology at Saint Louis University. He previously was an associate professor of dermatology, surgery and otolaryngology and director of dermatologic surgery training at Washington University School of Medicine. He has trained 21 Mohs surgery fellows.

Active in SLMMS, Dr. Hruza was president in 2008 and served on the Council from 2002 to 2009. He received the SLMMS President's Award in January 2015 in recognition of his advocacy work in response to insurance companies narrowing their provider networks and terminating many physicians from Medicare Advantage programs.

Dr. Hruza just completed a term as president of the American Academy of Dermatology. He also has served as president of the American Society for Dermatologic Surgery (ASDS) and the American Society for Lasers in Medicine and Surgery (ASLMS). He has authored more than 160 scientific articles and book chapters and four textbooks on laser surgery, and has lectured on dermatologic surgery and laser surgery on five continents.

He earned his medical degree from New York University, where he completed his dermatology residency. He also completed an internal medicine internship at New York Presbyterian Weill Cornell Medical Center, a laser surgery fellowship at Harvard University and a Mohs surgery fellowship at the University of Wisconsin-Madison. His MBA is from Washington University.

Herluf G. Lund, Jr., MD, Elected National President of the Aesthetic Society

Herluf G. Lund, Jr., MD

Herluf G. Lund, Jr., MD, FACS, has been elected president of the Aesthetic Society, an organization dedicated to aesthetic plastic surgery with over 2,600 members worldwide.

A partner in St. Louis Cosmetic Surgery in Chesterfield, Dr. Lund was a SLMMS Council member from 1997-2000, including one year as treasurer (1999) and one year as secretary (2000). A member since 1991, Dr. Lund remains active in SLMMS, serving on several committees and as a Third District Delegate from SLMMS with the Missouri State Medical Association.

The Aesthetic Society works to advance the science, art and safe practice of aesthetic plastic surgery and cosmetic medicine through education, research and innovation.

While COVID-19 has supplanted Dr. Lund's original goals for his presidential year, he said, "My priorities now are to help plastic surgeons and their patients return to delivering and receiving the treatments and services they desire and to do so in an as safe of a manner as possible."

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thank you

To all the **doctors**
nurses ICU staffers
practice managers first responders
infectious disease specialists
intensivists **medical examiners**
geriatricians nurse practitioners
respiratory technicians
ambulance drivers pulmonologists
epidemiologists social workers
life sciences engineers **microbiologists**
vaccine research lab technicians
pharmacists hospital administrators
public health officials **nursing homes**
pathologists hospital housekeepers
microbiology researchers
PPE manufacturers immunologists
medical research scientists paramedics

To the doctors, nurses, and other healthcare professionals battling COVID-19—the employees of ProAssurance and our families are deeply grateful for your leadership, dedication, and sacrifices.

To everyone else—please be safe, wash your hands, and most importantly...

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