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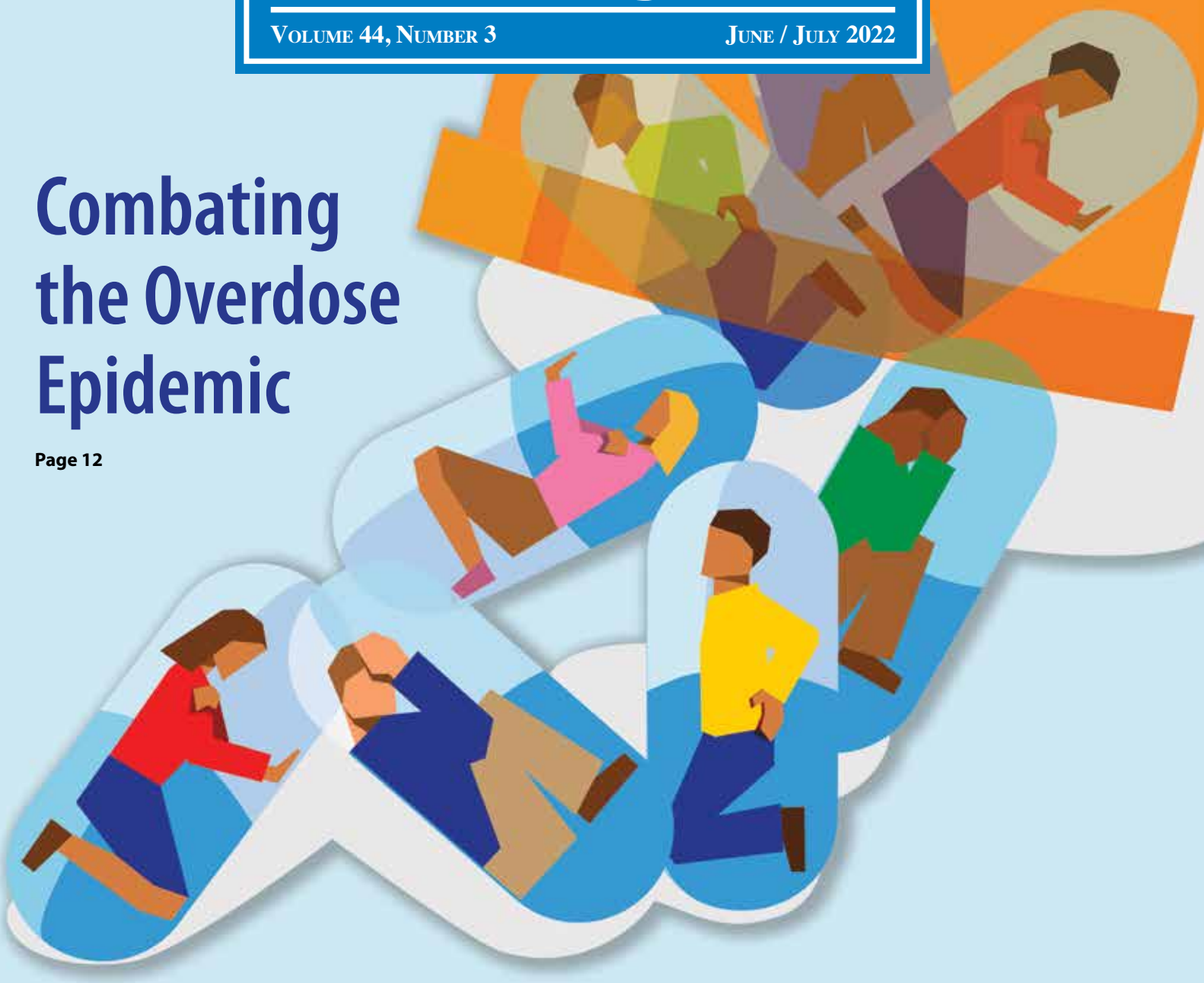
Combating the Overdose Epidemic

Page 12



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ST. LOUIS METROPOLITAN MEDICINE

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

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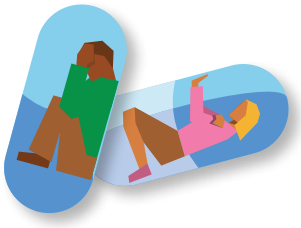
Substance Use Crisis



Features

AMERICAN COLLEGE of CARDIOLOGY

Columns

News

Organized Medicine Battles the Sources of Burnout

By Erin S. Gardner, MD, President, St. Louis Metropolitan Medical Society 2022

Erin S. Gardner, MD

Organized medicine brings to bear with legislators, bureaucrats, and other authorities not only the troubles that inhabit our profession, but also that detract from our patients' experiences with health care delivery.

By the time you read this column, we will be in the early days of summer—a welcome respite for many of us—with longer sunny days and more leisure time with friends and families and for ourselves. The appeal of a lunch date with a friend, or an outdoor barbecue with the family, or a good book and good coffee by ourselves beckons especially as summer opens up.

We physicians have stressful day jobs (Where are the eyeroll and lol emoji's?), and summertime is one season that coheres well with activities that bring stress relief and an enjoyment that is occasionally or too often scarce in our professional tasks. Burnout is now a common term that is bandied about, because there are rather a lot of obstacles to successfully and joyfully perform the tasks that drew us to medicine in the first place.

We seek rejuvenation in sundry activities, many salutary, but one realm where assuagement is sought and destructive is our journal's theme this issue. Substance abuse has of course always existed in human society, and it has also occupied a tranche in medicine. But physicians perhaps are particularly exposed to the potential for trouble with it, as we experience enduring and often acute stressors in our work lives.

Physicians' current stressors, including the COVID-19 pandemic, have worked to amplify the problem. One source of stress will be (is) the physician shortage crisis, as discussed in this column in the April-May issue of *St. Louis Metropolitan Medicine*. Another of course is the burnout crisis that has burgeoned over the last 15 years. Burnout stems from many origins, but loss of physician autonomy often stands as a pre-eminent cause upon deeper examination. That loss of autonomy may promote a greater sense of helplessness in what should be a natural self-direction in much of one's life.

One approach to burnout, employed by many of our physician professional organizations, has been to better understand burnout through study, and to provide education and benefits that promote successful coping strategies. Your St. Louis Metropolitan Medical Society will be serving this task in autumn 2022 by sponsoring a conference on physician wellness. The conference will aim to explore more deeply the sources of burnout and work-related stress, and to provide resources for engagement and self-care.

Regaining Physician Engagement

Beyond increased efforts at self-direction and self-care, there are multiple other approaches that we as physicians may take to battle burnout at its sources. One burnout culprit has been to allow atrophy in some of the inherent authority as physicians that our position in society bestows. As physicians have become consumed by the additional tasks that the execution of one's daily medical duties require, we have let go of some of the connections that formerly allowed us to speak with a unified voice to those in the governing sphere who make decisions that impact our daily work lives.

Decreased engagement with organized medicine is one realm where that phenomenon immediately leaps to mind. We simply don't have the time to include some activities that we formerly did. Like most all civic and professional societies, organized medicine is experiencing a downtrend in physician engagement and membership. Yet it seems we can't afford to let that slide! Organized medicine brings to bear with legislators, bureaucrats, and other authorities not only the troubles that inhabit our profession, but also that detract from our patients' experiences with health care delivery.

There are other ways to broadly think about approaches to stem the sources that lead to our disillusionment. Third-party payers have outsized influence on not only individual treatments that we can provide patients (think the Byzantine prior authorization requirements), but even whether or not we can provide care to our patients (think narrowing networks). A better system would reduce the influence that third-party payers are able to impose, and instead bolster the primacy and authority of the physician-patient relationship. Legislative policy changes for both prior authorization and narrow network restrictions, led by organized medicine groups, have been implemented to advance this cause.

This success in reducing documentation requirements shows how physicians through organized medicine efforts can depict to governmental authorities the difficulties that we face, and delineate pathways to ameliorate the troubles.

An Advocacy Success Story

Another source of consternation for more than two decades has been documentation requirements. In an effort to try to verify that quality and an indicated level of service were being delivered, administrators and payers have ladled on documentation requirements for physicians through the years. Yet, burdensome documentation requirements are often cited as a top reason for physician burnout. Certain quality metrics may be improved (to certain extents) with additional documentation and execution of specified tasks, yet at what cost? At the cost of alienating physicians to the extent that they retire early? Or that they choose to seek a position with fewer clinical responsibilities because the workload is otherwise sometimes overwhelming?

Quality is certainly at the forefront of almost all physicians' minds … we want to do well for our patients, and we want to feel good about the work that we are doing. However, it seems that we must seek ways to achieve those twin aims, while diminishing sources that provoke our disaffection. Another example of diminishing a burnout source is the modification in 2021 of the evaluation and management services requirements as instituted by the Centers for Medicare and Medicaid Services. Physicians now may focus their documentation efforts on medical decision making, rather than counting bullet points to determine whether they are providing this level of service or that.

This success in reducing documentation requirements shows how physicians through organized medicine efforts can depict to governmental authorities the difficulties that we face, and delineate pathways to ameliorate the troubles. Physicians must be the messengers, because we are the ones with firsthand experience. Our organized medicine institutions can help us lead the way.

Saint Louis University Physicians to Join SSM Health

SLUCare Physician Group is joining forces with SSM Health - St. Louis to form an integrated health network under an agreement announced by the two organizations. The goal of the agreement is to deepen "their partnership to advance health equity, strengthen medical education and improve the health of the St. Louis community and beyond," according to a joint news release.

Ownership of SLUCare Physician Group will transition from Saint Louis University to SSM Health when the transaction closes. The agreement is expected to be finalized later this summer, pending all regulatory and other approvals.

The agreement is an extension of a long-standing partnership between SSM Health, SLUCare Physician Group and Saint Louis University School of Medicine. The organizations say the integration will provide the community with improved and seamless access to all levels of care, from primary care and preventive services to highly specialized quaternary procedures and clinical trials that can deliver potentially breakthrough lifesaving treatments.

The agreement also represents a significant investment in the Saint Louis University School of Medicine to expand clinical research, medical training and education in the region.

SLUCare, with more than 600 faculty and other medical professionals, will become a dedicated academic physician division within SSM Health - St. Louis, and partner closely with SSM Health Medical Group's more than 600 community-based providers with more than 50 physician office locations as well as comprehensive virtual and digital health services.

"Both SSM Health and Saint Louis University School of Medicine have a rich legacy of providing hope and healing to those in need across the St. Louis community," said Laura S. Kaiser, FACHE, president and CEO of SSM Health. "We are thrilled to be taking this next step in our shared mission to ensure every patient gets the best care possible, while keeping that care affordable for the individuals and families we serve."

AMA Honors Sam Page, MD, for Outstanding Government Service

SLMMS member and St. Louis County Executive **Sam Page, MD**, has been honored by the American Medical Association with the Outstanding Government Service Award for Local Government. The award was presented on behalf of the AMA at the 2022 Missouri State Medical Association convention in April.

The award is considered one of the AMA's most prestigious awards honoring elected officials and career government employees. In announcing the award, AMA Board of Trustees Chair Bobby Mukkamala, MD, cited Dr. Page's distinguished public service starting as a municipal council member rising to state legislator then St. Louis County Council member, and since 2019, St. Louis County executive.

"Dr. Page has always brought a physician's perspective to his work in St. Louis County, municipal and state government," Dr. Mukkamala said. He emphasized Dr. Page's leadership using evidence-based approaches on masking and vaccines despite strong public pressure in opposition, and his initiative to establish the local prescription drug monitoring program that expanded to cover most of Missouri.

Former AMA president David Barbe, MD, MHA, who nominated Dr. Page, wrote, "It is uncommon for a nominee for this award to have been involved in such a broad range of governmental service and to have been so impactful at each level."

In his acceptance speech, Dr. Page urged physicians to speak up in defense of their patients and in favor of evidence-based government policies. "In recent times, ideology has replaced science. Shouting has replaced discussion. Threats have replaced thoughtfulness. If the currency of our new politics is volume, then the chorus of our combined voices as doctors must be the ones that people hear."

Sam Page, MD, left, accepts the AMA Outstanding Government Service Award for Local Government. MSMA 2021-22 President Alexander Hover, MD, is at right. (Photo courtesy Missouri State Medical Association)

Dr. Page is a board-certified anesthesiologist with Western Anesthesia. Elected to the Creve Coeur City Council in 1999, he then served as state representative for three terms, from 2003 to 2008. He was the Democratic nominee for Missouri lieutenant governor in 2008. He was a member of the St. Louis County Council from 2014 to 2019, and in April 2019 was appointed St. Louis County executive to complete the unexpired term of the previous executive who resigned.

In organized medicine, he is speaker of the MSMA House of Delegates and is the Missouri alternate director on the board of the American Society of Anesthesiologists. He is past president of the Missouri Society of Anesthesiologists and the Missouri Society of Interventional Pain Physicians.

Announces Candidacy for Missouri State Senate

Dr. George J. Hruza

SLMMS member **George J. Hruza, MD, MBA**, dermatologist and Mohs surgeon, has announced his candidacy for the Republican nomination for the Missouri State Senate 24th District in the August 2 primary. The district represents portions of central and west St. Louis County including the communities of Creve Coeur, Des Peres, Fenton, Frontenac, Glendale, Huntleigh, Kirkwood, Ladue, Maryland Heights, Sunset Hills and Valley Park. A long-time advocate for physicians and organized medicine, Dr. Hruza is past president of SLMMS and MSMA. At the national level, he has served as president of the American Academy of Dermatology, the American Society for Dermatologic Surgery and the American Society for Lasers in Medicine and Surgery. If elected, he would be the only physician in the Missouri Senate. For more information, visit www.hruzaformissouri.com.

CME Program Will Explore the Use of Artificial Intelligence in Health Care

SLMMS is excited to partner with VirtuSense Technologies and the Missouri Chapter of the American College of Healthcare Executives to present an informative continuing medical education workshop examining the emerging technology of using artificial intelligence and machine learning in health care.

The Utilization of Artificial Intelligence in Health Care Today is set for Wednesday, June 22, from 5:30 to 7:30 p.m. at the Lodge Des Peres, 1050 Des Peres Road, Des Peres, MO 63131. Participants may choose to attend in-person or join via Zoom. In-person attendees are invited to participate in a social hour immediately preceding the program with refreshments provided courtesy of the Keane Insurance Group.


Dr. Damon Broyles


Dr. Thomas Hale

The program will include presentations from two physicians—**Damon Broyles, MD, FAAFP**, vice president, clinical innovation services, Mercy Technology Services; and **Thomas Hale, MD, PhD**, chief medical officer, VirtuSense Technologies. SLMMS Vice President **Kirsten Dunn, MD**, internist, Mercy Virtual vEngagement, will moderate the question and answer session following the presentations.

Learning Objectives

At the conclusion of this activity, participants will be better able to:

- Define and describe common terms and definitions related to the emerging field of artificial intelligence and machine learning in health care, as well as demonstrate an understanding of currently deployed AI-based technology.
- Explain the basic premise of tools and techniques involving process mining, digital twinning and synthetic data to derive insights in care.
- Place machine learning and artificial intelligence within the continuum of other decision support and care delivery tools in providing quality patient care.
- Build a case for AI and ML opportunities to assist in patient care.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Missouri State Medical Association through the joint providership of Institute for International Medicine (INMED) and St. Louis Metropolitan Medical Society. INMED is accredited by the Missouri State Medical Association to provide continuing medical education for physicians. INMED designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Please visit **www.slmms.org** to access the registration links to attend in-person or virtually, or to download a program flyer. Please register by Monday, June 20.

The Utilization of Artificial Intelligence in Health Care Today

WEDNESDAY, JUNE 22, 2022

The Lodge Des Peres
1050 Des Peres Road

5:00 p.m.
Registration begins

5:30 p.m.
Social hour and refreshments provided courtesy of the Keane Insurance Group

6:00 – 7:30 p.m.
Program

Registration and more information available at slmms.org

SLMMS Seeks Future Physician Leaders

Are you interested in serving your fellow physicians while contributing to the practice of medicine? The St. Louis Metropolitan Medical Society invites any prospective leaders from within the membership to volunteer to help move our organization forward and fulfill our mission.

The SLMMS Nominating Committee will meet later this summer to consider candidates for terms beginning in 2023. 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. In fact, the SLMMS Council and all committees have been meeting virtually for the past two years during the pandemic. Because of the convenience factor and reduced time commitment, we expect this to continue in some capacity even as things return to normal.

Please 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 before Friday, July 8. If you wish to nominate another member for a leadership position, please speak with them first to confirm their willingness to serve. All recommendations will be considered.

Per the Society's bylaws, the Nominating Committee will present its slate of officers and councilors at a General Society meeting on Tuesday, September 20, beginning at 6:00 p.m. This meeting is open to all Society 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. Thank you in advance to those who are willing to serve and represent your profession.

VOLUNTEER FOR SLMMS LEADERSHIP

Survey Shows Practices Returning to Normal Post-COVID

Two years after shutdowns due to COVID-19, SLMMS member practices are generally returning to normal.

An email survey of SLMMS members in March found that for 70%, patient volumes have remained the same, returned to pre-pandemic levels or have grown. Only 28% are still seeing fewer patients in person. A total of 39 members responded to the survey, representing a full range of specialties. The survey is a follow-up of the member survey conducted in March 2021 that showed losses in patient volume and revenue during 2020.

"Initial decline followed by robust rebound," was the way one 2022 physician respondent characterized the current situation. "Dropped in 2020 and early to mid-2021, but now pretty similar to 2019," said another.

In the experience of one surgeon: "After several months of reduced accessibility in OR and admissions for surgery, the trend reversed and we are now doing more surgeries."

Explained another physician, "We have finally rebounded to pre-pandemic patient volume. There is slightly greater use of telemedicine. … The most troubling factor affecting the practice remains continued decreased reimbursement."

Indeed, practice revenue remains lower for 41% of those responding to the survey. Commented one physician, "We took a big hit in volume and revenue during the pandemic year (down at least 35%) but were helped by the PPP program. It's been much better this year but still not quite up to pre-pandemic volumes."

Telemedicine has become established as a part of patient care. Some 55% of respondents indicate that they are making greater use of telemedicine since pre-pandemic, with 25% making much greater use. Psychiatry has become practiced nearly entirely via telemedicine.

Patients Still Delaying Care

Of concern is that many patients continue to delay needed screenings and treatments. Over half, 51%, of physicians responding say more patients continue to delay or postpone care. However, another 38% say the number of patients delaying care is returning to pre-pandemic levels.

One physician commented: "There has been a huge delay in colon screening. We have tried to catch up with the backlog, but many patients have been lost to follow up. Unfortunately, there definitely is an uptick in colon cancer diagnosis."

Another offered similar sentiments: "We see patients with skin cancers that have been neglected due to fear of COVID, resulting in far more extensive surgery to clear the tumor."

Staffing Concerns

Increased stress and burnout among staff remains a concern for 57% of physicians responding to the survey. Another 31% say things are getting better, with conditions returning to normal.

As far as number of staff, a majority of physicians, 56%, indicate their staffing level has not changed since the pandemic.

"Staffing is a huge issue with a challenge getting and keeping staff. We have had to dramatically increase salaries to keep and attract staff despite frozen and declining reimbursements," noted one physician.

Another physician described the challenges of masking. "It's more difficult interacting with patients when using a face mask. I work on eyes all day long. I must tell the patients to remove the masks in order to properly examine the eyes. People who have hearing deficiencies and need to see your face especially have trouble."

"There has been a huge delay in colon screening. We have tried to catch up with the backlog, but many patients have been lost to follow up. Unfortunately, there definitely is an uptick in colon cancer diagnosis."

What Would Physicians Do Differently?

The survey asked physicians what they would do differently in preparation for future crises. Four said the offices should remain open.

"We should not have shut down the office and hospital. It led to delay and loss of care and I'm unsure it had any benefit," said one.

Others pointed to the importance of maintaining telemedicine capability or suggested having pandemic preparedness plans in place.

Summarized one: "It's hard to know because these things are so unpredictable. Have maximum flexibility in staffing and costs. Be prepared for telehealth. Have safety and testing masking protocols in place, keep supplies stocked. Insurance policies should be in place and money saved for an emergency fund."

Medicaid Expansion Preserved, Much Health Care Legislation Stalls in Missouri Legislature

The Missouri Legislature had one of its least productive sessions in 2022, stymied in the Senate by the "conservative caucus" group of senators and their battle over the Congressional district map. They held up many pieces of legislation favorable to health care that had otherwise bipartisan support.

The information in this summary is drawn from legislative reports provided by the Missouri State Medical Association and news reports.

Medicaid Expansion Continues

Funding for Medicaid expansion was approved in the state supplemental budget for fiscal 2022 ending June 30, and for the new fiscal year beginning July 1. In addition, the budget raises the provider reimbursement rate to 75% of Medicare. While the House passed a measure to put before the voters a plan to redo the 2021 Medicaid expansion, it died in the Senate. That measure (HJR 117), if approved by voters, would have given the legislature the power to determine annual funding for Medicaid expansion, and would have imposed a work requirement.

Health Care Measures Approved

The following have been submitted to Gov. Mike Parson for his signature:

Hospital Visitation (SB 710, HBs 2116, 2097, 1690 & 2221). Hospitals are required to allow at least two designated caregivers to visit a patient. Various exceptions are made such as the operating room. MSMA opposed this legislation and worked to insert exemptions.

Ivermectin and Hydroxychloroquine Prescriptions (HB 2149). Physicians and pharmacists are shielded from disciplinary action from their respective licensing boards for legally prescribing and dispensing ivermectin or hydroxychloroquine to a patient. Pharmacists are restricted from contacting a physician or patient to dispute the medical efficacy of the drug.

Loans for Health Care Students (SB 710, HB 2331). Eligibility is expanded for state-funded health care student loan programs. The language includes an increase in available loans from $7,500 to $25,000 per academic year for medical students. MSMA supported these provisions.

Preceptorship Tax Credit (SB 718, HB 2331). This provision creates a tax credit for physicians who serve as preceptors for medical students in rural areas. The program is funded through a $7 increase in physician licensure fees. MSMA supported this legislation.

School Seizure Plans (SB 710, SB 681). School staff are required to work with parents or guardians of a child with a seizure disorder to create a plan of care for schools to use in case of a seizure. MSMA supported this bill.

Other legislation approved establishes labeling requirements for kratom products and limits the number of times a physical therapist candidate may take the licensing exam.

Health Care Bills That Failed

Caught in the Senate logjam were several bills sought by health care advocates and supported by SLMMS and MSMA:

MO HealthNet Postpartum Coverage (SBs 698 & 639 & HB 2604). These bills would have extended MO HealthNet (Medicaid) postpartum benefits from the current 60-day coverage period to one year after a covered mother gives birth.

Needle Exchange (SB 690). This would have authorized safe needle exchange programs to operate in Missouri.

Texting While Driving Ban (SB 713 & HB 1487). These bills would have prohibited a driver from operating a vehicle while texting or talking on a cell phone.

Mammography Services (HB 2760 and SB 1166). Championed by a Kansas City physician, this measure would have extended insurance coverage for certain mammography screenings.

FOR MORE INFORMATION

For more information, consult the legislative reports available to MSMA members; you can join MSMA by visiting www.msma.org. Also see the Missouri legislative websites at www.house.mo.gov and www.senate.mo.gov.

SLU Student-Run Clinic Seeks Physician Volunteers

A few hours of your time could make a big difference for Saint Louis University medical students and underserved individuals.

The SLU Health Resource Center, a student-run free clinic in north St. Louis, is seeking practicing physicians to serve alongside them during their Saturday morning clinics. Physician volunteers work with first- through fourth-year medical students to see and follow up with patients at the clinic. Students will obtain the patient history, then you will see the patients with the students, formulate a management plan, and review/sign the student-written patient note. The Health Resource Center allows students, especially M1s and M2s, to practice their clinical skills and work with faculty.

Longtime HRC volunteer Miguel Paniagua, MD, PhD with students.

The Health Resource Center provides both acute and transitional care along with offering specialty clinics in ob-gyn, diabetes, heart health and asthma/allergy. It also helps connect patients with Medicaid and other insurance and establish a relationship with a primary care provider. The HRC sees over 1,000 patients free of charge every year. The HRC is located at 1408 N. Kingshighway in the former Sears building.

SAINT LOUIS UNIVERSITY.

HEALTH RESOURCE CENTER

FAQs

What does a typical day look like for the physician volunteer?

- The day starts with an 8:45 a.m. meeting with the clinic manager. You will then meet with the patient follow-up volunteers to go over labs from the previous week. You'll then work with both pre-clinical and clinical students (M1s to M4s). Students will obtain the history and present it to you. You will see the patients with the students, formulate a management plan, and review/sign the student-written patient note.

What is the time commitment?

- Saturday mornings 8:30 a.m. to 12:30 p.m. Sign up for as many or as few Saturdays as you would like.

Is there malpractice coverage?

- Some employers provide malpractice coverage that extends to volunteer work. If your employer does not provide malpractice coverage, the HRC will work with you on establishing malpractice coverage through SLU.

To volunteer or with questions:
Maxwell Todd, maxwell.todd@health.slu.edu

To learn more about the HRC:
https://sluhrc.wixsite.com/patient

Saint Louis University medical students at the Health Resource Center. (Photos courtesy Health Resource Center)

Advancing Opportunities for Women in Cardiology

Only 14% of practicing cardiologists are women

Toniya Singh, MD, FACC, in April completed a three-year term as national chair of the Women in Cardiology Section of the American College of Cardiology (ACC). In this role, she has worked to advance opportunities for women cardiologists.

Dr. Toniya Singh

Dr. Singh, a longtime SLMMS member, is managing partner of St. Louis Heart and Vascular and practices at the Bridgeton, Granite City and Christian Hospital offices. She is board-certified in internal medicine and cardiovascular disease. Dr. Singh obtained her medical degree from the Lady Hardinge Medical College in New Delhi, India, and completed an internal medicine residency and a cardiology fellowship at Saint Louis University Hospital, serving as chief resident and chief fellow.

In the community, Dr. Singh has served on the board of the St. Louis Metro American Heart Association and is a board member of the Gateway Regional Medical Center. She is currently the chief of medicine at Christian Hospital and serves on the National Cardiovascular Management Council of the American College of Cardiology.

Dr. Singh shared her thoughts with *St. Louis Metropolitan Medicine* about leading the Women in Cardiology Section.

"It has been a learning and empowering process to participate and lead the section. We have had collaborations not only with women across the country but have also had collaborations with women cardiologists in Australia, Europe and the Middle East."

What are the goals of the Women in Cardiology Section and your major activities?

According to the latest data, only 14% of practicing cardiologists are women. The number of trainees is at 22%. The Women in Cardiology Section of the ACC offers women cardiologists opportunities to strengthen their professional support system and skills through networking events, professional development and mentoring programs. In addition, membership and active involvement in the Section provides a training ground for developing leadership skills and understanding the governance structure and avenues to leadership within the ACC.

What have been the group's accomplishments during your time on the Section leadership?

Over the last three years, we have started regional meetings to allow greater opportunities for networking and for showcasing the talent for women in cardiology. The Midwest WIC was started in 2017 by me with our first meeting in St. Louis. This served as a model for the southwest and the northeast regional meetings.We have also established a work group for pediatric women cardiologists. More women are pediatric cardiologists; however, this is not equally represented in their leadership.

What is it like to lead this group and to serve with other leading female cardiologists from around the country and the world?

The ACC has a wide and diverse national and international membership. It has been a learning and empowering process to participate and lead the section. We have had collaborations not only with women across the country but have also had collaborations with women cardiologists in Australia, Europe and the Middle East. Women cardiologists face similar challenges across the world and the diversity of our members has led to wonderful collaborations as we continue to work on challenges.

Why have so few women entered the cardiology specialty?

According to a 2018 survey of medical residents, the major reasons why women chose not to have a career in cardiology included concerns about length of training, adverse job conditions, radiation exposure, interference with family life, and a lack of diversity.[1] We have been working actively to help educate people regarding these challenges as well as working on solutions to deal with them.

Why did you enter cardiology? Why do you find it fulfilling?

My father had coronary artery bypass grafting when he was 47 and I was 15. I saw what a profound impact that had on him and us as a family. His excellent physicians made me want to be like them. As I went through medical school, I was really interested in cardiac physiology, and I was fortunate to be able to become a cardiologist. I find it fulfilling as there is constant innovation in how we treat our patients, and this allows us to improve their quality of life and allow our patients to live full lives and be there for their families. As a general cardiologist, I take care of a variety of different cardiac conditions and also get to

follow my patients over many years. It is very rewarding to see someone recover from a critical illness and return to a full and productive life.

"A recent analysis of 13 studies published from 2009 to 2019 found that female patients are less likely to receive guideline-recommended care when they are treated by a male physician."

What challenges have women faced in a specialty that remains over 85% male?

Based on recent studies published in the *Journal of American College of Cardiology*, men and women reported similar, high levels of career satisfaction. However, two-thirds of women continue to experience discrimination, nearly three times the rate in men. Women in cardiology are more likely than men to be single, not have children or require paid /unpaid child care in order to work compared to male cardiologists. There is no consistency in rules for maternity leave across the spectrum during training and in the workplace. Women cardiologists have higher rates of pregnancy complications. Lack of consistent regulations also impacts their health, career development, salaries and career advancement.[2,3]

Can female cardiologists play a special role with female patients, especially since cardiovascular disease often is underestimated in women?

A recent analysis of 13 studies published from 2009 to 2019 ("Does Patient-Physician Gender Concordance Influence Patient Perceptions or Outcomes?") found that female patients are less likely to receive guideline-recommended care when they are treated by a male physician. Also, the group noted, one study revealed that patient mortality after a myocardial infarction was highest when the physician was male and the patient was female. When the physician was female, however, care was much more consistent; there was no difference in mortality between male and female patients.[4]

What is the Women in Cardiology Section doing to encourage more female medical students to specialize in cardiology?

The ACC has started a special mentoring program for women internal medicine residents where they have sessions geared toward understanding the various aspects of cardiology. They have an opportunity to talk to cardiologists from different subspecialties and be paired with mentors who can help them navigate a career in cardiology.

What advice would you give to women considering cardiology? Why is this an appealing career opportunity for a female medical student?

I think cardiology is a fascinating specialty that gives us as physicians the opportunity to interact with patients having a variety of different pathologies. It is constantly improving and innovating, which allows us to do more and more to get our patients well. As cardiovascular disease is the number-one cause of mortality for both men and women, focusing on prevention as well as treatment allows us to make a major impact in many people's lives. You can also specialize as an imager, interventionalist, structuralist, electrophysiologist, lipidologist or a preventive cardiologist based on your interests. You can have a family, find work-life balance and pursue your passion based on what you choose to focus on.

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Medical Alumni Award


Dr. Otha Myles

Otha Myles, MD, received the Distinguished Service Award from the Medical Alumni Association of the University of Maryland School of Medicine. The award recognizes Dr. Myles' service to the alumni association and the medical school. In September 2021, Dr. Myles joined ArchWell Health as medical director; he previously was in private practice. He is a member of the SLMMS Council.

Celebrates Renovated Clinic

Orthopedic Associates celebrated the re-opening of its renovated clinic at 1050 Old Des Peres Rd. The updated facility features onside digital X-ray and MRI, a surgery center and an Injury Access Clinic for walk-in treatment. SLMMS members in the practice include James Burke, Jr., MD; Robert Kramer, MD; Michael Nogalski, MD; and Christopher O'Boynick, MD.

Drug Overdose Deaths Reach Record Totals

Nationally, a 50% increase in overdose deaths is sparked by synthetic opioids such as fentanyl

Drug overdose deaths in the United States have soared in the last two years, reaching a record 107,000 deaths in 2021, the Centers for Disease Control and Prevention reported in May. This marks a 15% increase over the 92,478 overdose deaths that occurred in 2020 and 50% higher than the 71,130 deaths in 2019.

Missouri's totals parallel the national trend: 2,202 predicted deaths in 2021, up 15% over 2020 and 37% higher than 2019. In the City of St. Louis, overdose fatalities rose from 317 in 2017 to 492 in 2020 and 448 in 2021. In St. Louis County, there were 490 overdose deaths in 2021 compared to 301 in 2017.

The increase is largely driven by deaths due to synthetic opioids such as fentanyl. In Missouri, synthetic opioid overdose deaths climbed from 531 in 2016 to 1,230 in 2020, representing 65% of overdose fatalities. In 2021 for all forms of opioids, there were 352 overdose deaths in the City of St. Louis and 343 in St. Louis County.

Black males have been especially hard-hit by the epidemic. In Missouri, the rate of opioid overdose deaths among Black males more than doubled between 2016 and 2020, from 37.8 to 85.4 per 100,000 population. This compares to 30.0 for Black females, 24.6 for white males and 11.7 for white females.

Another growing concern is stimulant overdoses, which led to 221 deaths in St. Louis County in 2021 compared to 109 in 2017.

In February, the City of St. Louis issued a call to action urging residents to educate themselves about the signs of opioid overdose and reach out for support for addiction if necessary.

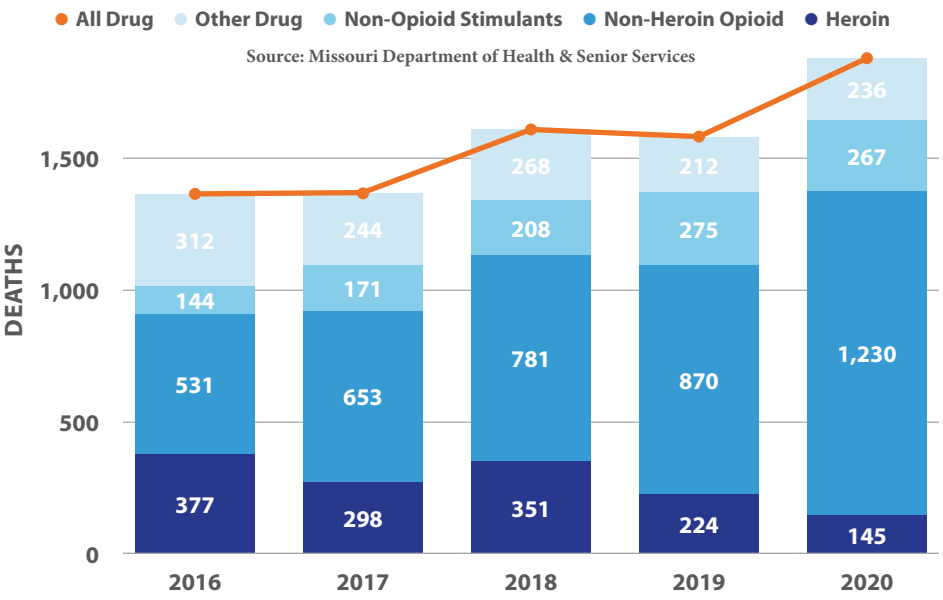
"Usually when someone survives an opioid overdose, it is because someone else recognized what was happening, knew what to do, and took action," says Matifadza Hlatshwayo Davis, MD, MPH, director of health for the City of St. Louis. "Therefore it is imperative that the community understands the signs and symptoms of opioid overdose."

In St. Louis County, curbing the opioid epidemic is one of five county-wide strategic priorities. Action steps include continuing to increase the availability of naloxone for overdoses, increasing support for medication-assisted treatment, and working to integrate medication-assisted treatment into the county Department of Public Health clinics.

For Information on Opioid Treatment Resources

https://www.nomodeaths.org/

MISSOURI RESIDENT OVERDOSE DEATHS



MISSOURI LAUNCHES OVERDOSE DASHBOARD

The Missouri Department of Health & Senior Services has launched a data dashboard to track the growing overdose epidemic. It includes sections on deaths, broken out by drug and demographics, as well as non-fatal hospital visits. View the dashboard at https://health.mo.gov/data/opioids/

Battling the Opioid Epidemic: Time to Change One Drug for Another

Substitution therapy and other harm reduction strategies have proven to be more effective than abstinence-based therapy

By Luis A. Giuffra, MD, PhD

At the end of World War II, methadone (an analgesic developed in Germany) was approved in the U.S. for pain control, since some of its pharmacological properties (including a longer half-life) made it more attractive than other morphine-based analgesics of the time. Soon, it began to be used to detoxify heroin-dependent individuals. And in the 1960s, it was studied as maintenance therapy for those chronically dependent on highly addictive opioids. **That was the beginning of substitution therapy: changing a highly lethal drug, like heroin, for another with a much better safety profile, like methadone.**

Methadone maintenance treatment was quickly proven to be a success. Since its introduction almost 60 years ago, methadone has saved innumerable lives. It has also prevented the consequences (e.g., HIV/AIDS and hepatitis) of injecting street drugs using dirty needles and has decreased the rates of criminal behavior associated with the procurement of illegal drugs. Methadone is, therefore, a prime example of the numerous benefits of substituting a dangerous drug for a safer one.

But why is substituting drugs needed in the first place? Wouldn't it be much better to simply detox those affected by opioid dependence and then help them remain fully abstinent? On the surface, the answer should be "yes," but in reality, abstinence-based treatment for opioid use disorder (OUD)—especially among people who inject drugs—has proven to be a catastrophic and lethal failure.

Abstinence and Mortality

One of the highest risk factors for mortality among OUD patients is taking them off opioids without providing appropriate substitution treatment. When forced into abstinence, patients quickly lose the tolerance developed to their opioid drug of choice. Then when they relapse—as they almost invariably do—they resume use without tolerance, and are at high risk of developing respiratory depression and die of an overdose. One study showed that patients who refuse to attend an abstinence-based 30-day program and who stay on the streets using drugs, had a better survival rate than those who went to treatment: Almost 10% of those going to abstinence treatment died of a subsequent opioid overdose, while none of the patients who "failed" (i.e., refused to go) died.

However, methadone is not without imperfections. As a full opioid agonist, it is still capable of killing by overdose, although the amount of annual methadone overdose deaths is minuscule when compared with the overdose deaths caused by heroin and fentanyl. And it is not an easy drug to prescribe; it is subject to tight regulations by federal and state government agencies. Using methadone to treat OUD patients requires it to be dispensed from an approved opioid treatment program (i.e., a "methadone clinic"). And it can only be dispensed in tightly regulated schedules, including only one dose at a time, requiring patients to go to the clinic on a daily basis. After several months of documented use and no diversion, take-home doses are slowly introduced.

Buprenorphine Now Preferred

Methadone's shortcomings can be largely overcome when prescribing buprenorphine, the best OUD drug in our armamentarium. Buprenorphine is quickly becoming the first-line drug used in substitution therapy worldwide. Unlike methadone, it is only a partial opioid agonist with an extremely small risk of causing respiratory depression and death. And it can be prescribed from any physician's office with refills, and not through any tightly regulated program. There are caps on how many patients a buprenorphine prescriber can have at any given time, but the requirements for prescribing (including prescribing by NPs and PAs) are being continuously relaxed.

The failure of abstinence-based programs for OUD and the success of substitution therapies with methadone and buprenorphine have led to the development of harm reduction methods, a group of interventions used to minimize the consequences of using opioids rather than keeping a blind

continued

Dr. Luis A. Giuffra

Luis A. Giuffra, MD, PhD, is a professor of clinical psychiatry at Washington University and a founding member of Clayton Behavioral. He can be reached at lgiuffra@claytonbehavioral.com.

insistence on complete abstinence. And on top of the list of successful harm reduction interventions is substitution therapy. Harm reduction is overwhelmingly supported among clinicians and scientists devoted to the study and treatment of OUD patients. Numerous studies show conclusively that harm reduction is far more effective than abstinence-based programs in retaining patients in treatment and in preventing overdose deaths, blood borne infections and criminality. Other harm reduction interventions include giving clean needles to people who inject drugs, providing safe injection sites, and in rare but strikingly successful cases, the use of chemically graded heroin as substitution therapy.

Overcoming Resistance to Substitution Therapy

Why, then, is substitution therapy not used more widely? Why are only a minority of OUD patients ever offered and started on buprenorphine or methadone? One of the main reasons is the stigma of this treatment modality among those in charge of treating OUD patients. Historically, the provision of addiction treatment services has been driven mostly by people in recovery and not by physicians or medical scientists. As a result, those in recovery try to replicate what worked for them (i.e., recovery without substitution therapy) and therefore rely on their own anecdotal personal experiences rather than the published scientific literature. A common argument against substitution therapy is that "it just replaces one drug for another"… which indeed it does!

Now, having a patient on buprenorphine is still given as a reason for treatment centers to deny them admission to treat any co-morbid addictions, like alcoholism. Patients are required to get off buprenorphine prior to going to a majority of rehab centers. And a quick online search for buprenorphine treatment centers is likely to provide places that "treat" the use of buprenorphine as one more addiction, and recruit and admit patients solely to take them off their medication, with the resulting loss of tolerance and increased overdose death risk.

Traditionally, programs created under an abstinence-based philosophy tend to insist on (if not demand) providing counseling as a requisite to accessing buprenorphine, and as a result, such programs can become a barrier to patients trying to access this lifesaving medication. In fact, there is a large body of data suggesting that methadone or buprenorphine alone (without counseling) is often as effective as when these same medications are given with concomitant and mandated counseling.

Fortunately, through the activity of dedicated harm reduction scientists both locally and nationally, this trend is being reversed, and substitution therapy is being offered first (and at times by itself) in several publicly funded treatment centers. Some abstinence-based centers insist on their outdated approach by not offering buprenorphine or methadone first, but by offering an opioid antagonist, extended-release naltrexone (Vivitrol). This is a very expensive and inferior drug with a controversial marketing history—the manufacturer, Alkermes, has been accused of minimizing the risks that patients on this medication have when they use it and lose tolerance to opioids, leading to an increase in subsequent overdose deaths. Furthermore, in order to start treatment with a naltrexone formulation, OUD patients have to be free of opioids for 10-14 days. In that extremely difficult period of withdrawals, about one third of those intended to be treated are lost to follow-up. It is a well-documented fact that naltrexone does not decrease overdose deaths among opioid-dependent patients. Methadone and buprenorphine do.

Opponents of more widespread access to buprenorphine point out the likely misuse and diversion of this drug. Indeed, abuse and diversion do occur and have been documented around the world. However, the death toll of abuse and diversion is minimal, so the benefits of low-barrier availability of this drug largely outweigh this problem. It is very rare for buprenorphine to cause a lethal overdose, and overdose deaths where buprenorphine is present in the toxicology analysis typically also include several other drugs.

Urgent Need as Opioid Epidemic Grows

As the COVID pandemic waxes and wanes, the ugly face of the opioid epidemic has resurfaced with a vengeance. Overdose deaths continue to rise, now topping over 100,000/year in the U.S. Although it hits all levels of society, the epidemic disproportionately affects minorities. And although it primarily kills younger adults, overdose deaths increased by 1,886% among adults 55 and older between 1999 and 2019. Over the last several years, heroin has been replaced as the top cause of overdose deaths by fentanyl, a synthetic analog with higher, deadlier potency and lower cost. This fact contributes to a sense of urgency in treating this devastation disorder properly and with our best tools.

When it comes to the opioid epidemic, it is urgent to implement effective and scientifically proven interventions, and not let anecdotes or personal opinions guide the treatment of this highly lethal disorder. Sadly, the main barrier for this to take place is, by far, the stigma against both patients with opioid use disorders and those in substitution therapy.

Commencing Substance Use Treatment for Already-Hospitalized Patients

When a patient is in the hospital for another condition and has substance use disorder, there are advantages to beginning treatment

By Evan Schwarz, MD, FACEP, FACMT, FASAM

Outpatient options for people with substance use disorders (SUDs) have grown over the last 10 years, including the formation of low-barrier clinics, emergency department buprenorphine programs, naloxone dispensation programs and other harm reduction programs. While all of these are great, the same energy has lagged in the inpatient setting.

Little is done for inpatients with SUDs, outside of maybe offering nicotine patches for smokers. And, those nicotine patches by themselves are likely inadequate without additional treatments.[1,2] This is despite the fact that nearly half a million hospitalized patients have a diagnosis of opioid use disorder (OUD).[3] In fact, up to 11% of all hospital inpatients have SUDs not related to alcohol or tobacco.[4,5]

Every day, patients are admitted due to complications from their SUD, including cellulitis, endocarditis, bacteremia, osteomyelitis, hepatitis, hematemesis, withdrawal and trauma, just to name a few. While medications may be provided, they mostly are used to treat specific symptoms (e.g., diarrhea) or withdrawal. For instance, patients with OUD may receive antiemetics or sympatholytics (e.g., clonidine).

If patients receive opioids and aren't forced to "detox," many times they are provided a rapid taper, which doesn't really treat the underlying disease; it just greatly diminishes their tolerance and puts them at risk for an overdose once they are discharged. Patients in ethanol withdrawal, of course, receive symptomatic treatment (i.e., benzodiazepines) but little is done to treat cravings and reduce long-term drinking. This is despite the fact that these patients are literally stuck right in front of us—sometimes for days or weeks at a time!

Dr. Evan Schwarz

Evan Schwarz, MD, FACEP, FACMT, FASAM, is division chief of medical toxicology and associate professor of emergency medicine at Washington University School of Medicine. He is on staff at Barnes-Jewish Hospital and St. Louis Children's Hospital. He also is a member of the SLMMS Council. He can be reached at schwarze@wustl.edu.

While there can be some logistical difficulty, the main reasons for not offering further treatment of their SUD generally are rooted in stigma. Some of the stigma is based on prior negative experiences or because the medical team may believe the patient won't change or doesn't want to get better, which generally is not true.

Treating patients with OUD with either methadone or buprenorphine in the hospital decreases their mortality.

AMA URGES SUBSTANCE ABUSE POLICY GOALS

The American Medical Association is asking state and federal policymakers to fight the overdose epidemic by embracing steps that will save lives by ensuring evidence-based treatment and harm reduction to patients. "Among the actions we recommend: decriminalize fentanyl test strips, remove the prescription status of naloxone and make it over the counter; and hold insurers accountable for repeated, willful violations of state and federal mental health and substance use disorder parity laws," said Bobby Mukkamala, MD, chair of the AMA Board of Trustees and chair of the AMA Substance Use and Pain Care Task Force. For more information on AMA efforts, see the issue brief, "Nation's drug-related overdose and death epidemic continues to worsen," at www.ama-assn.org.

continued

Commencing Substance Use Treatment …

Medical Complications of Substance Use Disorders

Additionally, there is a significant financial cost when these patients require admission for medical complications from their SUD. A recent study examined the U.S. National Inpatient Sample (NIS) from 1998 to 2016 to describe hospitalizations of patients with OUD.[6] NIS is a stratified sample of hospital discharges designed to create national estimates. In this study, nearly a quarter of patients were admitted for greater than three days, and nearly 10% were self-discharges (left against medical advice). Mean and median hospital charges were $32,792 and $18,244 for this cohort, respectively. Keep in mind that this data only included patients with OUD; it excludes other SUDs such as alcohol use disorder, which may be a bigger problem than opioids but just doesn't carry the same short-term mortality.

Patients who received a consult were much more likely to be started on MOUD, 87% compared to 17%.

The Need for a New Approach

So why change our approach? Well, there are many reasons. Treating patients with OUD with either methadone or buprenorphine in the hospital decreases their mortality. The Massachusetts Chapter 55 dataset was reviewed for patients with a nonfatal opioid overdose between 2012 to 2014.[7] This dataset represents more than 98% of Massachusetts residents. Patients were identified via ICD-9 codes or by having an ambulance encounter for an opioid overdose. Methadone was associated with decreased all-cause and opioid-related mortality (adjusted hazard ratio of 0.47 [CI 0.32-0.71] and 0.41 [0.24-0.70], respectively). Buprenorphine was associated with similar reductions. However, only a small amount of patients received methadone or buprenorphine (11% and 17%, respectively) in the 12 months following a nonfatal overdose.

Another retrospective study reviewed the Massachusetts Public Health Data Warehouse from 2011 to 2015 for patients admitted with infective endocarditis due to injection drug use.[8] The study included 2,700 patients, with 84% having follow-up for six months after the hospitalization. Medication for opioid use disorder (MOUD)—formerly referred to as medication for addiction treatment (MAT)—was associated with reduced mortality (adjusted hazard ratio 0.30 [95% CI 0.10-0.89]). Still, only 24% received MOUD in the three months after hospitalization, and individuals were more likely to stop existing MOUD treatment than to start it after hospitalization.

Medication for OUD Offers Many Benefits

Besides improved mortality, there are other benefits from offering MOUD to inpatients. A retrospective chart review evaluated patients who received an addiction medicine consult versus those who did not.[9] Patients were not randomized, and those who received a consultation were at the discretion of the treating team. Those limitations aside, patients who received a consult were much more likely to be started on MOUD, 87% compared to 17% (OR 31.68 [CI 10.25-81.29]). As importantly, they were also more likely to complete antibiotic therapy, 79% compared to 40% (OR 5.57 [CI 2.25-13.07]) and much less likely to self-discharge or leave against medical advice, 16% versus 49% (OR 0.19 [CI 0.08-0.48]).

Patients who received a consult were also less likely to be readmitted within 90 days; and when readmitted, they were much less likely to be admitted to the intensive care unit. In another study, all-cause readmission rates at 90 days in patients with serious injection drug related infectious complications were lower in those who received addiction medicine consultation services and follow-up than those who did not, 23% compared to 41% (OR 0.44 [CI 0.25-0.80]).[10] Additionally, unpublished survey data from my institution after implementing interventions aimed at improving the

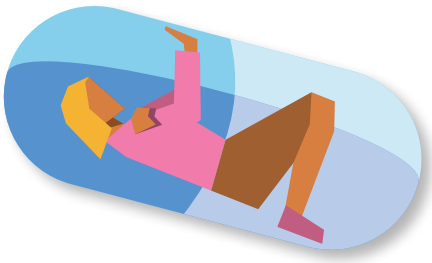
STUDY FINDS BUPRENORPHINE UNDERUSED

Less than half of Americans who received treatment for opioid use disorder over a five-year period were offered buprenorphine, a potentially lifesaving medication, researchers at Washington University School of Medicine and Saint Louis University have found. The study was published May 10 in the *JAMA Network Open*.

The study analyzed health insurance data from 2011–2016 involving about 180,000 people treated for opioid use disorder. Researchers found that nearly 53% of the patients with the disorder alone were not prescribed the medication. Among those with polysubstance use disorder, the number prescribed buprenorphine dropped to about 30%.

care of patients with OUD demonstrated decreased incidence of violent events involving patients who required security and greater nursing comfort and satisfaction in patients who received MOUD.

The benefits don't stop there. Many of these patients are admitted with infectious complications. These patients can require between 2-8 weeks of intravenous antibiotics. These are long and costly hospitalizations … so even more reason to treat their SUD to prevent a readmission, but I digress. While patients without SUDs may receive peripherally inserted central catheters (PICC) to complete their course of antibiotics at home, those who inject drugs historically have not been eligible for this due to concerns of them misusing the PICC.



If the patient is admitted for a different primary reason (e.g., trauma, cellulitis, bacteremia), there are no restrictions on starting medication.

While most patients who inject drugs and require intravenous antibiotics will need to remain in the hospital, some can actually receive outpatient parenteral antimicrobial therapy![11-13] As it turns out, if selected properly, patients who do well on MOUD and have social support can receive parenteral antibiotics at home, which potentially cuts weeks off costly hospitalizations and opens up those rooms to other patients.

Though treating patients in the outpatient setting can be tricky, it is much easier in the inpatient setting. While access to addiction consult services is beneficial, treating inpatients with OUD is possible even if this service is unavailable.[14] For those with OUD, no special license is needed to start or continue buprenorphine or methadone. If the patient is admitted for a different primary reason (e.g., trauma, cellulitis, bacteremia), there are no restrictions on starting medication. If they are admitted only for OUD, and it isn't in a specially licensed facility, then you can only treat them for up to 72 hours.[15] Of course, these patients shouldn't need to be admitted as they can be started on buprenorphine in the emergency department and discharged.[16,17]

To discharge a patient with a prescription for buprenorphine, providers will still need an x-waiver. Good news, though. You no longer need any education to obtain the waiver, although I would recommend some.[18] You can just apply to get it directly. It takes approximately 10 minutes, is free, and allows you to have 30 active prescriptions at one time. Even better news. As of late March, the Drug Enforcement Agency (DEA) is now allowing hospitals and providers without a waiver to just give patients up to 72 hours of either buprenorphine or methadone under the three-day rule.[15] This is brand new, so it's still being determined how this will be implemented as the DEA must be notified prior to implementing a three-day rule. No special licensing is necessary to treat patients with alcohol use disorder in the hospital.

Resources for Physicians

Fortunately, there are plenty of resources available to assist physicians in the hospital. CA Bridge (https://cabridge.org) has easy-to-use algorithms and education for OUD and other SUDs. The website includes information to start buprenorphine and methadone. There are also new protocols that allow for induction with either very high doses or low doses (microdosing or the Bernese method) of buprenorphine for patients who can't tolerate a typical induction.[19,20] While buprenorphine is very safe with multiple dosing regimens, methadone induction is a little more rigid. No more than 30 mg po can be administered on day one, with the exception that 10 mg more can be administered one hour later if the patient is still in withdrawal.

Afterwards, it must be titrated slowly to prevent stacking and respiratory depression. Additionally, physicians cannot write a bridge prescription for methadone. For alcohol use disorder, more can be done besides benzos or clonidine. Anticraving medications such as gabapentin, valproic acid or carbamazepine can be started. Naltrexone and acamprosate can be administered to decrease drinking, too. Medications for stimulant use disorder from methamphetamine are still being studied, but there may be a role for a combination of naltrexone with bupropion, mirtazapine or even buprenorphine.[21–23]

While these therapies may demonstrate some utility in stimulant use disorder, much more research is needed prior to widespread implementation. Though medications are important, an existing hospitalization also offers an opportunity to initiate other psychosocial treatments for patients that desire them.

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SSM Health Efforts for the Underserved in COVID-19

Editor's Note: The following is a supplement to the April-May St. Louis Metropolitan Medicine *article on the efforts of local health departments and hospital systems to advance health equity around COVID-19. The original article included information on BJC HealthCare and Mercy; the information below covers SSM Health.*

SSM Health has worked to advance health equity during COVID-19 through its support of the St. Louis Metropolitan Pandemic Task Force and outreach efforts for testing and vaccination in the community.

Chairing the task force has been Alex Garza, MD, chief community health officer of SSM Health. From the start of the pandemic in March 2020, he has given briefings to media and the community as many as six times a week over Facebook, providing current data and highlighting issues of concern. Formation of the task force forged an increased level of cooperation and collaboration between health systems, public health, the business community, community-based clinics and more, and the task force advocated for equity issues such as vaccine distribution.

On the health delivery side, SSM Health emphasized and advocated for the most vulnerable populations with regards to protective measures and vaccinations. In addition to prioritizing the elderly population, SSM Health focused outreach and vaccination efforts on 10 ZIP codes having the greatest socioeconomic disparities. Nearly 7,000 patients were reached in these areas.

In partnership with Home State Health, Affinia, and the Urban League of Metropolitan St. Louis, SSM Health administered 1,000 first and second doses of COVID-19 vaccine to patients with high socioeconomic needs in March and April 2021 at the Urban League of Metropolitan St. Louis. SSM Health provided vaccine supply, administration, and physician oversight for

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events. This included a vaccination clinic held March 27-28, 2021, at the Victor Roberts Building on North Kingshighway, focusing on providing COVID-19 vaccines to people over the age of 65 in underserved ZIP codes.

In the Ritenour School District, which has a high percentage of Hispanic families, SSM Health hosted multiple vaccine events. Jayceen Ensrude, vice president of operations of SSM Health Medical Group, described the effort: "Through our mobile vaccination team, we offered vaccinations to students and families in a familiar and non-intimidating location and provided Spanish-speaking interpreters."

Drive-through COVID-19 testing was offered in underserved communities at the Ronald McDonald House location on South Grand and SSM Health Cardinal Glennon Pediatrics in North County. Testing was also offered at SSM Health urgent care locations across the metropolitan region.

"The relationships and partnerships that we have developed throughout the pandemic in serving the highest-risk communities can be leveraged to address a multitude of other ongoing health inequities beyond COVID-19," said Deidre Griffith, SSM Health St. Louis regional director of community health.

ALLIANCE

Members Recognized: Two SLMMS Alliance members were honored at the MSMA Alliance annual meeting during the MSMA convention April 2. **Angela Zylka** received the Jean Wankum Spirit of the Alliance Award for her work with the Hungry Heroes program distributing gift bags to frontline staff at area hospitals; she also was presented a special award along with former St. Louisan **Millie Bever** for their 28 years of service to medical students by organizing Match Day events. **Sue Ann Greco** received the Sandra Mitchell Member of the Year Award along with a special resolution from the MSMA House of Delegates honoring her service to the state and national Alliance including service as AMA Alliance president for 2020-2021.

2022-2023 Officers Elected: Leading the SLMMS Alliance for the 2022-2023 year are **Jo-Ellyn Ryall, MD**, and **Gill Waltman**, co-presidents; **Angela Zylka**, vice president-health; **Sue Ann Greco**, vice president-membership; **Sandra Murdock**, treasurer; and **Jean Raybuck**, corresponding secretary. Dr. Ryall also is serving as vice president-legislation; Gill also is serving as vice president-foundation and recording secretary.

Joyce E. Woolsey, MD

Joyce E. Woolsey, a pediatric neurologist, died April 1, 2022, at the age of 92.

Born in Pittsfield, Mass., Dr. Woolsey received her undergraduate degree from Fontbonne University, and her medical degree from Saint Louis University School of Medicine. Following an internship at SSM Health St. Mary's Hospital, she completed her residency at Boston Children's Hospital. With her husband, the late Robert M. Woolsey, MD, she helped establish the Department of Neurology at Saint Louis University Medical Center. Dr. Woolsey served as a pediatric neurologist at Cardinal Glennon Children's Hospital for many years. In gratitude for the full scholarship she received to Fontbonne, in 2009 Dr. Woolsey established the Leo V. and Bess D. Devine Endowed Scholarship at the university in honor of her parents. Dr. Woolsey joined the St. Louis Metropolitan Medical Society in 1956.

She was predeceased by her husband Dr. Robert M. Woolsey. SLMMS extends its condolences to her daughter Kathleen Bilderback; and her two grandchildren.

Paul B. Webb, Jr., MD

Paul B. Webb, Jr., MD, an ophthalmologist, passed away April 28, 2022, at the age of 96.

Born in St. Louis, Dr. Webb earned both his undergraduate and medical degrees from Saint Louis University. He interned at what was then St. John's Mercy Hospital, before completing his residency in ophthalmology at Indiana University School of Medicine. Prior to attending college and medical school, he served in the U.S. Army in World War II from 1943 to 1946 with the 110th Infantry Regiment, and saw combat in both the Battle of Hurtgen Forest and the Battle of the Bulge. Dr. Webb was in private practice in ophthalmology in St. Louis for 37 years and was an assistant clinical professor at Saint Louis University School of Medicine. Dr. Webb joined the St. Louis Metropolitan Medical Society in 1953, and remained a member for more than 68 years. At the time of his passing, he was the second longest continuing member of the Society.

SLMMS extends its condolences to his wife Bessie (Brenneisen) Webb; his children Paul Webb, David Webb, Stephen Webb, Richard Webb, Timothy Webb, Matthew Webb, Kevin Webb, Diane Leek and Patricia Heard; his 23 grandchildren; and his seven great-grandchildren.

Substance Use References … *continued from page 17*

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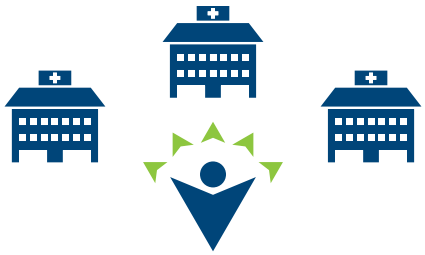
Private Equity Firms Acquiring Physician Groups

Portion of total practices remains small

The number of physician medical groups acquired by private equity firms nationally nearly doubled to 400 in the 12 months ended November 15, 2021, according to a report from the accounting and management consulting firm PWC.[1]

This compares to about 200 to 250 deals per year during 2017 to 2019. Practices have experienced challenging economics and are concerned about Centers for Medicare and Medicaid Services (CMS) payment cuts, the report said. Overall, private equity deals in the health care sector rose 56% in the 12-month period.

Deals are being driven by forces including capital availability, regulatory pressures, searches for value, resilience imperatives and evolving value chain power dynamics, PWC said.



"Private equity firms' typical investment strategy is to acquire 'platform' practices with large community footprints and then grow value by recruiting additional physicians, acquiring smaller groups and expanding market reach."

Another study, published in *JAMA* in February 2020, found that between 2013 and 2016, private equity firms acquired a total of 355 physician practices comprising 5,714 physicians and 1,426 locations. These numbers still represent a small portion of the 18,000 group medical practices across the U.S., the *JAMA* study noted.[2]

"Private equity firms expect greater than 20% annual returns and these financial incentives may conflict with the need for longer-term investments in practice stability, physician recruitment, quality, and safety," the researchers cautioned.

The most commonly acquired practice specialties from 2013 to 2016 were: anesthesiology, 19.4%; multispecialty, 19.4%; emergency medicine, 12.1%; family practice, 11.0%; and dermatology, 9.9%.

A profile of practices with several sites and many doctors matches "private equity firms' typical investment strategy of acquiring 'platform' practices with large community footprints and then growing value by recruiting additional physicians, acquiring smaller groups and expanding market reach," the study authors commented.

Also attractive are specialties such as dermatology where there is potential for additional revenue through elective procedures, adds a 2019 study published in the *Annals of Internal Medicine*.[3]

Changes in reimbursement are making practices less attractive to hospital systems, explained Roseland, N.J., health care attorney John Fanburg, in *ENT Today*. "In an era of reimbursement reform, with recent legislation that eliminates so-called site of service payment differential, the incentive for hospital systems to continue to acquire private practices will decline." Private equity options, he added, offer physicians greater independence and autonomy while securing greater financial security.[3]

Fanburg suggested that practice owners work with experts including an account and a mergers and acquisitions lawyer to ensure that negotiations with the private equity firm deliver the desired contract.

There are three main ethical concerns that practices should consider when selling to private equity, according to G. Richard Holt, MD, of the Center for Medical Humanities and Ethics at the University of Texas Health Science Center, as quoted in *ENT Today*:

- Ensure that patient care is not compromised.
- Maintain the physician-patient relationship.
- Adhere to the physicians' ethical responsibilities to their patients.[3]

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

Gregory B. Auffenberg, MD
12855 N. Outer 40 Dr., Ste. 375 63141-8657
MD, Northwestern Univ., 2009
Born 1983, Missouri Licensed 2021 ► **Active**
Certified: Urology

Brandon Tyler Beal, MD
540 E. Cherry Street 63379-1410
MD, Saint Louis Univ., 2015
Born 1986, Missouri Licensed 2022 ► **Active**
Certified: Dermatology

Paul S. Catanzaro, MD
7537 Lovella Ave. 63117-2139
MD, American Univ. of the Caribbean BWI, 1983
Born 1957, Missouri Licensed 1986 ► **Active**
Certified: Internal Medicine

Michael F. Donovan, MD
2340 Hampton Ave. 63139-2935
MD, Univ. of Illinois-Chicago, 2015
Born 1982, Missouri Licensed 2018 ► **Active**
Certified: Family Practice

Brendan M. Fong, MD
12855 N. Outer 40 Dr., #375 63141-8657
MD, Univ. of California, 2013
Born 1987, Missouri Licensed 2017 ► **Active**
Neurological Surgery

Sarah J. Fouke, MD
12855 N. Outer 40 Dr., Ste. 375 63141-8657
MD, Washington Univ., 2000
Born 1974, Missouri Licensed 2015 ► **Active**
Certified: Neurological Surgery

Katherine E. Huhn-Usry, MD
1368 Haute Loire Dr. 63011-2964
MD, American Univ. of the Caribbean, 2004
Born 1970, Missouri Licensed 2008 ► **Active**
Certified: Family Practice

Majdee M. Islam, MD
12855 N. Outer 40 Dr., Ste. 375 63141-8657
MD, Univ. of Missouri-Columbia, 2015
Born 1989, Missouri Licensed 2021 ► **Active**
Urology

Stephen J. Johans, MD
12855 N. Outer 40 Dr., Ste. 375 63141-8657
MD, Univ. of Missouri-Columbia, 2012
Born 1984, Missouri Licensed 2019 ► **Active**
Certified: Neurological Surgery

Rohit Kesarwani, MD
12855 N. Outer 40 Dr., Ste. 125 63141-8663
MD, Saint Louis Univ., 2014
Born 1986, Missouri Licensed 2021 ► **Active**
Certified: Neurological Surgery

Michael N. Polinsky, MD
12855 N. Outer 40 Dr., Ste. 375 63141-8657
MD, Washington Univ., 1990
Born 1964, Missouri Licensed 1997 ► **Active**
Certified: Neurological Surgery

David J. Prelutsky, MD
2340 Hampton Ave. 63139-2935
MD, Saint Louis Univ., 1979
Born 1954, Missouri Licensed 1981 ► **Active**
Certified: Internal Medicine

Scott H. Purvines, MD
12855 N. Outer 40 Dr., #375 63141-8657
MD, Indiana Univ. Sch. of Med., 1999
Born 1970, Missouri Licensed 2005 ► **Active**
Certified: Neurological Surgery

Joseph R. Ritchie, MD
1377 S. Mason Rd. 63131-1210
MD, Ohio State Univ., 1998
Born 1962, Missouri Licensed 1997 ► **Retired**
Orthopedic Surgery

Neil M. Wright, MD
12855 N. Outer 40 Dr., Ste. 375 63141-8657
MD, Univ. of California, 1993
Born 1967, Missouri Licensed 1999 ► **Active**
Certified: Neurological Surgery

Andrew S. Youkilis, MD
12855 N. Outer 40 Dr., #375 63141-8657
MD, Univ. of Cincinnati, 1996
Born 1968, Missouri Licensed 2003 ► **Active**
Certified: Neurological Surgery

WELCOME STUDENT MEMBERS

Saint Louis University School of Medicine

Maleeha Fatima
Megan L. Halloran
Margo Kahn
Morgan Ross
Olivia A. Spaedy

Washington University School of Medicine

Madeleine Busby
Erika B. Madrian
Joseph G. Ribaudo
Maytal M. Silberberg
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Naazanene M. Vatan

Sound Health MSO Offers Practice Management Services

Sound Health Services, a private practice otolaryngology group, has formed Sound Health MSO, a management services organization (MSO) that provides a wide range of administrative services and management functions needed by physician practices to be successful in today's health care environment. The MSO offers multiple service and integration scenarios to address the needs and circumstances of different practices.

James Hartman, MD, otolaryngologist, president of Sound Health Services and SLMMS member, noted, "Over the past few years, physicians have faced increasingly difficult challenges managing their practices. We now have a better way to utilize our expertise and resources in both practice management and practice integration to help physicians navigate the future and remain in private practice." ◄

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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