

ST. LOUIS METROPOLITAN MEDICINE

VOLUME 43, NUMBER 3

JUNE / JULY 2021

Telemedicine Post-COVID-19

Inside

Telemedicine

- 12 ▶ Post-Pandemic Outlook
- 15 ▶ Local Physicians Utilize Telemedicine
- 16 ▶ State and Federal Regulations Changing

Features

- 8 ▶ Improving Online Reviews
- 10 ▶ Brain-Computer Interface for Stroke Recovery
- 19 ▶ About the ONC Cures Act Final Rule



COVID-19 Vaccine: Now Is the Time

Resources for Physician-Patient Education

Attention physicians: Please encourage your patients to get the COVID-19 vaccine. During the coming weeks, it will be critical to vaccinate as many people as possible—so we can reach that much-desired goal of herd immunity (75-80%) as quickly as we can.

Why get the vaccine?



It's safe.

Over 130 million vaccine doses have been administered in the U.S. to date.



Protect your family.

Avoid infecting family members, especially those with health risks.



Protect yourself.

Don't risk serious illness.



Protect the community.

The sooner most of us get immunized, the sooner that life can return to normal.

Where can I get the vaccine?

Hospital Systems

- BJC HealthCare – <https://www.bjc.org/Coronavirus/Covid-19-Vaccines>
- Mercy – <https://www.mercy.net/forms/vaccinations/>
- SSM Health – <https://webforms.ssmhealth.com/covidvaccine>
- St. Luke's Hospital – <https://lukesvaccine.com/>

Health Departments

- St. Louis County – <https://stlcorona.com/covid19-vaccines/> or 314-615-2660
- City of St. Louis – <http://bit.ly/stl-vacc> or 314-612-5100
- St. Charles County – <http://bit.ly/scc-vacc> or 636-949-1899
- Jefferson County – <https://www.jeffcohealth.org/covid19-vaccine> or 636-797-3737

Pharmacies and Retail

- CVS – <https://www.cvs.com/immunizations/covid-19-vaccine>
- Walmart – <http://bit.ly/wm-vacc>
- Missouri Pharmacy Program (independent pharmacies) – <http://bit.ly/mopharm>
- Walgreens – <https://www.walgreens.com/findcare/vaccination/covid-19>

State of Missouri Vaccination Events

- <https://covidvaccine.mo.gov/navigator/> or 877-435-8411



ST. LOUIS METROPOLITAN
MEDICAL SOCIETY

David M. Nowak, Executive Editor
dnowak@slmms.org

James Braibish, Managing Editor
Braibish Communications
editor@slmms.org

Graphic design by Lisa Troehler Graphic Design, LLC

Publications Committee

Samer W. Cabbabe, MD
Emily D. Doucette, MD
Arthur H. Gale, MD
Richard J. Gimpelson, MD
Erin S. Gardner, MD
Harry L.S. Knopf, MD
Jennifer L. Page, MD
Pearl Serota, MD

St. Louis Metropolitan Medicine (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society, 1023 Executive Parkway, Suite 16, St. Louis, MO 63141; (314) 786-5473, FAX (314) 786-5547. Annual Subscription Rates: Members, \$10 (included in dues); nonmembers, \$45. Single copies: \$10. Periodicals postage paid at St. Louis, MO. POSTMASTER: Send address changes to: St. Louis Metropolitan Medicine; 1023 Executive Parkway, Suite 16, St. Louis, MO 63141. Copyright © 2020 St. Louis Metropolitan Medical Society

Advertising Information: www.slmms.org/magazine, or editor@slmms.org or (314) 786-5473. Online copies of this and past issues are available at www.slmms.org/magazine.

Printed by Messenger Print Group, Saint Louis, MO 63122.



ST. LOUIS METROPOLITAN
MEDICAL SOCIETY

www.slmms.org

Facebook: saint.louis.metropolitan.medical.society

Twitter: STLMedSociety

Officers

Jennifer L. Page, MD, President
Erin S. Gardner, MD, President- Elect
Mark C. Gunby, DO, Vice President
Robert A. Brennan, Jr., MD, Secretary-Treasurer
Jason K. Skyles, MD, Immediate Past President

Councilors

M. Laurin Council, MD
Emily D. Doucette, MD
Kirsten F. Dunn, MD
Luis A. Giuffra, MD
Sara Hawatmeh, MD
Otha Myles, MD
David M. Niebruegge, MD
Mark S. Pelikan, DO
David L. Pohl, MD
Farheen N.K. Raja, MD
Damien L. Ricklis, MD
Richard H. Wieder, MD

Council Medical Student Liaisons

Amrita Bhat, Washington University
Alexis L. Hartman, Saint Louis University

Executive Vice President

David M. Nowak

Telemedicine Post-COVID-19

- 12 Telemedicine's Post-Pandemic Outlook** ➔
*By Todd Zigrang, MBA, MHA, FACHE, CVA, ASA,
and Jessica Bailey-Wheaton, Esq.*



- 15 Telemedicine Finding its Place with Local Physicians**

- 16 State and Federal Telemedicine Regulations:
What's Changed and What Might Remain Post-COVID-19?** ➔
By Sanja Ord, JD



Features

- 8 Member Creates Startup to Improve Online Reviews** ➔

- 10 Stroke-Recovery Device Uses
Brain-Computer Interface** ➔



- 19 ONC Cures Act Final Rule –
One of the Most Significant Advancements Since HIPAA**
By Brandy K. Simpson, JD, and Kelly M. "Koki" Sabatés, JD

Point/Counterpoint

- 22 The Equality Act: "To Follow the Right or to Do Right?" That Is the Question!**
By Frank A. Cornella, DDS, MD
- 23 Rebuttal: Equality Act Would Do Harm**
By Richard J. Gimpelson, MD

Columns

- 2 President: Preserving Patient and Family Communication
During a Pandemic**
By Jennifer L. Page, MD
- 4 Executive Vice President: A Virtual Success**
By David M. Nowak
- 24 Parting Shots: COVID-19**
By Richard J. Gimpelson, MD

News

- 5 Leadership Opportunities with Organized Medicine**
- 6 A Big Year for Health Care in the Missouri Legislature**
- 6 Congratulations Science Fair Winners**

The advertisements, articles, and "Letters" appearing in St. Louis Metropolitan Medicine, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. SLMM reserves the right to make the final decision on all content and advertisements.

Preserving Patient and Family Communication During a Pandemic

Jennifer L. Page, MD, President, St. Louis Metropolitan Medical Society 2021



Jennifer L. Page, MD

For a hospitalized patient, the designated family member becomes an ally in your efforts to improve quality and safety.

The physician-patient relationship is the foundation of clinical care. Physician-patient relationships can have profound positive implications that can improve patients' medical care and health outcomes. For a hospitalized patient, the designated family member becomes an ally in your efforts to improve quality and safety. They contribute by helping patients make informed choices, observe care processes, and report complications. Effective communication improves patient and family satisfaction, trust in physicians, and the psychological well-being of your patient. This all translates into measurable improvements in quality and safety.^{1,2}

But the pandemic strains our ability to provide effective patient and family communication. This is especially challenging for an acute rehab unit, where a primary focus is on training family members about the patient's new impairments and injuries in preparation for the patient's successful return home. Challenging us has been the need to adopt social distancing and self-isolation as ways to stop the spread of COVID-19—and this includes regulating visitors to health care institutions. There is compelling epidemiological reasons for visiting rules: A visitor is a potential disease vector between those with an infection and those without. Just as hospitals closed to visitors, so did the acute rehab unit. This action was vital early on since we knew the elderly and those with chronic medical illness were the most vulnerable. This fear was not unwarranted, as the *JAMA* study revealed that by July 9, 2020, COVID infections in extended care facilities accounted for 10% of all U.S. cases but 44% of U.S. deaths.³

Restriction of hospital visitors during a pandemic is nothing new. At one time,

hospitals imposed strict visitation rules. By the late 1800s, regulating visitors to the sick was considered part of the modern, well-ordered hospital—especially in so-called “isolation hospitals,” which cared for patients with infectious diseases such as scarlet fever, diphtheria, typhus and polio.⁴ In the UK in the early 1900s, there were more than 750 isolation hospitals, catering mainly to children. “Window” viewings were common; children in isolation hospitals could only be seen by parents through glass. Prior to World War II, most children's hospitals limited visits to one to two hours a week. It was the recognition of separation anxiety and changing social views on childcare that helped liberalize visiting hours for children starting in the 1950s.

Fortunately we have come a long way since the early 1900s, and have realized the important role of effective communication with family. In this respect, technological advances have provided new options. Videoconferencing and similar television systems have provided communication for patients who were hospitalized and families who may have been quarantined to reduce the risk of exposure to others and employees. Videoconferencing, which involves the electronic exchange of health information, is protected under HIPAA law. Security considerations with videoconferencing provide some extra challenges. These involve a) making sure unauthorized third parties cannot record or “listen in” on a videoconferencing session; b) making sure recorded videoconferencing sessions are stored and identified in a secure and proper manner; and c) having a procedure for initiating and receiving video calls.

Physicians who provide video communication technology in good faith are allowed to provide telemedicine to patients during the

COVID-19 nationwide public health emergency using any non-public facing remote communication product that was available to communicate with patients. Public-facing video communication applications, such as Facebook Live, Twitch and TikTok, are not allowed.⁵

Videoconferencing and similar television systems have provided communication for patients who were hospitalized and families who may have been quarantined to reduce the risk of exposure to others and employees.



Our hospital used a combination of HIPAA-protected products such as Caregility,⁶ but at times we struggled to reach families with poor internet access. This made it difficult at times to share live training for mobility and adaptive equipment and to address the barriers toward having their loved ones return home sooner.

Broadband access is a public health issue, and one that is being recognized more often as a social determinant of health. It disproportionately affects those who are already vulnerable. Those who are older, are racial/ethnic minorities, have lower incomes, are less educated, or live in rural areas may experience worse health outcomes under normal circumstances and are even less able to access health resources during social-distancing orders.

In fact, over 18 million people in the U.S. live in regions without broadband access, according to the 2020 annual report released April 24 by the Federal Communications Commission. But polls and other studies place the number far higher.⁷ The pandemic has proven how vital internet access is for health care and has forever changed how we utilize these services. Yet 20% of Missourians lack broadband access (which includes access to cellular data via a smartphone or other mobile device).⁸

To address this inequity, the 2021 MSMA House of Delegates in April adopted the resolution from the MSMA Medical Student Section Governing Council for support for universal internet access. This resolution stated that our MSMA supports legislation and policies that reduce barriers and increase access to broadband internet, including federal, state and local funding. It also calls for reducing prices and increasing the number of devices and streams covered per household.⁹

This crisis is our opportunity to rethink our approach to patient and family communication. Preserving patient and family communication during a pandemic is critical, and it is time to bring it into the electronic age. —

Jennifer L. Page, MD, is medical director of the Acute Rehab Program at Mercy Hospital South.

References

1. Coulter A, Ellins J. Effectiveness of strategies for informing, educating, and involving patients *BMJ* 2007; <https://www.bmj.com/content/335/7609/24>
2. Dykes PC, Rozenblum R, Dalal A. The Promoting Respect and Ongoing Safety Through Patient Engagement Communication and Technology Study. *Crit Care Med*. 2017;45(8):e806. <https://www.uptodate.com/contents/communication-in-the-icu-holding-a-family-meeting/abstract/14>
3. Panagiotou O, Kosar C, White E, et al. Risk Factors Associated With All-Cause 30-Day Mortality in Nursing Home Residents With COVID-19. *JAMA Internal Medicine*. Jan. 4, 2021. 2021;181(4):439-448. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2774729>
4. Mooney G, Reinartz J. Hospital visiting in epidemics: an old debate reopened. *History & Policy*. April 9, 2020. <https://www.historyandpolicy.org/opinion-articles/articles/hospital-visiting-in-epidemics-an-old-debate-reopened>
5. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. HHS website. <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
6. Caregility website. <https://caregility.com>
7. Barna M. Access to internet crucial during COVID-19 outbreak: Broadband connection considered social determinant of health. *Nation's Health*. American Public Health Assn. <https://www.thenationshealth.org/content/50/7/5.2>
8. Missouri Wireless and Broadband Speed Coverage 2019. <https://ded.mo.gov/sites/default/files/MO%20Broadband%20Coverage%20FCC%20Dec%202019.pdf>
9. 163rd (2021) House of Delegates Resolution Actions & Decisions. <https://www.msma.org/resolution-actions.html>

Renovation at Becker Medical Library

A major renovation of the Bernard Becker Medical Library at Washington University School of Medicine has been completed. Visitors are greeted by a new look for the ground floor entry lobby featuring full-height glass windows and doors complementing the existing brick walls and granite flooring. Departments on the second through sixth floors were relocated and spaces were rebuilt; three floors of books were moved. The renovation also included a refresh of the seventh-floor meeting rooms and a state-of-the-art recording studio on the lower level. The SLMMS rare book collection is stored at the Becker Library. —



A Virtual Success

By David M. Nowak, Medical Society Executive Vice President



David M. Nowak

They turned lemons into lemonade by organizing a highly successful and well-attended virtual 163rd annual meeting,

“When life gives you lemons, make lemonade” is a proverbial phrase used to encourage optimism and a positive can-do attitude in the face of adversity or misfortune. Lemons suggest sourness or difficulty in life; making lemonade is turning them into something positive or desirable.¹

Kudos to our colleagues at the Missouri State Medical Association (MSMA) who did just that April 10-17. Faced with a second consecutive year of canceling their in-person annual convention due to the COVID-19 pandemic, they turned lemons into lemonade by organizing a highly successful and well-attended virtual 163rd annual meeting, conducting CME programs, reference committees, and two sessions of the House of Delegates via Zoom. The business affairs of the state association and all necessary actions and decisions came off without a hitch. Congratulations to Jeff Howell, Benita Stennis, Liz Fleenor and the entire MSMA team for a job well done.

The convention attracted more than 200 attendees via Zoom. I was pleased to see a strong showing of SLMMS members who participated in the virtual sessions throughout the week.

The convention was “book-ended” by the two sessions of the House of Delegates, who met on Saturday, April 10 for session one, and closed the convention with session two on Saturday, April 17. This year, the House of Delegates discussed and debated no less than 20 resolutions brought forward by individual members and medical societies from across the state, including three that were sponsored by the District 3 (St. Louis) delegation, which are summarized as follows:

Cardiac Disease Terminology, authored by Gary Gaddis, MD, PhD, was referred by the House of Delegates to the MSMA Council for further study. This resolution asked that MSMA advocate to the American Medical

Association (AMA) that physicians should adopt the term “Cardiac Insufficiency” (CI) or “Heart Insufficiency” (HI) rather than “Congestive Heart Failure” (CHF) or “Heart Failure” (HF) when discussing this disease with members of medical care teams and with patients. It further resolved that MSMA advocate to the AMA that physicians should adopt the terms “Cardiac Insufficiency with Preserved Ejection Fraction” (or “CIPEF”) or “Heart Insufficiency with Preserved Ejection Fraction” (or “HIPEF”); and “Cardiac Insufficiency with Reduced Ejection Fraction” (or “CIREF”) or “Heart Insufficiency with Reduced Ejection Fraction” (or “HIREF”) to delineate the two major sub-classifications of this disease. In conclusion, the resolution asked MSMA to advocate to the AMA that, pending adoption of this resolution by the AMA House of Delegates, the AMA will advocate to the American College of Cardiology (ACC) and to the American Heart Association to implement these nomenclature changes within their literature and other communications, toward a more accurate characterization of these disease states.

Given the far-reaching implications of Dr. Gaddis’ resolution, it was referred to the MSMA Council for more in-depth review. Dr. Gaddis testified that the idea for his resolution lies in the history of medical terminology in America. He pointed out that the initial term for magnetic resonance imaging (MRI) was nuclear magnetic resonance (NMR), but that the term nuclear was dropped as it had significant negative connotations to the public in the years following the Three Mile Island incident.

Support for No-Excuse Vote by Mail, introduced by the MSMA Medical Student Section Governing Council and SLMMS, asked that the MSMA support policies like no-excuse voting by mail that facilitate equitable access to voting, especially for physicians and other health care professionals who face barriers to in-person voting; it

further resolved that MSMA encourage safe voting practices, including but not limited to expanded early voting and no-excuse voting-by-mail, that align with public health guidelines during times of public health concern.

This resolution, authored by medical students, emerged from the modifications made to voting in the 2020 election due to the COVID-19 pandemic. As one might imagine, because of the political sensitivity of the topic, it resulted in a fair amount of discussion among delegates. Due to the potential to become a divisive political issue, the resolution was ultimately referred to the MSMA Council for further study.

Mental Health Services for Medical Students, also introduced by the MSMA Medical Student Section Governing Council and SLMMS, asked MSMA to work to publicize and promote the mental health services available to medical students through the Missouri Physicians Health Program (MPHP); to encourage medical schools to continue to access and reduce barriers to accessing mental health services among their own student populations; and that MSMA encourage medical schools to provide opt-out preventive and acute mental health services that are easily accessible, free and confidential for all their students.

Due to compelling testimony regarding the need for improved mental health services for medical students, this resolution faced little opposition and was adopted by the House of Delegates.

The 17 other resolutions introduced this year during the convention covered a range of topics including independent review of Medicare Advantage plans; unambiguous language by insurers; insurance coverage regarding fertility; elimination of the seasonal time change; assistant physicians; encouraging third-party opioid litigation; and HPV vaccine insurance coverage. Of the 20 total resolutions presented, nine were adopted, one not adopted and ten referred to the MSMA Council. A complete review of all resolutions, including actions and decisions, can be found at <https://www.msma.org/resolution-actions>.

During this year's virtual convention, SLMMS member and past president George Hruza, MD, completed his term as MSMA president. He was succeeded by Alexander Hover, MD, a gastroenterologist from Springfield. Other SLMMS members elected to statewide leadership roles included Elie Azrak, MD, MSMA treasurer, and David Pohl, MD, Council vice-chair. Robert Brennan, Jr., MD, and Inderjit Singh, MD, were re-elected to the MSMA Council representing District 3. Congratulations to these physicians and thank you for sharing your gifts of leadership to advance the medical profession. ➡

Reference

1. "When life gives you lemons". *Theidioms.com*. The Idioms. Referenced 5-18-2021.

Leadership Opportunities with Organized Medicine

The St. Louis Metropolitan Medical Society invites any prospective leaders within the membership to submit their names if interested in serving in a volunteer leadership role within the organization.

The SLMMS Nominating Committee will meet later this summer to consider candidates for terms beginning in 2022. 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. SLMMS Council members also serve as trustees for the St. Louis Society for Medical and Scientific Education, our charitable foundation.

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. The SLMMS Council and all committees have been meeting virtually for more than a year, and we expect that to continue in some capacity post-pandemic.

You are encouraged to 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 for 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 Tuesday, July 6. 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 2022 slate of officers and councilors at a General Society meeting on Wednesday, September 1, at 6:00 p.m. This meeting is open to all members.

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. ➡

A Big Year for Health Care in the Missouri Legislature

A number of pieces of legislation supported by physicians passed in this year's session of the Missouri Legislature, while many opposed by physicians were defeated. The results of the 2021 legislature were summarized by the Missouri State Medical Association in a May 16 Zoom call with physicians from across the state. Presenting the call were Heidi Geisbuhler Sutherland, director of government relations, and Shantel Dooling, director of legislative affairs.

Legislation Passed

Prescription Drug Monitoring Program (PDMP). After 18 years of advocacy efforts, Missouri is set to finally join the 49 other states with PDMPs. The program approved is modeled after the St. Louis County PDMP, which has been used by many jurisdictions across the state since 2018.

COVID-19 Liability. Protects physicians and other non-physician health care providers from liability for medical services provided during the pandemic.

County Health Department Orders. Local public health agencies are permitted to institute public health orders of more than 30 days in length only once every 180 days; otherwise the orders must be approved by the local governing body. While MSMA opposed this legislation, it was successful in scaling back from the original proposals which were much more severe.

Vaccine Passport Restrictions. Jurisdictions in Missouri cannot require "vaccine passports" for entry into public transportation or public accommodations.

HIV Prevention. Allows pharmacists to dispense pre- and post-exposure medication for HIV prevention without a prescription to broaden access.

Legislation Defeated

Medicaid Expansion. The legislature passed a state budget blocking funding for the state's portion of Medicaid expansion costs. A lawsuit was filed in Cole County Circuit Court on May 20 by Medicaid expansion advocates demanding that the state uphold the constitutional amendment passed in August 2020. MSMA and SLMMS support expansion.

Assistant Physicians. The proposal would have allowed practicing as an assistant physician to be an alternative path to medical licensure. MSMA opposed this because it would bypass traditional medical residency.

Scope of Practice. Defeated were various attempts by nurse practitioners and nurse anesthetists to act with less physician supervision, for physical therapists to be accessed without a prescription, and for pharmacists and dentists to give types of vaccines.

Loosening of Childhood Immunization Requirements. Would have exempted private schools from state childhood immunization requirements and added "conscientious belief" to current religious and medical exemptions.

For more information on MSMA advocacy efforts, visit www.msma.org. —

Congratulations Science Fair Winners 2021

Congratulations to the following high school and middle school students who earned top honors in the Health and Medicine category of the 2021 Greater St. Louis Science Fair, which was held virtually this year. Each received a scholarship from the Medical Society's charitable arm, the St. Louis Society for Medical and Scientific Education. Thanks to the SLMMS member volunteer judges, Ali Etemady-Deylami, MD; and William Fogarty, Jr., MD.

Grade 7 – Rohan Dixit Brentwood Middle School

Using old shirts in the battle against COVID-19!



Grade 8 – Ric Jain Mary Institute and Saint Louis Country Day School

Study of Achilles Tendon Exercises, and the Effect of Time Taken on Achilles Tendon Flexibility

Grade 11 – Oviya Srihari Ladue Horton Watkins High School

Predictors of health service utilization rates among patients with eating disorders: a meta-analysis

Grade 11 – Lawrence Liu Marquette High School

*Overfitting Reduction
Strategies in Deep Learning
for Medical Image Analysis*



"I am overjoyed for the recognition. The award ... gives me confidence that continuing to pursue science and medicine is the right decision. Helping others has always been my devotion, and I am grateful for the support you have given me." – Lawrence Liu



When it's time to retire, will you have what you need to enjoy it?

Our team of financial professionals can help you understand your trajectory.



TRIAD *financial group, LLC*

Richard C. Fitzer, CPM[®], Wealth Manager
Triad Financial Group

☎ 314.503.6012

✉ rcfitzer@triadfinancialgroup.net

🌐 triadfinancialgroup.net

📍 425 N. New Ballas Rd – Suite 205
Creve Coeur, MO 63141

SLMMS Member Creates Startup to Improve Online Physician Reviews

By Sonia Coleman

Online reviews are a point of contention and concern among physicians.



Dr. Ian Dorward

As a practicing neurosurgeon at Washington University Physicians, Ian Dorward, MD, recognized the need for a better online review system.

“More than 90% of patients use online reviews to evaluate physicians, yet the mainstream online review platforms lack validation and detail,”¹ said Dr. Dorward.

The result was the creation of Lucid Ratings, an online rating and review platform designed to solve the problem of fake and fraudulent reviews of health care providers.



We're creating a mechanism for communication, which can result in better care and patient satisfaction.

Reputation Challenge

“The fact that reviews are easily faked is a real problem,” said Dr. Dorward. “And when someone has a bad experience, they can torpedo a doctor’s reputation—even if the situation had nothing to do with the patient care provided,” he said.

To the chagrin of physicians, this lack of review validation results in a negativity bias, fraudulent reviews and vague complaints—which are often about front office functions rather than patient care.

Furthermore, most physicians’ hands are tied when it comes to responding to negative reviews, due to privacy laws (HIPAA). This can further impact a physician’s reputation and compensation, which contributes to frustration about reviews in the medical community.

Blockchain-Backed Verification

Lucid Ratings started when Dr. Dorward took a deep dive into blockchain and cryptocurrency a few years ago.

“I realized that there was a way to leverage blockchain technology to develop an automatic verification system for reviews,” he said.

With Lucid Ratings, reviewers’ identities will be anonymized publicly but will be verified within the system.

By using a blockchain system, there’s a record that shows the reviews are legitimate and unchanged, Dr. Dorward explained.

“Unlike Google Reviews, patients’ privacy is preserved; by using a pseudonym they can review without revealing their sensitive health history,” he said. “This also provides a better opportunity for doctors to respond and engage with patients.”

Improving Patient Communication

Dr. Dorward points out that improving online reviews involves better communication.

“We’ve built this review platform with the doctor’s perspective in mind. We’re creating a mechanism for communication, which can result in better care and patient satisfaction,” he said.

In addition to reviews, Lucid Ratings also enables patients to relay their concerns to their physician privately; this gives the physician the opportunity to interact and intervene in the situation. Not only can this diffuse challenging situations, it also helps both the patient and the physician.

“Most doctors want to get more ratings. We want to help the doctor’s office become more involved in bringing patients into the fold and soliciting feedback,” Dr. Dorward said.

Dr. Dorward hopes Lucid Ratings will help improve transparency for physicians on the internet.



Coming to St. Louis This Summer

Scheduled to launch this summer in St. Louis, Lucid Ratings will also provide a dashboard and analytics. The startup is free for physicians and other clinicians to join the platform and receive and respond to reviews.

Once the product is available, Dr. Dorward recommends that physicians download the Lucid Ratings app, update their profiles and start giving out their unique code to patients to get reviews. Information about the app currently is available at <https://www.lucidratings.net>.

Lucid Ratings will also have a premium subscription that includes an enhanced profile, other marketing opportunities, and tools to manage patient engagement and online reputation.

As launch nears, Dr. Dorward described his current focus. “We’re in the process of fundraising. It’s an exciting time after spending the past year and a half building the platform.”

Dr. Dorward hopes Lucid Ratings will help improve transparency for physicians on the internet.

“Rather than avoiding online reviews, let’s create a better system that lets everyone—patients and physicians—have a clearer understanding of what’s going on. More transparency is better,” he said. —

Reference

1. How Patients Use Online Reviews. *Software Advice*. April 3, 2020. <https://www.softwareadvice.com/resources/how-patients-use-online-reviews/>

Tips for Managing Online Reviews

What can physicians do to improve their online reputations? Here are suggestions from Ian Dorward, MD, founder of Lucid Ratings.

- Be aware of where you’re being rated and what’s going on with those ratings.
- Reach out to patients who give negative reviews. See if they have any additional issues that need to be addressed. Sometimes a simple conversation can resolve the problem, and the patient will take down the negative review.
- Respond with concern, not defensiveness. With a negative review, you feel attacked. But you’re not fighting back; you’re opening the conversation.
- Keep in mind that when you respond, it’s more for the next patient. You’re showing future patients how you deal with conflicts. When you demonstrate maturity and grace, it can help your reputation.
- A recent study found that spending as little as 10 minutes a week cultivating your online presence and addressing feedback publicly reduces the impact of negative reviews by up to 70%.¹

PICKING UP THE PHONE COULD COST YOU YOUR MOST VALUABLE ASSET: Your license.

First Step: Seek counsel before you call back. The Health Care Advisory Team at Lashly & Baer helps doctors and other medical professionals with all types of regulatory matters and agency investigations.

LASHLY & BAER, P.C.
ATTORNEYS AT LAW



Offices in St. Louis, MO and Belleville, IL
PHONE: 314.621.2939 or 618.233.5587
www.lashlybaer.com

DON'T FEEL SCARED OR BE INTIMIDATED - WE ARE HERE TO HELP

The choice of a lawyer is an important decision and should not be based solely upon advertisements.

Stroke-Recovery Device Using Brain-Computer Interface Receives FDA Market Authorization

SLMMS member spearheads technology

A first-of-its kind device that helps people disabled by stroke regain significant control over their arm and hand function by using their minds has received market authorization from the Food and Drug Administration (FDA). The technology behind the device was spearheaded by SLMMS member Eric Leuthardt, MD, professor of neurosurgery at Washington University School of Medicine.

The IpsiHand Upper Extremity Rehabilitation System leverages brain-computer interface (BCI) technology licensed from the university. The device was developed by Neurolutions Inc., a Washington University startup company.

The IpsiHand system includes a wearable robotic exoskeleton that fits over a patient's hand and wrist and assists with opening and closing the hand based on the patient's thoughts. By mentally controlling the IpsiHand exoskeleton with the aid of BCI technology, patients may improve their upper extremity motor function, giving them more purposeful and effective movement of the affected hand, wrist and arm. Designed for use in the home or clinic, the IpsiHand system may assist stroke patients in recovering critical abilities such as feeding themselves, grasping objects and performing other everyday tasks. It is the first stroke-rehabilitation device that relies on a brain-computer interface.

"Generally, any motor impairments experienced by a patient six months after a stroke have been considered permanent," said Dr. Leuthardt. "What we've found with this device is that many patients can get a meaningful improvement in recovery of upper extremity movement when we wouldn't expect them to get any. That's not really true for any of the current therapies for stroke aimed at restoring function after the initial recovery period. One of the key elements that made it a breakthrough was the innovative use of a brain-computer interface. It's also what gets us incredibly excited to be able to create a novel solution that may help millions of stroke patients."

In clinical trials, stroke patients who wore the device and engaged in the therapy for approximately five days a week for 12 weeks showed statistically significant improvement in motor control. A patient learning to use the device is displayed in one of the episodes of *Brainworks*, the public television program that Dr. Leuthardt co-costs with Albert Kim, MD, PhD, also of the Department of Neurosurgery.

More than 12 years ago, Dr. Leuthardt began studying the neurobiology that would lead to development of the IpsiHand.



Eric Leuthardt, MD, models a device that helps people disabled by stroke regain significant control over their arm and hand function by using their minds.

(Screenshot from Washington University School of Medicine video)

In clinical trials, stroke patients who wore the device and engaged in the therapy for approximately five days a week for 12 weeks showed statistically significant improvement in motor control.

In general, areas of the brain that control movement are on the opposite side of the body from the limbs they control. However, it was discovered by Dr. Leuthardt and his lab that brain signals for motor intentions could be found on the side of the brain that was on the same side of the body. These are referred to as ipsilateral brain signals.

If the signal of intention to move could be detected from the uninjured left side of the brain and translated into movement of the left hand with the aid of a brain-computer interface, stroke patients might be able to better recover control of the arm and hand by enhancing motor learning. That is the goal of IpsiHand.

Dr. Leuthardt also is a professor of neuroscience, of biomedical engineering, and of mechanical engineering and applied science, as well as section chief of the Division of Neurotechnology in the Department of Neurosurgery. He cofounded Neurolutions in 2007 with Daniel Moran, PhD, a professor of biomedical engineering at the university's McKelvey School of Engineering, to further develop the technology.

“It is exciting to say that this is the first FDA-approved brain-computer interface for rehabilitation. ... With this, we’ve shown that BCI is finally ready for prime time.”



Besides market authorization, IpsiHand has received Breakthrough Device Designation, an FDA program to promote the development of innovative and effective solutions to critical, unmet health needs. The FDA also gave it De Novo authorization, indicating that there is no similar, or substantially equivalent, medical device on the market today.

“It is exciting to say that this is the first FDA-approved brain-computer interface for rehabilitation,” Dr. Leuthardt said. “People have been trying for a long time to convert BCI

from an experimental technology into something that will truly help patients. With this, we’ve shown that BCI is finally ready for prime time. I sincerely hope there are many more such devices to follow.” —

The above is adapted from an article on the Washington University School of Medicine website by Tamara Bhandari.



ALWAYS WANTED TO GET A **PILOT'S LICENSE**

but have never had the time? I supply one-on-one private ground school at your home or office. Do the written first. www.privategroundschool.com.



Student Loan Advisory Services for Physicians and Dentists

We understand managing complex student loan plans on your own gets frustrating — that's why we're here to help you find the right strategy to meet your goals.

Connect with one of our certified student loan professionals to guide you to a solution in managing your student loan debt.

Schedule your complimentary consultation at
commercebank.com/StudentLoanAdvisoryServices

**Commerce Bank**
Member FDIC
Challenge Accepted.

Telemedicine's Post-Pandemic Outlook

How will patient acceptance of telemedicine/telehealth balance against logistical and regulatory hurdles?

By Todd Zigrang, MBA, MHA, FACHE, CVA, ASA and Jessica Bailey-Wheaton, Esq.

Telemedicine has rapidly advanced over the past couple of decades. These virtual services have the potential to allow greater access to and quality of care, while also resulting in significant cost savings. However, the technology also has numerous challenges, such as infrastructure gaps, capital requirements and knowledge barriers among patients. The utilization of this technology significantly accelerated during the COVID-19 pandemic—made possible by a number of regulatory relaxations and changes. The popularity of this service line over the past year has spurred conversation regarding the place of telemedicine/telehealth in the health care industry at the conclusion of the COVID-19 public health emergency (PHE). To clarify terminology, "telemedicine" refers specifically to remote clinical services, while "telehealth" refers to a broader range of remote clinical and non-clinical services.

Review of Telemedicine Expansions & Relaxations

In response to the COVID-19 pandemic, federal and state governments enacted an array of regulatory waivers, relaxations and expansions related to telemedicine. This was done in an effort to help medical practices whose revenue was decimated as a result of canceled in-person office visits, as well as provide backup to hospital providers who were overwhelmed by the virus. It also gave patients an alternative to in-person medical treatment without the risk of infecting themselves or others. Some of those regulatory actions include:

1. The \$8.3 billion Coronavirus Preparedness and Response Supplemental Appropriations Act that was enacted in March 2020 gave authority to the Secretary of Health and Human Services (HHS) to lift some telehealth delivery restrictions,

such as the "originating site" requirements for telehealth services.¹

2. The \$2 trillion Coronavirus Aid, Relief and Economic Security (CARES) Act—passed in March 2020—included a number of additional provisions related to telehealth services such as:
 - Allocating \$200 million to the Federal Communications Commission (FCC) for telehealth development support;
 - Waiving the requirement that a physician must have treated a patient within the last three years to receive payment for telehealth;
 - Allowing hospice care to be recertified via telehealth; and,
 - Expanding eligibility for home dialysis patients to receive telehealth.²
3. Centers of Medicare & Medicaid Services (CMS) Guidance—CMS issued new rules and waived other rules, effective through the end of the PHE, which:
 - Allow beneficiaries to receive care wherever they were located, including in their home;
 - Allow physicians to treat patients (both new and established) outside of the state in which they are licensed;
 - Expand the types of providers that can conduct telemedicine visits to include physical therapists, occupational therapists and speech language pathologists;
 - Expand telemedicine reimbursement coverage to 135 new services, including emergency department visits;
 - Establish a pay parity rule for telemedicine visits, so they are reimbursed at the same rate as in-person visits; and,
 - Extend coverage to over 80 additional services, including emergency department visits, initial visits, discharges from nursing facilities and home visits.^{3,4}
4. Drug Enforcement Agency (DEA) guidance – Allows physicians to prescribe controlled substances via telemedicine, without an in-person examination.⁵



Todd A. Zigrang



Jessica Bailey-Wheaton

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices and other health

care enterprises. Jessica Bailey-Wheaton, Esq., is vice president and general counsel. They can be reached at 314-994-7641. Their website is <https://www.healthcapital.com>.

5. State waivers – 41 states enacted waivers for out-of-state physicians, preexisting relationships and audio-only requirements.⁶
6. August 3, 2020 executive order – Allows some of the 135 telehealth services that were originally waived on a temporary basis to be permanently delivered via telemedicine technology going forward.⁷
7. The 2021 Medicare Physician Fee Schedule (MPFS) final rule – Added numerous telemedicine procedure codes, either permanently or temporarily, to those currently covered by Medicare.⁸



While patients were relatively apathetic toward telemedicine prior to the COVID-19, exposure to the technology has largely changed their minds.

Post-Pandemic Interest in Telemedicine

Over the past year, a multitude of studies has been conducted related to the utilization, efficiency and quality of telemedicine. Analyses suggest that telehealth could be further expanded in the coming years, with anywhere from \$106 billion up to \$250 billion of current U.S. health care spending that could be “virtualized” (up from \$29 billion in 2020).^{9,10} This is in part due to the popularity that telemedicine has achieved among patients, providers and payers, although to differing degrees. The interest of each of these stakeholders in continuing the level of telemedicine services currently in place—as well as the federal government’s appetite for extending or even expanding the coverage of and payment for telemedicine—will significantly drive the future outlook for these services.

Patient Interest. While patients were relatively apathetic toward telemedicine prior to the COVID-19, exposure to the technology has largely changed their minds. Approximately 61% of patients have accessed telehealth services as of March 2021 (compared to only 11% in 2019);¹¹ importantly, 74% of those who utilized telehealth reported high satisfaction.¹² Going forward, nearly 88% of survey respondents want to continue using telehealth for non-urgent consultations post-pandemic.^{9,13}

Despite these assertions, the number of telemedicine visits dropped precipitously in the latter part of 2020 as patients felt comfortable enough to return to in-office visits.¹⁴ In particular, telemedicine usage among privately insured individuals fell approximately 18.6% and 15% in January and February 2021, respectively.¹⁵ Further, future reforms will still likely rescind the current waiver allowing telemedicine visits via FaceTime, Zoom and other non-HIPAA-compliant platforms, which may make virtual care less convenient for patients, further deteriorating their asserted interest.¹⁴

Provider Interest. Similar to patients, providers’ interest in telemedicine has also increased, with a study reporting that 54% of providers view telemedicine more favorably, and 64% are more comfortable using it than before COVID-19.¹² However, the extra work required of non-physician providers to serve patients via telehealth, and the impending requirement that telehealth services be performed on a HIPAA-compliant platform, may erode that desire to continue providing telehealth services. A recent analysis of nursing activities performed for type 2 diabetes and hypertension patients found that nurses performed approximately twice as many activities with telehealth patients compared to in-person patients.¹⁶ This additional work could result in additional nurse burnout, accelerating staffing shortages.¹⁷ Further, as any future reforms will still require the use of HIPAA-compliant platforms,¹⁴ requiring providers to come up with the capital necessary to purchase a telemedicine-specific platform may serve as an unscalable barrier, especially for smaller practices.

These required resources to operate telemedicine services going forward may be moderated by recent research indicating that practices utilizing telemedicine may secure more downstream (i.e., follow-up) care. An analysis of privately insured patients between 2016 and 2019 found that those who used telemedicine for upper respiratory infections were more likely to attend an in-person visit within seven days (10%) than those who sought in-person care (5.9%).¹⁸ Researchers did not quantify the value of the follow-up care, but they did note that the telemedicine cohort had fewer emergency department visits (0.5% versus 0.6%) and more subsequent office, urgent care and telemedicine visits.



Future reforms will still likely rescind the current waiver allowing telemedicine visits via FaceTime, Zoom and other non-HIPAA-compliant platforms, which may make virtual care less convenient for patients, further deteriorating their asserted interest.¹⁴

Payer Interest. Private Payers. Prior to the COVID-19 pandemic, most private payers offered some level of telemedicine coverage. Due to the federal government’s outsized presence in the health care marketplace, most private payers tend to follow Medicare’s lead on reimbursement. So when Medicare expanded telemedicine beginning in March 2020, most private payers did the same. However, private payers have largely already ended their temporary telemedicine expansion policies.¹⁹

Continued on next page

Post-Pandemic Outlook ... *continued*

Additionally, while private insurers remain interested in telemedicine, their alignment focus has largely been with telemedicine companies and not providers. Therefore, private reimbursement for telemedicine services may not be a windfall for practices, as payers may direct patients to their own platform that utilizes health plan-employed providers.¹⁴

Public Payers. CMS in particular has indicated its interest in maintaining some of the telemedicine expansions and relaxations it put in place during the PHE. For example, the 2021 MPFS permanently added over 60 services to the Medicare telemedicine list.⁸ Additionally, CMS announced in December 2020 that it was commissioning a study of the telehealth flexibilities it has provided during the COVID-19 pandemic, which “will explore new opportunities for services where telehealth and virtual care supervision and remote monitoring can be used to more efficiently bring care to patients and to enhance program integrity,”⁸ indicating the agency’s belief that telehealth will endure past the end of the pandemic.²⁰



While private insurers remain interested in telemedicine, their alignment focus has largely been with telemedicine companies and not providers.

However, as CMS has pointed out, “Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home.”⁸ Therefore, congressional intervention may be required for more fundamental changes to telehealth coverage.

Congressional Interest. Congress has also indicated some willingness to expand telehealth coverage over the past year in a slew of proposed (largely bipartisan) legislation. To date, the Alliance for Connected Care has identified 19 telehealth-related bills,²¹ the most notable of which are summarized below:

- (1) *Telehealth Modernization Act* (Senate Bill) – Would allow rural health clinics and federally qualified health centers to serve as the distant site; a beneficiary’s home to serve as the originating site for all services (other than for only certain services); and all types of practitioners to furnish telehealth services.²²

- (2) *Protecting Access to Post-COVID-19 Telehealth Act* (House Bill) – Would eliminate most geographic and originating site restrictions on Medicare coverage and include the patient’s home as an eligible distant site;^{23,24} and,
- (3) *The Expanded Telehealth Access Act* (House Bill) – Would permanently expand Medicare-covered telehealth services for physical therapists, occupational therapists, audiologists and speech and language pathologists.²⁵

Despite this activity, lawmakers have expressed concerns related to telehealth expansion, including whether it may lead to overutilization of health care services, result in health care fraud and abuse, or intensify current disparities in health care.²⁶ Some industry commentators believe that specific areas of telehealth, where physical examinations are not needed (such as behavioral health and chronic care management), may be an easier sell.¹⁴

Conclusion

Telemedicine/telehealth technology has undoubtedly been one of the few beneficiaries of the COVID-19 pandemic. The significant number of actions taken over the past year to relax regulatory and reimbursement restrictions has resulted in a windfall of demand for telehealth providers, and may be unfeasible to reverse at the conclusion of the pandemic, as patients and providers become more comfortable with the new technology. As has been seen time and again in health care, once industry stakeholders get used to a new benefit or technology, it is extremely difficult to take it away. —

References

1. “Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020” Pub. L. No. 116-123, 134 Stat. 146 (March 6, 2020). Previously, the patient receiving the telemedicine services had to be located at a healthcare facility in a county outside of a Metropolitan Statistical Area (MSA); or, a rural Health Professional Shortage Area (HPSA) located in a rural census tract.
2. “Coronavirus Aid, Relief, and Economic Security Act” Pub. L. No. 116-136, 134 Stat. 281 (March 27, 2020).
3. “COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers” Centers for Medicare & Medicaid Services, April 8, 2021, <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf> (Accessed 5/6/21).
4. “Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge” Centers for Medicare & Medicaid Services, March 30, 2020, <https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient> (Accessed 5/6/21).
5. “COVID-19 Information Page” U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, <https://www.deadiversion.usdoj.gov/coronavirus.html> (Accessed 5/6/21).
6. “U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19” Federation of State Medical Boards, March 31, 2021, <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf> (Accessed 5/6/21).

References continued on page 21

Telemedicine Finding its Place with Local Physicians

A year after physicians resorted to telemedicine to continue patient care during COVID-19 closures, the next phase of telemedicine at St. Louis-area medical practices is beginning to take shape.

Both BJC Medical Group and Mercy Clinic report that about 10% of their visits continue to be via telemedicine today. This includes 15% in adult primary care.

“I think telemedicine is here to stay,” said Michele Thomas, MD, FAAFP, chief medical information officer for BJC Medical Group. “We’re still figuring out the best places to use these virtual tools, where they make the most sense. Visits where the patient talks with the physician rather than receives an examination lend themselves better to telemedicine.”

For Mercy Clinic, specialties with the highest virtual visit rates include gastroenterology, cardiology and neurology, according to Jeffrey Ciaramita, MD, Mercy Clinic St. Louis president. “Conversely, dermatology, oncology and skilled nursing facility visits have remained in the clinic office setting, as well as surgical specialty and ob-gyn visits,” he said.

Impact in Behavioral Health

The continued use of telemedicine is highest in behavioral health. BJC reports that 84% of its behavioral health visits remain virtual; at Mercy the rate is 68%. Dr. Thomas noted that virtual visits have contributed to a significant drop in missed appointments for behavioral health providers.

Psychiatrist Luis Giuffra, MD, sees telemedicine as widely accepted in behavioral health. “Virtual is rapidly becoming the most common way of delivering psychiatric care. The vast majority of patients enjoy the convenience of seeing their clinicians in the comfort of their homes or offices, saving themselves the time they used to spend going to the doctor’s office. It allows rural clinics, nursing homes, prisons, emergency

rooms and even inpatient psychiatric units to have easy and reliable access to psychiatrists.”

Dr. Giuffra pointed out that several clinical studies have shown that telepsychiatry works as well as in-person encounters.


Improving Access

Where the patient has limited physical access to the physician’s office is another advantage of telemedicine. This applies to people who lack transportation, are not physically mobile, or live a long distance from the clinic. But telemedicine has revealed its usefulness at other times when accessibility is limited as well.

One of the lessons Mercy has learned is the usefulness of telemedicine during inclement weather, when many patients cancel or fail to keep appointments, Dr. Ciaramita added. “In February, during a late-season snow storm, Mercy Clinic was quickly able to switch 1,500 of its in-person doctor appointments to virtual visits. That capability did not exist a year ago.”

Another important consideration with telemedicine is the platform in which it is delivered. While HIPAA rules have been relaxed during the COVID-19 public health emergency to allow use of such platforms as Zoom, this is not expected to continue. At BJC, Dr. Thomas said they use a HIPAA-compliant package, Teladoc, that integrates with the patient’s electronic health record.

While local physicians and patients are accepting telemedicine, the future also will be shaped by the rules and payment schedules adopted by the federal government and insurance companies. Legislative action may be needed to make permanent some of the temporary relaxations made during the public health emergency. —



“I think telemedicine is here to stay. We’re still figuring out the best places to use these virtual tools, where they make the most sense.”

State and Federal Telemedicine Regulations: What's Changed and What Might Remain Post-COVID-19?

Emergency orders loosening telemedicine rules will soon expire

By Sanja Ord, JD

Telemedicine is not a new concept to the delivery of health care. Before COVID-19, providers were utilizing advances in technology to provide health care services to patients; however, there were a lot of impediments to effective implementation including licensure restrictions, establishment of the patient-physician relationship, technology requirements and reimbursement for these services.

The pandemic resulted in the relaxing of some of these restrictions and expanded reimbursement to provide ease of access to medical care; however, the question remains: What, if any, COVID-19-era telemedicine rule changes will remain post-pandemic? This article will examine a few key telemedicine issues that have been changed since COVID-19 but is not, and should not be, considered as a comprehensive overview of all telemedicine issues.

What is telehealth/telemedicine in Missouri?

Missouri defines “telehealth” or “telemedicine” as the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at the originating site [a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine] and the health care provider is at the distant site, simply a site at which a health care provider is located while providing health care services by means of telemedicine.¹



Sanja Ord

Sanja Ord, JD, is an associate attorney with Greensfelder, Hemker & Gale, P.C. She advises hospitals, health systems and other providers and organizations on contracts, fraud and abuse laws, medical staff bylaws and other policies and transactions. Sanja also regularly assists physicians with employment contract review. She can be reached at sord@greensfelder.com.

How has COVID-19 changed physician and surgeon licensure requirements in Missouri?

Prior to the pandemic, Missouri required all health care providers, including physicians, to be licensed in the state before providing services. In response to COVID-19, Gov. Mike Parson, on March 18, 2020 through Executive Order 20-04, authorized different government agencies to waive or suspend the operation of “any statutory requirement or administrative rule ... where strict compliance with such requirements and rules would prevent, hinder or delay necessary action ... to respond to the COVID-19 health threat and to best serve public health and safety.”²



Non-Missouri licensed physicians treating Missourians during COVID-19, and Missouri-licensed physicians treating patients in other states, should monitor state of licensure with respect to the COVID-19 waivers.

In response, the Missouri Board of Registration for the Healing Arts (BOHA), instituted a full licensure reciprocity waiver for physicians and surgeons who wish to assist Missouri residents (in person or via telehealth) during the COVID-19 crisis as long as they are actively licensed in another jurisdiction and their license has not been disciplined.

Typically, the reciprocity statute requires that a physician seeking reciprocity to be licensed in Missouri notify the BOHA of his or her intent to practice in Missouri, pay a fee and complete an application. The reciprocity waiver, currently in effect until August 31, 2021, waives the fee, BOHA notification and application requirements. As written, the reciprocity waiver is limited to one specific instance—allowing physicians from other jurisdictions to help Missourians fight the pandemic. Even though Missouri has relaxed the reciprocity

requirement, providers still may have to be credentialed with their employers (e.g., hospitals or physician groups) and/or third-party payers. For example, a physician who is not a Missouri-licensed physician could provide telehealth services to a Missouri Medicaid patient as long as that provider is enrolled with MO HealthNet.³ The waiver does not allow for any other circumstances to practice medicine in Missouri.

How is a COVID-19 physician-patient relationship established?

Before the COVID-19 outbreak, Missouri required that Missouri-licensed physicians who use telemedicine *properly* establish a physician-patient relationship before providing such services and prescribing any drug, controlled substance or other treatment through telemedicine.⁴ This “properly-established” relationship could be created in a number of ways, such as: (i) an in-person encounter through a medical interview and physical examination, (ii) consultation with another physician, or that physician’s delegate, who has an established relationship with the patient and an agreement with the physician to participate in the patient’s care; or (iii) a telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.⁵ Further, if this relationship was established via telemedicine, a few other requirements would be applied. The technology used must have been sufficient to establish an informed diagnosis as though the medical interview and physical exam were performed in person and the physician needed to interview the patient, collect or review relevant medical history and perform an exam sufficient to diagnose and treat the patient.⁶

The March 2020 order also temporarily suspended these requirements to allow flexibility in establishing physician-patient relationships and related telemedicine technology requirements “to allow [Missouri] licensed physicians to decrease the risk of [COVID-19] exposure to both health care providers and patients.”⁷ This executive order has been extended until August 31, 2021.⁸

What platforms have been utilized to provide telehealth services to patients during the pandemic and what about HIPAA’s requirements?

The U.S. Office of Civil Rights (OCR) is responsible for enforcing HIPAA requirements and is known for imposing high civil monetary penalties for HIPAA violations. Before the pandemic, telehealth services were required to be performed via secure HIPAA platforms. To allow more flexibility and ease of access to telehealth services (for COVID-19 and non-related complaints), the OCR published a guidance that it would “exercise its enforcement discretion and not impose penalties for noncompliance under the HIPAA Rules” against health care providers, who in “good faith” provide telehealth services during the COVID-19 nationwide public health emergency.⁹



It remains to be seen whether the legislature takes a “things learned from its COVID-19” approach in order to make improvements to its previous patient-physician relationship requirements.

Consequently, the OCR has allowed a health care provider, in the exercise of their professional judgment, to use any non-public facing remote communication product that is available to communicate with patients, such as Zoom, Skype, FaceTime, Facebook Messenger, etc.¹⁰ Public-facing apps such as Facebook Live, Snapchat, TikTok or similar platforms have not be allowed. The OCR has encouraged health care providers to notify patients that such non-HIPAA secured platforms “potentially introduce privacy risks” and that providers should enable “all available encryption and privacy modes when using such applications.”¹¹

How has COVID-19 impacted telehealth reimbursement generally?

Prior to COVID-19, the Centers for Medicare and Medicaid Services (“CMS”) administering the Medicare program, had strict requirements regarding how telehealth could be provided and reimbursed for limited telehealth services. For example, telehealth was only a covered benefit if certain health care providers provided telehealth services and originating site (where the patient was located) was (i) a county outside of a Metropolitan Statistical Area, or (ii) a rural Health Professional Shortage Area located in a rural census tract. Otherwise, the telehealth services were not payable. Due to the pandemic, Medicare temporarily waived the originating site requirements and expanded the services that could be provided by telehealth. Many private payers, such as UnitedHealthcare, followed suit.¹²

What predictions can we make about telehealth/telemedicine in Missouri post COVID-19?

As with all things pandemic, telemedicine’s rules and regulations are in a state of flux. Gov. Parson’s executive orders relating to the issues discussed here have been extended until August 31, 2021. We are also still under the national COVID-19 public health emergency declaration. Neither CMS nor the State of Missouri have given any indication as to what telemedicine’s rules and regulations will be after the executive orders and national emergency orders expire. However, it is safe to make certain predictions on the future of telehealth in Missouri and beyond based on the state and federal government’s goals to provide safe, effective and efficient care during the pandemic while balancing the need for their oversight activities.

Continued on next page

Telemedicine Regulations ... ➤ *continued*

It is highly unlikely that Missouri will keep the COVID-19 provisions surrounding physician licensure reciprocity since, as written, the waiver is very limited in scope and not a free pass to freely practice medicine in Missouri without a license. Additionally, Missouri does not currently participate in the Interstate Medical Licensure Compact (although legislation has recently been introduced to change that). Non-Missouri licensed physicians treating Missourians during COVID-19, and Missouri-licensed physicians treating patients in other states, should monitor state of licensure with respect to the COVID-19 waivers and possibly advocate for any changes to occur at the state level with respect to Missouri's participation in the compact.



OCR's relaxation of rules surrounding HIPAA has been a welcomed change from requiring HIPAA-compliant platforms to provide telehealth/telemedicine services.

Further, Missouri is also likely to revert back to its previous requirement with respect to establishing a proper physician-patient relationship when telemedicine services are provided. It remains to be seen whether the legislature takes a "things learned from its COVID-19" approach in order to make improvements to its previous patient-physician relationship requirements. In fact, it would be the best approach to streamline and continue to improve the telehealth/telemedicine experience for both providers and Missouri patients.

Beyond Missouri, the OCR's relaxation of rules surrounding HIPAA has been a welcomed change from requiring HIPAA-compliant platforms to provide telehealth/telemedicine services. This is a drastic departure from OCR's before-COVID-19 stringent HIPAA requirements, and this change is highly unlikely to become permanent. Finally, with respect to CMS relaxing its originating site restrictions and expanding reimbursement for telehealth services, we hope that CMS is evaluating the effects of the expanded access to care resulting from its waivers, which would not have been possible under pre-COVID-19 rules. Even if some of the COVID-19 telemedicine waivers revert back to their pre-pandemic state, telemedicine will never be the same again. ➤

This article is for informational purposes only and does not constitute legal advice. For legal advice on any telemedicine issues, please contact an experienced health care attorney.

References

1. Mo. Rev. Stat. 191.1145.
2. <https://www.sos.mo.gov/library/reference/orders/2020/eo4>
3. <https://dss.mo.gov/covid-19/pdf/covid-19-faqs.pdf>
4. Mo. Rev. Stat. §§191.1146, 334.108.1 and 4.
5. Mo. Rev. Stat. 191.1146.1.
6. Mo. Rev. Stat. 191.1146.2.
7. <https://www.sos.mo.gov/library/reference/orders/2020/eo4>
8. <https://www.sos.mo.gov/library/reference/orders/2021/eo7>
9. <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
10. Id., see also <https://www.uhcprovider.com/content/provider/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-services-telehealth.html>
11. <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
12. <https://www.uhcprovider.com/content/provider/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-services-telehealth.html>

SSM HEALTH FILM DOCUMENTS COVID-19 STORIES

The experiences of frontline health care workers during the COVID-19 pandemic are shared in a new film, *Behind the Mask*, produced by SSM Health. Filmmakers, including a former NBC News producer, visited hospitals, homes and a PPE supply center across Missouri, Oklahoma and Wisconsin to capture stories of the pandemic. The result gives *Behind the Mask* an emotional look at a historic event in ways largely unseen by the public. The 36-minute film can be viewed at <https://www.youtube.com/watch?v=YZHrtXuNN7U>.



ONC Cures Act Final Rule – One of the Most Significant Advancements to Patient Health Care Rights Since HIPAA

Improves transparency and accessibility by prohibiting the practice of information blocking

By Brandy K. Simpson, JD, and Kelly M. "Koki" Sabatés, JD

Transparency and accessibility. Two of the many components all patients seek in their medical care, and a premium goal many health care providers hope to deliver. In further pursuit of patients' rights, and a commitment to allow patients to control their own medical care, the ONC Cures Act Final Rule (Final Rule) aims to increase accessibility to health care by providing patients with broader access to their medical records and transparency related to their care.

Information blocking is any practice that is "likely to interfere with, prevent or materially discourage access, exchange or use of electronic health information."⁴

The 21st Century Cures Act (Cures Act) is a bipartisan law that was passed in December 2016.¹ The purpose of the Cures Act is to accelerate medical product developments and advance innovation and patient care.² While the Cures Act encompasses many facets from increased funding and research to attempts to address mental health and the opioid crisis, the underlying purpose is to put patients at the center of their own medical care.

Most significant in advancing this purpose is Title IV, which addresses the access, use and exchange of electronic health information (EHI). It advances transparency and accessibility

by prohibiting the practice of information blocking.³ Title IV is commonly referred to as the "ONC Cures Act Final Rule."

Significance of the ONC Cures Act Final Rule

The Final Rule requires that lab results, pathology reports, imaging studies, operative reports, genetic tests, neonatal screens and more be released immediately to patients to prevent information blocking. Information blocking is any practice that is "likely to interfere with, prevent or materially discourage access, exchange or use of electronic health information."⁴ While there are eight isolated exceptions to information blocking to account for flexibility, privacy and security, the law is very specific and aims to cover even the most creative loopholes.⁵ Thus, the Final Rule:

- Enables patients to have access to the cost and outcomes of care
- Allows patients to shop for and understand the options in getting medical care
- Provides patients with convenient, easy access and visualizations of health information through smartphone apps that provides innovation and choice to patients, health care providers, hospitals, payers and employers.⁶

Who must comply with the ONC Final Rule?

The Rule applies to three different categories of entities:⁷

1. Health care providers
2. Health information networks or health information exchanges
3. Health IT developers of certified health information technology

What is "information blocking?"

Information blocking is anything likely to "interfere with access, exchange or use of electronic health information (EHI)." Examples include a health care provider unnecessarily delaying a patient or other health care provider's access to or exchange of EHI, or refusal on the part of a health care provider to release a patient's medical records.



Brandy K. Simpson



Kelly M. "Koki" Sabatés

Brandy K. Simpson, JD, is an attorney with Baker Sterchi Cowden & Rice, LLC, specializing in medical malpractice defense along with premises liability, personal injury and products liability matters. She can be reached at bsimpson@bscr-law.com. Kelly M. "Koki" Sabatés, JD, is an attorney with Baker Sterchi Cowden & Rice, LLC, practicing in premises liability, personal injury, insurance coverage and medical malpractice. She can be reached at ksabates@bscr-law.com.

Continued on next page

Information Transparency Benefits to Physicians

- Patients can assist with accuracy of their medical records
- Greater adherence to medications
- Stronger relationship between patients and their physicians
- Improved monitoring and treatment of chronic illnesses

What is “electronic health information?”

The Office of the National Coordinator for Health Information Technology (ONC) has defined EHI consistent with the definition of “electronic protected health information” in a designated medical record as defined under HIPAA. If a provider does not maintain EHI, the rule does not apply. Clinical information subject to the information-blocking provisions includes:⁸

- Consultation notes
- Discharge summaries
- History and physical
- Imaging narratives
- Laboratory reports
- Pathology reports
- Procedure notes
- Progress notes

Exceptions to the information blocking provision

While the Final Rule is intended to allow for transparency and access, the rule is not without restrictions. There are eight exceptions that allow health care providers to decline to fulfill requests for the exchange of or access to medical records or EHI. The exceptions can be divided into two classes:⁹

- Exceptions that involve **not fulfilling** the requests to access, exchange or use EHI; and
- Exceptions that involve procedures for **fulfilling** requests to access, exchange or use EHI.

Of the eight exceptions, five involve not fulfilling the request, while the remaining three involve procedures for fulfilling.

Exceptions that involve not fulfilling the request to access, exchange or use EHI include:

- **Preventing harm.** Engaging in practices reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met.
- **Privacy.** Declining to fulfill a request to access, exchange or use EHI to protect an individual’s privacy, provided certain conditions are met.

- **Security.** Interfering with the access, exchange or use of EHI to protect the security of EHI, provided certain conditions are met.
- **Infeasibility.** Declining to fulfill a request to access, exchange or use EHI due to the infeasibility of the request (internet service interruption, terrorist attack, civil or regulatory authority, etc.), provided certain conditions are met.
- **Health IT performance.** Taking reasonable and necessary measures to make health IT temporarily unavailable or to degrade the health IT’s performance for the benefit of the system’s overall performance, provided certain conditions are met.

Exceptions that involve procedures for fulfilling requests to access, exchange or use EHI include:

- **Content and manner.** Limiting the content of its response to a request to access, exchange or use EHI or the way it fulfills a request to access, exchange or use EHI, provided certain conditions are met.
- **Fees.** Charging fees, including fees that result in a reasonable profit margin, for accessing, exchanging or using EHI, provided certain conditions are met.
- **Licensing.** Licensing interoperability elements for EHI to be accessed, exchanged or used, provided certain conditions are met.

What does this mean for providers?

While patient transparency is not a new concept, this is the first time it has been required of all providers. The transparency movement has been going strong since approximately 2010 when Beth Israel Deaconess Medical Center in Boston, Geisinger Health System in rural Pennsylvania, and Seattle’s Harborview Medical Center launched a study allowing 20,000 patients to read their clinic notes.¹⁰ The movement to empower patients and remain transparent has been fueled by the OpenNotes project, a research group at Beth Israel Deaconess Medical Center, a Harvard Medical School teaching hospital.

The OpenNotes project has reported potential benefits to physicians with patient transparency including: 1) the ability for patients to assist with the accuracy of their medical

records which in turn may reduce medical errors; 2) improved adherence to medications when a patient can review their chart and the medication instructions; 3) a stronger relationship between patients and their physicians when a patient is more involved in their health care and feels more in control; and 4) improvement in monitoring and treating chronic illness, among other things.¹¹

While the Final Rule may cause additional challenges at the outset in terms of provider compliance, increased patient questions, and the time associated with providers trying to modify their documentation style when they know their notes may be read by a patient, many are still anticipating an overall improvement in the patient experience and the health care system.

Conclusion

Admittedly, the Final Rule has a lot of moving parts and still more convoluted language. The implementation and deadlines for compliance with the Final Rule have been ever-changing during the pandemic and enforcement has the potential to be further delayed. While the transition to enhance patient care and transparency may not be easy, it should be worth it. ◀

Post-Pandemic Outlook ... ▶ continued from page 14

7. "President Trump Signs Executive Order to Permanently Expand Telehealth Benefits for Medicare Recipients" By Jack O'Brien, *HealthLeaders*, August 4, 2020, www.healthleadersmedia.com/innovation/president-trump-signs-executive-order-permanently-expand-telehealth-benefits-medicare (Accessed 5/6/21).
8. "Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients" Centers for Medicare & Medicaid Services, December 1, 2020, <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment> (Accessed 5/6/21).
9. "2020 State of Telemedicine Report" Doximity, September 2020, <https://c8y.doxcdn.com/image/upload/v1599769894/Press%20Blog/Research%20Reports/2020-state-telemedicine-report.pdf> (Accessed 5/6/21).
10. "Virtual health: A look at the next frontier of care delivery" By Jennifer Fowkes, et al., McKinsey & Company, June 11, 2020, <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/virtual-health-a-look-at-the-next-frontier-of-care-delivery> (Accessed 5/6/21).
11. "How Americans Feel About Telehealth: One Year Later" Sykes, <https://www.sykes.com/resources/reports/how-americans-feel-about-telehealth-now/> (Accessed 5/6/21).
12. "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" By Oleg Bestsennyy, et al., McKinsey & Company, May 2020, <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Telehealth%20A%20quarter%20trillion%20dollar%20post%20COVID%2019%20reality/Telehealth-A-quarter-trilliondollar-post-COVID-19-reality.pdf> (Accessed 5/6/21).
13. "Most consumers want to keep telehealth after the COVID-19 pandemic" By Jeff Lagasse, *Healthcare Finance*, <https://www.healthcarefinancenews.com/news/most-consumers-want-keep-telehealth-after-covid-19-pandemic> (Accessed 5/6/21).
14. "Digital doctors: What role will telehealth play after COVID-19?" By Todd Shryock, *Medical Economics*, Vol. 97, Issue 15 (November 2020), available at: <https://www.medicaleconomics.com/view/digital-doctors-what-role-will-telehealth-play-after-covid-19-> (Accessed 5/6/21).
15. "Monthly Telehealth Regional Tracker, Jan. vs. Feb. 2021." FAIRHealth. <https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/feb-2021-national-telehealth.pdf> (Accessed 5/6/21); "Monthly Telehealth Regional Tracker, Dec. 2020 vs. Jan. 2021" FAIRHealth, <https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/jan-2021-national-telehealth.pdf> (Accessed 5/6/21).
16. "Primary Care Clinic Nurse Activities with a Telehealth Monitoring System" By Chelsea Howland, et al., *Western Journal of Nursing Research*,

References

1. 21st Century Cures Act. <https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf>
2. 21st Century Cures Act—A Summary. HIMSS. <https://www.himss.org/resources/21st-century-cures-act-summary>
3. 45CFR Parts 170 and 171. 21st Century Cures Act.
4. 42 USC 300jj-52: Information blocking.
5. Information Blocking Exceptions. Office of the National Coordinator for Health Information Technology. <https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf>
6. The ONC Cures Act Final Rule. Office of the National Coordinator for HIT. <https://www.healthit.gov/sites/default/files/cures/2020-03/TheONCCuresActFinalRule.pdf>
7. Cures Act Final Rule: Information Blocking Actors. Office of the National Coordinator for Health Information Technology. <https://www.healthit.gov/sites/default/files/cures/2020-03/InformationBlockingActors.pdf>
8. United States Core Data for Interoperability (USCDI) | Interoperability Standards Advisory (ISA). Office of the National Coordinator for HIT. <https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi>
9. Cures Act Final Rule: Information Blocking Exceptions. Office of the National Coordinator for HIT. <https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf>
10. Our History: Fifty Years in the Making. <https://www.opennotes.org/history/>
11. OpenNotes for Health Professionals. <https://www.opennotes.org/opennotes-for-health-professionals/>
- Vol. 43, Issue 1 (January 2020), available at: <https://missouri.app.box.com/s/xvs6av7r6rou3zyvdfw43bhpzvkv7vuv7> (Accessed 5/6/21).
17. "Telehealth can increase nurses' workloads, study finds" By Alex Kacic, *Modern Healthcare*, April 30, 2021, <https://www.modernhealthcare.com/operations/telehealth-can-increase-nurses-workloads-study-finds> (Accessed 5/6/21); "Staffing stress leading to calls for more nurses" By Maria Castellucci, *Modern Healthcare*, February 20, 2021, <https://www.modernhealthcare.com/safety-quality/staffing-stress-leading-calls-more-nurses> (Accessed 5/6/21).
18. "Direct-To-Consumer Telemedicine Visits For Acute Respiratory Infections Linked To More Downstream Visits" By Kathleen Yinran Li, et al., *Health Affairs*, Vol. 40, No. 4 (April 2021), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01741?journalCode=hlthaff> (Accessed 5/6/21).
19. "An Analysis of Private Payer Telehealth Coverage During the COVID-19 Pandemic" Center for Connected Health Policy, 2021, <https://cchp.nyc3.digitaloceanspaces.com/files/2021-01/Private%20Payer%20Telehealth%20Coverage%20Reportfinal.pdf> (Accessed 5/6/21), p. 2.
20. "How can telemedicine evolve in the post-Covid era" By Michael Botta, *MedCity News*, March 16, 2021, <https://medcitynews.com/2021/03/how-can-telemedicine-evolve-in-the-post-covid-era/> (Accessed 5/6/21)
21. "117th Congress - Introduced Legislation" Alliance for Connected Care, <https://connectwithcare.org/telehealth-legislation/>
22. "Telehealth Modernization Act" S.368, 117th Cong. (February 23, 2021), available at: <https://www.congress.gov/bills/117/congress/senate/bills/368> (Accessed 5/6/21).
23. "Protecting Access to Post-COVID-19 Telehealth Act of 2021" H.R.366, 117th Cong. (January 19, 2021), available at: <https://www.congress.gov/bills/117th-congress/house-bill/366/cosponsors?r=7&s=1&searchResultViewType=expanded> (Accessed 5/6/21).
24. "Congress to Get Another Shot at Telehealth Coverage for Specialists" By Eric Wicklund, *mHealth Intelligence*, March 26, 2021, <https://mhealthintelligence.com/news/lawmakers-reintroduce-post-covid-19-telehealth-bill-hoping-for-a-better-outcome> (Accessed 5/6/21).
25. "To amend title XVIII of the Social Security Act to expand the scope of practitioners eligible for payment for telehealth services under the Medicare program, and for other purposes" H.R.2168, 117th Cong. (March 23, 2021), available at: <https://www.congress.gov/bills/117th-congress/house-bill/2168/text?r=16&s=1> (Accessed 5/6/21).
26. "Ways & Means reps bullish on telehealth, but say questions remain" By Jessica Kim Cohen, *Modern Healthcare*, April 28, 2021, <https://www.modernhealthcare.com/politics-policy/ways-means-reps-bullish-telehealth-say-questions-remain> (Accessed 5/6/21).

The Equality Act: “To Follow the Right or to Do Right?” That Is the Question!

By Frank A. Cornella, DDS, MD

Editor's Note: The following is in response to the “Parting Shots” column by Richard J. Gimpelson that appeared in the April/May St. Louis Metropolitan Medicine. Dr. Gimpelson's rebuttal appears on the facing page.

In your April/May edition, Dr. Richard J. Gimpelson, speaking from his experiences as a retired gynecologic surgeon and as an ordained minister of the Universal Life Church (a little tongue-in-cheek, I suspect), urged opposition to the Equality Act—legislation that places gender identity among the prohibited categories of discrimination. Titled, “XY or XX? That is the Question,” Dr. Gimpelson's opinion warned that passage of this bill would jeopardize women's rights, rob women of occupational and educational/scholarship opportunities, and expose them to physical injury and assault. Dr. Gimpelson's position coincides with a political agenda that runs counter to our role as physicians.

Dr. Gimpelson's assertion that women are endangered when trans females are allowed access to women's “bathrooms, showers, locker rooms, battered women's shelters and other facilities,” is baseless fear-mongering. As far as Dr. Gimpelson's warning of physical injury to cis females by trans females in contact sports, offensive linemen pose roughly the same size-ratio risk to quarterbacks. Personally, as a small kid, it never occurred to me that I shouldn't have to compete with players at a significant height advantage on the grounds that stature, like gender, is an immutable, genetically determined attribute which could physically harm me or rob me of a scholarship. It is often suggested that the Equality Act will result in a stampede of boys faking gender identity so they can compete against girls. In the public debate, examples of injury in sports to cis women or instances where transgender athletes capitalized on unfair

athletic advantages are glaringly absent. Physicians should have no problem calling out these claims as poppycock (no pun intended).

Dr. Gimpelson argued that physicians following personal/religious beliefs could face “... legal repercussions for refusing to treat these patients.” Like most religious-freedom objections, this is more about limiting the freedom of others. Moreover, it falsely implies that physicians could be forced to perform/facilitate gender-affirming treatments. To the contrary, much of the anti-trans legislation pouring out of conservative states makes it a crime for physicians to render gender-affirming treatments to minors.

In an amicus brief before the U.S. Court of Appeals for the Ninth District, the American Academy of Pediatrics, the American Medical Association and the American Psychiatric Association warned of “predictable harms to health of transgender girls and women who are excluded from participation in school sports consistent with their gender identity.” The brief explained the consensus that treatments “... allowing transgender women to live in accordance with one's gender identity in all aspects of life” were highly effective in treating gender dysphoria. Gender-dysphoric adolescents, according to at least two studies, have attempted suicide rates of over 25%. Many red-state anti-trans laws would require humiliating gender-proving physicals of any girl accused of being too masculine.

As physicians we must not support this thinly veiled, conservative political effort that stirs bigotry, that is devastatingly harmful to trans youth, and that protects no one's health or rights. Hopefully, Dr. Gimpelson will look at the evidence and follow his Universal Life Church's founding doctrine: “Do what is right.” —



Dr. Frank A. Cornella

Frank A. Cornella, DDS, MD, is an oral and maxillofacial surgeon in Springfield, Mo. He is on the editorial committee of the Greene County Medical Society Journal and is a member of the Missouri State Medical Association.

We Want to Hear from You

Do you have thoughts or reactions to something you read in *St. Louis Metropolitan Medicine*? You're invited to write a commentary or letter to the editor. Send it to editor@slmms.org.

Rebuttal: Equality Act Would Do Harm

By Richard J. Gimpelson, MD

I have reviewed Dr. Cornella's letter and will respond clearly to help him understand the problems with the Equality Act. The Equality Act defines gender identity as the appearance, mannerisms or other gender-related characteristics of an individual, regardless of the individual's designated sex at birth. This means a person who was born (XY) male can decide to be an (XY) female at any time. This does not require any specific treatment or surgery to hormonally or anatomically change from (XY) male to (XY) female.

Dr. Cornella compares football linemen to quarterbacks, and his small stature to his taller peers, as unfair situations that one must put up with. However, he is comparing "apples with apples" since all persons involved are (XY) males. This is not the same as (XY) females competing with (XX) females. Studies show that (XY) males retain many physical advantages over (XX) females at puberty even if these (XY) males decide to become (XY) females. This advantage remains even if the (XY) female takes medication to reduce testosterone. Therefore, (XY) females competing with (XX) females is comparing "apples to oranges." These (XY) females are reducing the (XX) females' opportunities for college scholarships in spite of Title IX legislation. Lawsuits are being filed to stop this unfair competition. Many schools are now prohibiting the (XY) females from competing against (XX) females for very good reasons that Dr. Cornella just cannot agree with.

I did not address physicians performing/facilitating gender-affirming treatment to minors, so I do not even understand Dr. Cornella's comments regarding this issue. Psychiatrists are treating gender-dysphoric children and adolescents, and I am sure Dr. Cornella is aware of this. I have no problem treating LGBTQ patients. But some physicians do have religious or other beliefs that make this uncomfortable, and they are best not treating LGBTQ patients and should not risk legal repercussions.

I do not dispute that the exclusion of (XY) females from school sports for (XX) females may cause harm, but allowing them to participate to the detriment of (XX) females also causes harm to (XX) females and would seriously jeopardize the protection and opportunities that (XX) females have as a result of Title IX legislation. The AAP, AMA and APA need to work harder to help (XY) females without harming (XX) females.

I am disappointed that Dr. Cornella wrongly assumed that I was trying to stir bigotry. By what he calls "Do what is right," he actually wants to benefit (XY) females by harming (XX) females. As a gynecologist, my first obligation is to females, be they (XX) or (XY) as long as I do no harm.

Note: cis-gender and trans-gender are often used, but many women resent these terms, so I have chosen to use (XX) and (XY) so there is no confusion. ➡



Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. He has been writing a column for St. Louis Metropolitan Medicine for over 20 years.

Dr. Richard J. Gimpelson

FOR MORE INFORMATION ON THE EQUALITY ACT

General Background ➡ NPR: <http://bit.ly/equality2021>

Arguments in Favor ➡ American Progress: <https://ampr.gs/3bBds90>

Arguments Against ➡ Heritage Foundation: <https://herit.ag/33RIE0K>

➡ Scientific American: <https://bit.ly/2RkBUVB>

➡ Christian Headlines: <https://bit.ly/3eXw19F>

COVID-19

By Richard J. Gimpelson, MD

With the election of Joseph Biden as 46th president of the United States, many changes have taken place since the presidency of Donald Trump. Many are of no significance to the health or well-being of U.S. citizens and others living in the United States, but those relating to COVID-19 are very significant. I will add my opinion when I feel it is needed; and to my colleagues, feel free to agree or disagree to enhance the excitement in this column.

President Biden stopped the withdrawal from the World Health Organization that former President Trump had planned to carry out. It was shown that the WHO was slow in investigating the COVID-19 infection, and essentially supported the Peoples Republic of China in the cover-up of the origin of the COVID-19 virus. In addition, the U.S. gave almost \$900 million to WHO every year. President Trump felt we got very little in return and could put this money to better use at home.

President Biden is still advocating mask wearing most of the time even though the CDC has established new recommendations based on the number of U.S. residents who have been vaccinated. Thirty-one percent of the people living in the United States have been fully vaccinated, and 44% have received their first vaccination injection. When broken down by age range, of the highest risk people (over 65 years old), at least 70% are fully vaccinated and 85% have received their first injection. The numbers decrease by age as expected, with 60% of those between 50 to 64 years of age getting at least one dose and nearly 50% fully vaccinated. Of those in the 40- to 49-year-old range, 40% are fully vaccinated and over 50% have received their first dose. Results are lower in younger people; however, they are also at less risk for serious problems from COVID-19. By the time this column is published, the numbers should be even more favorable. On May 10, the FDA announced emergency use authorization for the Pfizer-BioNTech vaccine among adolescents ages 12-15.

As I alluded to in the prior paragraph, the CDC has released new mask guides, and I advise President Biden to follow these guides to give good news to our people, so life can move in a positive direction. People who are fully vaccinated and those who have recovered from COVID-19 do not need to wear a mask in lightly populated outdoor activities. At outdoor activities, where there are large numbers of people, such as concerts and sporting events, masks are still recommended. Masks are still recommended for indoor activities and on all public transportation.

When 80% of the population is vaccinated or recovered from COVID-19 infection, herd immunity will result. This is interpreted to show that four out of every five people cannot spread the infection. Herd immunity may require annual booster shots similar to the annual flu shots. While the U.S. COVID-19 infection rate is rapidly decreasing, there are other parts of the world, like India, that are experiencing a rising deadly incidence of COVID-19 infection. There are several new vaccine manufacturers that are in line for FDA approval, and hopefully these new vaccines, as well as the established ones, will be made available throughout the rest of the world.

As physicians, we need to encourage all of our friends, relatives and patients to get vaccinated. I do want to thank President Biden for taking advantage of former President Trump's Herculean effort to get the COVID-19 vaccines developed at "warp speed" and into the arms of so many of the U.S. population. There is no doubt that many lives have been saved and will be saved. —



Dr. Richard J. Gimpelson

Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. The opinions expressed in this article do not necessarily represent the opinion of the Medical Society. Send comments on this column to editor@slmms.org.

See commentary response from Frank Cornella, MD, DDS, to Dr. Gimpelson's April-May column on transgender issues.

Pages 22-23

◀ WELCOME NEW MEMBERS ▶

Thank you for your investment in advocacy, education, networking and community service for medicine.

Aamina B. Akhtar, MD

10004 Kennerly Rd., Ste. 171B, 63128-2176
MD, Saint Louis Univ., 1998
Born 1973, Mo. Licensed 2000 ▶ **Active**
Certified: Internal Medicine and Infectious Disease

Bradley K. Baker, MD

10010 Kennerly Rd., 63128-2106
MD, Univ of Missouri-Columbia, 1985
Born 1959, Mo. Licensed 1986 ▶ **Active**
Certified: Diagnostic Radiology

Daniel J. Choe, DO

11475 Olde Cabin Rd., Suite 200, 63141-7129
DO, Touro New York College of Osteopathic
Medicine, 2013
Born 1984, Mo. Licensed 2020 ▶ **Active**
Certified: Diagnostic Radiology

Jesse D. Helton, DO

3619 Richardson Square Dr., #150, 63030-6021
DO, Kirksville College of Osteopathic Medicine, 1997
Born 1957, Mo. Licensed 1998 ▶ **Active**
Internal Medicine

Muhammad Hanif Pathan, MD

18119 Resort View, 78255-3339
MD, Chandka Medical College Hospital, 1985
Born 1959, Mo. Licensed 2008 ▶ **Active**
Certified: Pathology, & Anatomic & Clinical Pathology

Sara N. Reggie, MD

12990 Manchester Rd., Suite 102, 63131-1860
MD, Louisiana State Univ., New Orleans, 2013
Born 1987, Mo. Licensed 2020 ▶ **Active**
Certified: Ophthalmology

Robert T. Ruiz, MD

5505 Fireridge Ct., 63129-3505
MD, Creighton Univ., 1988
Born 1953, Mo. Licensed 2021 ▶ **Retired**
Family Practice

Justin M. Sacks, MD

660 S. Euclid Ave., CB-8238, 63110-1010
MD, Icahn School of Medicine at Mt. Sinai, 1998
Born 1971, Mo. Licensed 2020 ▶ **Active**
Certified: Plastic Surgery

WELCOME STUDENT MEMBERS

Saint Louis University School of Medicine

Neal A. Modi

Washington University School of Medicine

Jacob Strelnikov

◀ OBITUARIES ▶

Carlos A. Maitz, MD



Carlos A. Maitz, MD, an obstetrician/gynecologist, died December 25, 2020, at the age of 68.

Born in Buenos Aires, Argentina, he immigrated to St. Louis when he was just seven years old.

He obtained his undergraduate degree at the University of Missouri-St. Louis, and his medical degree from Saint Louis University School of Medicine. He completed his internship and residency in obstetrics and gynecology at Mercy Hospital. From 1982-1985, Dr. Maitz served as a medical officer for the U.S. Navy. Returning to St. Louis, he was in private practice for more than 30 years. In retirement, he pledged his support to numerous charitable organizations and volunteered for multiple service-based organizations. He joined the St. Louis Metropolitan Medical Society in 1980.

Dr. Maitz was predeceased by his first wife, Judy Maitz. SLMMS extends its condolences to his wife, Marlene Maitz; his children Douglas Maitz, Jeffrey Maitz, Charles Maitz, Christopher Dillon, Amy Boyle, and Andrew Westerfeld; and his 13 grandchildren. ▶

Charles A. Sigmund, MD



Charles A. Sigmund, MD, an ophthalmologist, died March 29, 2021, at the age of 88.

Born in St. Louis, Dr. Sigmund received his undergraduate and medical degrees from the University of Missouri. After completing an internship at Pontiac General Hospital in Pontiac, Mich., he served his country as a flight surgeon and officer in the U.S. Air Force from 1961-1963. He returned to St. Louis to complete his residency and ophthalmology fellowship at Washington University School of Medicine. Dr. Sigmund was in private practice in St. Louis for nearly 50 years. An Eagle Scout and member of the Order of the Arrow, he was an active and lifelong supporter of the Boy Scouts of America. He joined the St. Louis Metropolitan Medical Society in 1966.

SLMMS extends its condolences to his wife Sharon Ann Sigmund; his children Julie Azar; Gregory Sigmund; and Jeffrey Sigmund; and his nine grandchildren. ▶



more control

protecting **doctors**
nurses cardiologists
practice managers family physicians
infectious disease specialists
internists **anesthesiologists**
podiatrists nurse practitioners
long term care specialists
neurosurgeons pulmonologists
epidemiologists **oncologists**
pediatricians **general surgeons**
obstetricians & gynecologists
allergists hospital administrators
emergency physicians
urologists geriatricians chiropractors
pathologists immunologists
orthopaedists **radiologists** and more

At ProAssurance, we work to protect medical professionals and support their patient safety efforts with custom healthcare professional liability insurance solutions.

If a malpractice claim is made, we listen and provide experienced counsel, bringing clarity and fair treatment to the claims process.



PROASSURANCE.

Treated Fairly

Healthcare Professional Liability Insurance

ProAssurance.com