ST. LOUIS METROPOLITAN
MEDICINE
VOLUME 45, NUMBER 3 THIRD QUARTER 2023

Telemedicine Continues to Grow Post-Pandemic

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Inside

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.

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ST. LOUIS METROPOLITAN MEDICINE NOW QUARTERLY

St. Louis Metropolitan Medicine contains timely news and features impacting medicine in the St. Louis area. For current SLMMS news, watch for the Member Update email about the 15th of each month. If you are not receiving the Member Update, contact Dave Nowak at dnowak@slmms.org.

Next issue: Nov. 1 | Article and ad space reservation deadline: Oct. 1

Fixing Medicare Payment System Must Be Priority

AMA delegates call for reforms

By M. Laurin Council, MD, MBA, FAAD, FACMS, President, St. Louis Metropolitan Medical Society 2023

M. Laurin Council, MD, MBA, FAAD, FACMS

When one includes inflation-adjusted earnings, payments have actually decreased by 26%.

Early this summer, physicians from all specialties and all parts of the country gathered in Chicago for the Annual Meeting of the American Medical Association (AMA). Members of the St. Louis Metropolitan Medical Society (SLMMS) and members of the Missouri State Medical Association (MSMA) were among those in attendance, aiming to advocate for issues affecting our practice of medicine. While the many resolutions that were considered covered a great breadth of topics, physicians made it resoundingly clear that something drastic must be done to sustain our Medicare payment system.

The topic of Medicare payment reform is not at all a new concept for physicians across the country. It seems as though every year we have the conversation about major impending cuts, only to have Congress release a temporary and incomplete fix at the very end of the legislative session. SLMMS 2022 President Erin Gardner, MD, wrote about this issue in the August/September 2022 *St. Louis Metropolitan Medicine*, and here we are, a year later, having a very similar conversation.

So what exactly are the issues? In a compelling image drafted by the AMA (Table 1), one can see that physician payments have increased very little over the past two decades. When one includes inflation-adjusted earnings, payments have actually decreased by 26%.[1] With costs of maintaining a medical practice soaring astronomically, this direction is an incredible threat to the sustainability of the practice of medicine as we know it.

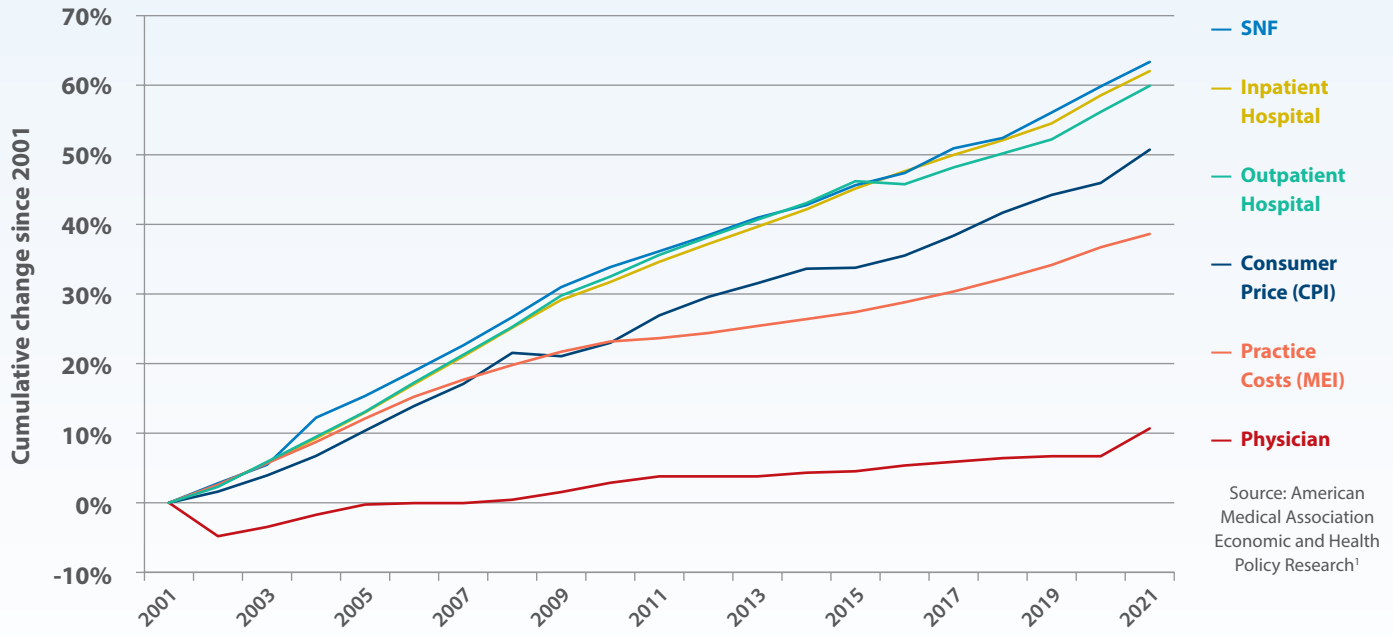
In order to counteract these trends, AMA delegates at the Annual Meeting committed to prioritizing significant increases in funding for federal and state advocacy budgets especially allocated to Medicare physician payment reform. Specifically, the delegate-adopted policy asks that physician payments are to be updated annually at least equal to the Medicare Economic Index, a measure of practice cost inflation that was developed decades ago. This measure estimates annual changes in physicians' operating costs and establishes appropriate Medicare physician updates. In other words, if the cost of maintaining a practice rises because of inflation, so would the Medicare reimbursement rate. Pretty straightforward, right?

Unfortunately, there are significant barriers to making these annual adjustments. The current fee system operates under a system of budget neutrality: if payments are increased in one segment of the physician payment system, by definition, they must be reduced in another segment. The AMA has voiced commitment to ending budget neutrality and to implementing a comprehensive advocacy campaign to engage patients and physicians in promoting payment reform.

What Can SLMMS Members Do?

So what can we, the members of the St. Louis Metropolitan Medical Society, do to advocate for our patients? We absolutely must continue to engage our legislators in meaningful dialogue to come up with both short- and long-term solutions to fix our broken Medicare system. Towards that end, I encourage you to contact your U.S. senators and representatives to voice your concerns about Medicare payment. Legislators need and want to hear from those with a great understanding of the issue. Both patients

TABLE 1: MEDICARE UPDATES COMPARED TO INFLATION (2001-2021)



Source: American Medical Association Economic and Health Policy Research[1]

and physicians are constituents, and constituents place votes which determine whether or not a legislator remains in office for additional terms.

If you have not engaged in advocacy efforts previously, now is the time to begin to do so. This applies not just to our U.S. senators and representatives on Medicare payment, but also to our state legislators on other important issues impacting physicians.

Our broken Medicare system is a tremendous threat to the long-term sustainability of our practices, and we physicians have an obligation to advocate for our patients and practices.

Many specialty and regional medical societies release advocacy updates alerting physicians to legislation affecting the practice of medicine. Some of these updates contain links to email senators and representatives a recommended response indicating physician support or opposition. Often, these standard letters can be personalized to add patient anecdotes that further strengthen the argument(s). The more emails a legislator receives with regards to a particular topic, the more he or she will recognize the magnitude of the decision that will be made when voting for or against the issue.

Another avenue to maintaining a dialogue that should always be considered is to make a personal phone call or request an electronic meeting with the legislator or staff member.

Repeated meetings serve to strengthen the relationship, and influence can therefore grow with time. Specialty and regional medical societies, again, are often a tremendous resource for talking points on issues. It is important to go into these meetings prepared for questions that may arise during the conversations. Even if there are no pressing issues (and a fix to Medicare clearly is), you should consider touching base with your senators and representatives—at both the federal and state levels—on an annual basis.

Finally, in-person meetings with legislators and/or their staff can have even more impact than an email, call, or electronic meeting. If you can't make the trip to Jefferson City or Washington, D.C., you can always schedule a meeting when your legislator is local, in his/her district office. During these conversations, particularly when discussing an issue with someone whose political beliefs differ from yours, it is important to remain non-partisan and to approach the conversation from the perspective of what unites physicians and patients alike.

Politicians aim to serve their constituents well, so that they can preserve their constituents' future votes and financial support. I encourage you to set aside both time to commit to advocacy efforts, and money to support political action committees that advance the practice of medicine. As relationships with legislators are formed and maintained, personal contributions to campaigns can ensure that physician allies remain in office.

At the end of the day, physicians want to be able to continue to deliver high-quality, compassionate care to their patients. Our broken Medicare system is a tremendous threat to the

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Wrong Direction

Our surprising decline in life expectancy in the U.S.

By David M. Nowak, Medical Society Executive Vice President

David M. Nowak

What is most alarming is that while life expectancy around the world decreased in 2020 due to the COVID pandemic, most peer countries rebounded in 2021, while the U.S. continued to decline.

Last December, data from the Centers for Disease Control and Prevention (CDC) reported that U.S. life expectancy had declined to 76.4 years, the lowest in more than two decades. Young people in America are dying at rates higher than their counterparts in other high-income countries, and the U.S. has some of the highest maternal and infant mortality rates among the world's wealthiest nations.

The decline over the past two years has been surprising to many, and rates are definitely moving in the wrong direction. With some notable exceptions—such as the 1918 influenza pandemic, World War II and the HIV crisis of the 1980s—life expectancy has had a gradual upward trajectory over the past century. But that progress has steeply reversed in the past two years as COVID and other tragedies have cut millions of lives short. The total drop of 2.7 years between 2019 and 2021 brought life expectancy to the lowest rates since 1996, according to the CDC's National Center for Health Statistics. The overall two year decline was 3.1 years for males and 2.3 years for females.[1]

Life expectancy is calculated and defined in many different ways. In general, it is the average length of life that a hypothetical set of people would experience if they lived their entire life based on the age-specific mortality rates of a particular year. There's a death rate for people who are between the ages of zero and one, people between the ages of one and two and so forth. Every year, the age-specific death rates change, and life expectancy is calculated based on those age-specific death rates in a single year.[2]

There are a myriad of factors that impact these numbers. Researchers across the board point to the COVID-19 pandemic as a primary one, mainly in 2020 and 2021. But it's not all COVID related. We've seen increases in rates of mortality due to drug-related deaths (opioids), suicide, liver disease, traffic accidents, homicides and even heart disease over the last two years.

But what is most alarming is that while life expectancy around the world decreased in 2020 due to the COVID pandemic, most peer countries rebounded in 2021, while the U.S. continued to decline. Across the lifespan and across nearly all demographic groups, Americans are dying at a younger age. How can this be happening in a country that is known for scientific excellence and innovation, and where spending levels on health care are among the world's highest?[3]

Causes of the Decline

While I called these trends "surprising" earlier, not everyone is shocked. Researchers and demographers have noted that poor health habits would catch up with Americans at some point. Apparently, the proverbial birds have "come home to roost."

A landmark study published more than 10 years ago by the National Institutes of Health compared U.S. health and death rates with other developed countries. The results convincingly showed that the U.S. was stalling on health advances in the population while other countries "raced ahead."[3] In the U.S., we've become accustomed to hearing about our poor diets and sedentary lifestyles that negatively impact our health. But the fact is, very little is actually done about it. And now, American life expectancy is lower than that of Cuba and Lebanon.

In an April 2023 *Washington Post* podcast,

Harvard researchers discussed the American decline. One conclusion is that the problem stems from the way the U.S. health care system is structured. "We have a wonderful sick care system that takes care of very sick people, but a very inadequate health care system," they noted. "Although the U.S. is a leader in medical and health innovation, we are different than other high-income countries in that we emphasize rescue care and acute care at the expense of investing in, supporting, and enabling health promotion and disease prevention."[4]

> In the U.S., we've become accustomed to hearing about our poor diets and sedentary lifestyles that negatively impact our health. But the fact is, very little is actually done about it.

They also point out that improving population health in the U.S. is not just the morally right thing to do but could also boost the nation's economic and social stability. Also noted are countries like Costa Rica and Portugal where efforts have been made to integrate the public health and health care infrastructure, and huge strides have been made that the U.S. could learn from.[4]

Other studies point to additional contributing factors. According to the CDC, COVID is "far from the only explanation for America's dismal trend line," estimating that the pandemic accounted for about half of the recent years' declines. "Unintentional injuries," a category that includes drug overdoses, contributed an additional 16%, followed by heart disease (4.1%), chronic liver disease and cirrhosis (3.6%) and suicide (2.1%).[5]

Health Disparities and Life Expectancy

Those factors are all connected to what the CDC terms "the social determinants of health—economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems. Americans with the shortest life expectancies tend to have the most poverty, face the most food insecurity, and have less or no access to health care."[5] To no one's surprise, research also shows a strong relationship between life expectancy and income and your ability to afford health care and food and housing security.

The CDC also reports that America is seeing the greatest gaps in life expectancy across regions of the country in the last 40 years. The lowest life expectancies are seen in states of the Southeast, yet much higher figures are seen on the West Coast, the northern Midwest and the Northeast.

SLMMS member Kate Lichtenberg, DO, MPH, addressed the declines from both a national perspective as well as changes here in Missouri in her article "Reversing the Decreasing Life Expectancy: A National Health Priority" published last year in *Missouri Medicine*. Dr. Lichtenberg is the physician director of enhanced personal care at Anthem in St. Louis. She also sits on the *Missouri Medicine* editorial board in public health, and is a member of the SLMMS Publications Committee.

Dr. Lichtenberg's article noted that a report published by the Missouri Department of Health and Senior Services in 2021 showed that deaths in Missouri outnumbered births for the first time since officials began tracking this statistic in 1911. While not as significant as the national declines, Missouri's life expectancy declined 2.1 years—males dropping 2.3 years to 72.3 and females dropping 1.9 years to 78.4.[6] She noted life expectancy disparities are widening based on race/ethnicity, socioeconomic status, gender, and geography (rural versus urban).

Dr. Lichtenberg concluded, "There is a long road ahead to reverse the recent declines in life expectancy. Engaging individuals to start exercising, lose weight, eat better, and stop smoking and using drugs are all needed. Proven social and public health policies at the community, state and national levels are necessary and may be equally or more effective than individual efforts."[6]

JOIN THE CONVERSATION AT THE SLMMS GENERAL SOCIETY MEETING

Evaluating life expectancy through a public health lens is an important—and necessary—conversation. That is why I'm excited for our upcoming SLMMS General Society Meeting on Tuesday, September 12. Our featured presenters will be Kanika Cunningham, MD, MPH, director of the St. Louis County Department of Public Health, and Matifadza Hlatshwayo Davis, MD, MPH, director of health for the City of St. Louis. Please plan to join us for a virtual discussion via Zoom examining "Public Health Needs in the St. Louis Region." Find more details on page 6 or visit slmms.org.

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Region's Public Health Needs Will Be the Focus of SLMMS General Society Meeting Sept. 12

Dr. Kanika Cunningham

Dr. Matifadza Hlatshwayo Davis

Kanika Cunningham, MD, MPH, director of the St. Louis County Department of Public Health, and **Matifadza Hlatshwayo Davis, MD, MPH**, director of health for the City of St. Louis, will be the co-presenters for the annual SLMMS General Society Meeting scheduled for Tuesday, September 12 at 6 p.m. via Zoom. All SLMMS members are invited to participate.

The featured topic will be **"Public Health Needs in the St. Louis Region"** with an update from both physicians followed by Q&A. They will provide an overview of public health needs for the region and their continued efforts as St. Louis continues to emerge from the COVID-19 pandemic, one of the nation's largest public health emergencies in recent years.

Dr. Cunningham, a SLMMS member and St. Louis native, was appointed St. Louis County Public Health director in January. She received both her medical and MPH degrees from Saint Louis University. Dr. Hlatshwayo Davis has been the director of health for the City of St. Louis since October 2021. She earned her medical degree from Cleveland Clinic Lerner College of Medicine and her MPH from Case Western Reserve University.

The General Society Meeting is an annual event where the slate of nominees for SLMMS officers and councilors, proposed by the Nominating Committee, is presented to the membership. The membership will also receive an update from the SLMMS Strategic Planning Committee.

Pre-registration is required to receive the meeting link and information. If you wish to participate, please register using the link at slmms.org, or email Dave Nowak, executive vice president, at dnowak@slmms.org and the registration link will be sent to you. ◄

SLMMS GENERAL SOCIETY MEETING AGENDA

Tuesday, September 12, 2023
6:00 p.m. via Zoom
Registration: slmms.org

Call to Order
2023 President M. Laurin Council, MD, MBA

Nominating Committee Report
Ravi S. Johar, MD, Committee Chair

The committee will be recommending members for nomination to the following offices:

- President-Elect
- Vice President
- Secretary-Treasurer
- Councilors (4)

Educational Presentation by Kanika Cunningham, MD, MPH, and Matifadza Hlatshwayo Davis, MD, MPH, "Public Health Needs in the St. Louis Region", followed by Q&A

Strategic Planning Committee Report
M. Laurin Council, MD, MBA, SLMMS President, Committee Chair

Medicare Payment System … *continued*

long-term sustainability of our practices, and we physicians have an obligation to advocate for our patients and practices. Whether by sending advocacy emails, meeting with a legislative staffer electronically, or traveling to Washington, D.C. in person, our statements make our positions known.

The relationships that we build with our legislators ensure that we maintain our voice, with the hope that the next two decades of Medicare physician payments are more in line with payments that will sustain our practices and maintain access for our most vulnerable populations. I encourage you, the members of the St. Louis Metropolitan Medical Society, to continue to give your time and efforts towards the development of solutions to repair our Medicare physician payment system for the betterment of our patients and practices. ◄

M. Laurin Council, MD, MBA, FAAD, FACMS, is a professor of dermatology at Washington University School of Medicine, along with director of dermatologic surgery and director of the micrographic surgery and dermatologic oncology fellowship.

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Legislative Report 2023

Following are highlights of legislation passed by the Missouri Legislature during the 2023 session and signed into law by Gov. Mike Parson. Laws are effective August 28 unless specified to take effect immediately. This text is adapted from the Missouri State Medical Association Legislative Review 2023. For detailed discussion of these and other legislation, see the report at msma.org/resources/SiteAlbums/Advocacy/2023%20MSMA%20Legislative%20Review.pdf

Advanced Practice Registered Nurses (APRNs). This establishes a new licensure category for APRNs and sets up a new waiver process for APRNs and collaborating physicians who desire to practice outside the previous 75-mile proximity limit. APRNs also can administer, dispense and prescribe Schedule II controlled substances to hospice patients.

Direct-Access Physical Therapy. Physical therapists can treat patients for 10 visits or 30 days before an initial consultation with a physician. If a patient presents with issues beyond the scope of a PT, or does not show functional improvement after 10 visits or 30 days, that patient must be referred immediately.

Interstate Medical Compact. Missouri becomes the 38th state to enter the Medical Licensure Compact, which enables physicians to obtain an expedited license from another Compact state.

Postpartum MO HealthNet Benefits. MO HealthNet coverage for low-income women is extended to one-year postpartum instead of the previous 60 days.

Distracted Driving. Missouri becomes the 49th state to enact a law prohibiting texting while driving. Drivers also are prohibited from using social media, retrieving data, watching or recording video, and making a phone call. Hands-free communications are exempted.

Transgender Health Care. Gender transition surgeries for minors are now prohibited. Also prohibited are the administration and prescription of hormones or puberty-blockers to minors, unless that person was already receiving such treatment prior to August 28, 2023. The prohibition on puberty-blockers and cross-sex hormones sunsets in 2027.

Unconscious Patient Exams. A physician (or any student or trainee under that physician's supervision) cannot perform a prostate, anal or pelvic examination on an anesthetized or unconscious patient without patient consent or if other exception has been met. ◄

SLMMS TO HOST ANNUAL LEGISLATIVE UPDATE

What happened in the 2023 Legislative Session that will affect Missouri physicians? Plus a preview of the upcoming 2024 Session

Wednesday, September 27, 2023
6 p.m. via Zoom

Every legislative session is unique, and 2023 was no exception. A large contingent of new representatives and senators meant that there would be a learning curve for both elected officials and lobbyists. It was also the first session since 2020 that wasn't overly affected by the pandemic. As for physicians, the session was a frustrating one. There was not a physician in the Senate for the first time in 12 years. Other groups noticed, and introduced a record number of scope-of-practice bills. Some of those passed. On the other hand, it was a good year for some public health initiatives that we have pursued for years. Through it all, MSMA remains the voice for physicians in Jefferson City.

SLMMS invites you to join the MSMA lobbying team on **Wednesday, September 27 at 6 p.m.** via Zoom to hear a recap of the 2023 legislative session and what new laws are impacting the practice of medicine in Missouri. Plus, there will be a preview of the upcoming 2024 session followed by Q&A. **MSMA 2023-24 President Lancer Gates, DO**, will also provide an update from our state organization.

To register, visit www.slmms.org and under Latest News, follow the links to register on line. Advance registration is required to receive the link to join the Zoom event. This event is free and open to all physicians, residents, medical students and others. You need not be a member of SLMMS or MSMA to participate. ◄

Telemedicine Continues to Grow Post-Pandemic

Health systems market range of virtual care choices

By Jim Braibish, St. Louis Metropolitan Medicine

Post pandemic, telemedicine is solidifying its place in the care delivery mix. Conducting patient visits via video or phone is considered a valuable and convenient option in the right circumstances.

While telemedicine visits skyrocketed temporarily during the pandemic and then leveled off as clinics reopened, now they are gradually increasing. Telemedicine represented 5.3% of health insurance claims in April 2023, up from 4.9% in April 2022 as tracked by FAIRHealth.[1] In a July 2022 U.S. Census Bureau survey, 25% of adult patients said they had used telemedicine in the past four weeks.[2]

Area health systems now actively market telemedicine as an option to reach a care provider. The websites of BJC HealthCare, Mercy and SSM Health each have prominent pages on connecting the viewer with a provider via video or telephone, in addition to the traditional in-person appointment.

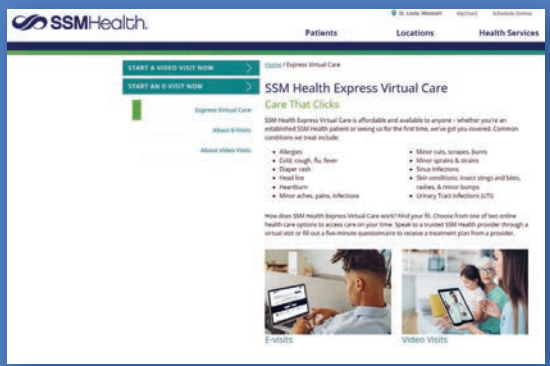
"Patient demand for easy access and more convenient ways to engage with their care team and their overall health has been a catalyst for redefining options for care delivery," explained Kristin Ebert, MBA, chief experience officer for the Mercy system.

"And now it is a possibility to meet that demand with the increasing availability of new digital tools and more sophisticated technology solutions to support and augment the traditional in-person visit and provide continuity of care no matter how the patient chooses to engage with us," she continued.

During the first half of 2023, Mercy completed 127,842 virtual visits across the four states where it operates hospitals. This puts Mercy on track to see about a 5% increase over 2022's total of 292,230, plus an expected increase in the second half of the year when cold and flu season arrives, said spokesman Joe Poelker.

BJC also embraces virtual care. "Each patient is unique and so is each interaction they have with BJC Medical Group. It makes sense that we now offer different types of care that fit

"We're excited there are more ways to connect with our patients depending on their needs and availability. . . . Our goal is to be accessible for whatever our patients need."



their needs," said Michele Thomas, MD, FAAFP, chief medical information officer, BJC Medical Group and associate chief clinical information officer-ambulatory, BJC HealthCare.

"We're excited there are more ways to connect with our patients depending on their needs and availability. … Our goal is to be accessible for whatever our patients need," she added.

In what situations is telemedicine most often used?

Said BJC's Dr. Thomas: "There are many opportunities to connect with patients on issues that don't need a physical exam. For example: following up after a procedure or a recent hospitalization, discussing a new medication and possible side effects, behavioral health such as ADHD or depression, and providing education on lifestyle medicine—diet, exercise, etc.

"For patients who live in more remote areas, telemedicine can be a life-changing option to connect with specialists more frequently, as research has shown that prolonged travel to see a specialist is a significant barrier to care."

Besides provider visits, telemedicine also can include remote patient monitoring for chronic conditions, the "store and forward" of patient information to consulting physicians, and use of mobile smart devices to monitor patient activities.

Behavioral Health Care

Telemedicine has gained its greatest foothold in behavioral health care. At Saint Louis University School of Medicine, the Department of Psychiatry continues to complete about 30% to 50% of its patient visits virtually, according to Erick Messias, MD, MPH, PhD, Samuel W. Fordyce Professor and department chair.

"Virtual visits gained popularity during the pandemic, and given their convenience, most clinics and patients are keeping these as options. At our clinic we request that the first visit is in person, but subsequent visits can be done virtually," Dr. Messias said.

Behavioral health care is well suited to telemedicine because a physical examination is most often not required. "A lot of our work can be done by video/phone, as our mental status examination is dependent on observing the patient without requiring touching or auscultation," Dr. Messias noted.

SLMMS member Luis Giuffra, MD, PhD, of Clayton Behavioral explained, "Talk therapy never requires a physical examination. Psychiatry rarely does. In therapy, the trend to telemedicine is irreversible." Almost 100% of his patient visits are done virtually.

Another advantage of telemedicine is that it helps people gain access to a psychiatrist if none are present locally, Dr. Giuffra added. "About 60% of the counties in the United States do not have a psychiatrist, and it can be difficult to get an appointment in an urban area."

Impact of Regulations

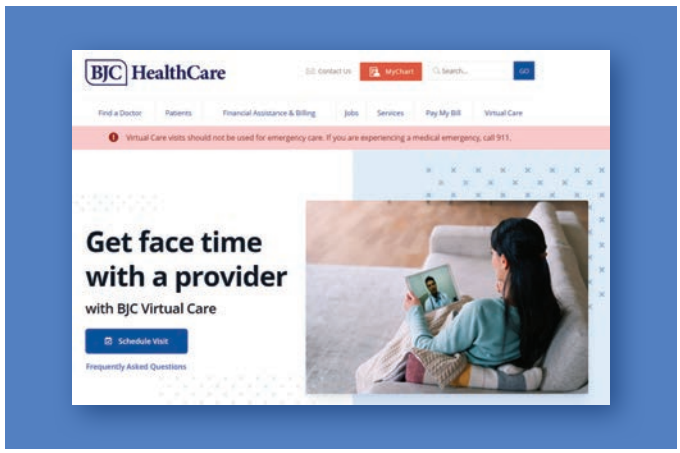
Key to the future of telemedicine will be the evolution of federal and state regulations and insurance reimbursement, all of which were relaxed during the COVID-19 pandemic. Federal temporary rules originally were set to expire in May with the end of the COVID public health emergency.

However, Congress extended many COVID-era telehealth flexibilities related to Medicare through the end of 2024 via the Consolidated Appropriations Act of 2023. These include 1) enabling access to telemedicine in any geographic area of the U.S., 2) allowing patients to stay in their homes for telemedicine visits, and 3) permitting certain Medicare visits to be delivered using audio-only technology if the patient is unable to use video.[3]

In May, the ability of providers to prescribe controlled medications via telemedicine was extended through November 11, 2023, while the Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) consider a permanent rule. The post-COVID rule that DEA and SAMHSA had originally proposed in March was withdrawn after it was criticized for being too strict.[4]

continued

"Talk therapy never requires a physical examination. Psychiatry rarely does. In therapy, the trend to telemedicine is irreversible."



In Missouri, insurance companies are required to cover telemedicine but may limit coverage to in-network providers. The state Medicaid program MO HealthNet reimburses for services provided via telemedicine when the service can be performed with the same standard of care as a face-to-face service.[5]

"Insurance coverage is improving but is still variable per payer," said BJC's Dr. Thomas. "However, the percentage of insurance companies that now cover telemedicine has substantially increased which means BJC Medical Group is now able to bill telemedicine visits as we do all other types of care."

Looking Ahead

The health systems are planning for the continued growth of telemedicine.

"It's important to BJC Medical Group that we connect with our patients in the best way possible. For us that means continuing to expand all types of telemedicine (video visits, telephone visits and e-visits) and consider new options as they become viable—think secure chat, hospital at home or remote patient monitoring. We want to expand our on-demand virtual care in terms of availability and scope," said Dr. Thomas.

Concluded Mercy's Ebert: "We look at telemedicine as an integrated part of the care model. Patients should have that choice of how they engage with their care team, limited only by clinical appropriateness. For us at Mercy, that means ensuring that our patients have options for digital, virtual and in-person care, with the information readily available to help them make that choice in a clinically appropriate manner." ◄

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SLMMS Honors Science Fair Winners

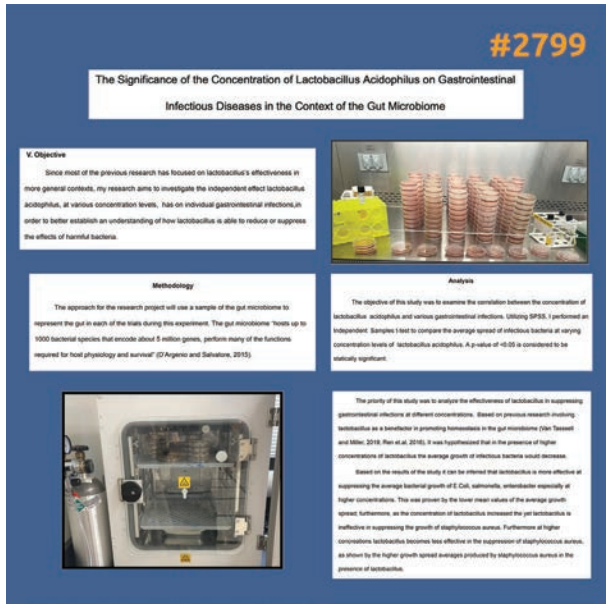
Congratulations to the following high school students who earned top honors in the Health and Medicine category of the 2023 Greater St. Louis Science Fair in May. Each received a $250 scholarship award from the Medical Society's charitable arm, the St. Louis Society for Medical and Scientific Education.

Yahya-Ibn-Muhamed Dizdarevic, Grade 9, Gateway Science Academy High School, "Which Type of Exercise Has the Most Influence on Increasing the Heart Rate"

Benjamin Su, Grade 11, Mary Institute Country Day School, "Development and Evaluation of a Novel 3D-Printed Driver with Integrated Phantom for Magnetic Resonance Elastography (MRE)"

Reed Frakes, Grade 12, Logos School, "What Demographic is Best at Washing Their Hands?"

Audra Yoder, Grade 12, Marquette High School, "The Significance of the Concentration of Lactobacillus Acidophilus on Gastrointestinal Infectious Diseases in the Context of the Gut Microbiome" *(pictured right)*



"I am so excited to see my research get recognized at such a young age by great science scholars in the St. Louis area. I am honored to be recognized and even more motivated to continue pursuing science research. Thank you!"
– Audra Yoder

SLMMS Member Elected to AMA Council on Science & Public Health


Dr. Marc Mendelsohn

Congratulations to SLMMS Member **Marc Mendelsohn, MD, MPH**, who in June was elected to a four-year term on the American Medical Association's Council on Science and Public Health (CSAPH). Dr. Mendelsohn is an assistant professor of emergency medicine at Washington University School of Medicine and an emergency physician at Barnes-Jewish Hospital.

No stranger to AMA service, Dr. Mendelsohn has served as member-at-large on the AMA's Young Physician Section (YPS) Governing Council. During his residency, he also served for three years on the AMA Council on Ethical and Judicial Affairs.

The CSAPH works to represent the AMA's core belief that scientific evidence is the basis for improving the quality of patient care, promoting medical progress and enhancing the health of the public.

Dr. Mendelsohn said he hopes his extensive background in public health can positively influence the published papers and recommended actions of the CSAPH. "I'm also excited to bring a unique perspective as the first emergency physician to serve on this Council in a number of years," he added, "as emergency doctors experience public health issues first-hand."

Dr. Mendelsohn has been an active member of SLMMS since 2019. ◄

Appointed to SLMMS Council


Dr. Brian J. Bausano

The SLMMS Council has unanimously approved the nomination of **Brian J. Bausano, MD, MBA, FACEP**, to complete the unexpired term on the Council expiring in December 2024 previously held by Evan Schwarz, MD, who relocated to California earlier this year.

Dr. Bausano is an associate professor of emergency medicine at Washington University School of Medicine and an emergency department staff physician at Barnes-Jewish Hospital and Missouri Baptist Medical Center. He also serves as the associate medical director and director of strategic initiatives and advancement within the Department of Emergency Medicine at Washington University.

Dr. Bausano received his undergraduate degree from the University of Notre Dame, and his medical degree from the Baylor College of Medicine in Houston, Tex. He completed his emergency medicine residency at Washington University, where he also later earned an MBA.

He has been active in organized medicine for a number of years, mainly with the American College of Emergency Physicians (ACEP). He is the current president of the Missouri Chapter of ACEP, and has served on the board since 2016. He has also been a member of the Council of Emergency Medicine Residency Directors (CORD) since 2012. ◄

Elected to International Dermatologic Board


Dr. George Hruza

George Hruza, MD, MBA, past president of SLMMS and dermatologist in Chesterfield, was elected to the International League of Dermatologic Societies Board of Directors at the World Congress of Dermatology in Singapore on July 5. The ILDS is a worldwide organization of 202 dermatologic organizations focusing on bringing access to dermatologic care to underserved communities around the world, along with meeting every four years to exchange knowledge between dermatologists from more than 100 countries.

Dr. Hruza also has announced his candidacy for Missouri state representative from district 89 in the 2024 election. The district includes Des Peres, Frontenac, Huntleigh, Town and Country and eastern Chesterfield. For more information about his campaign, go to hruzaformissouri.com. ◄

Seeking to Attract More Black Women to Medicine

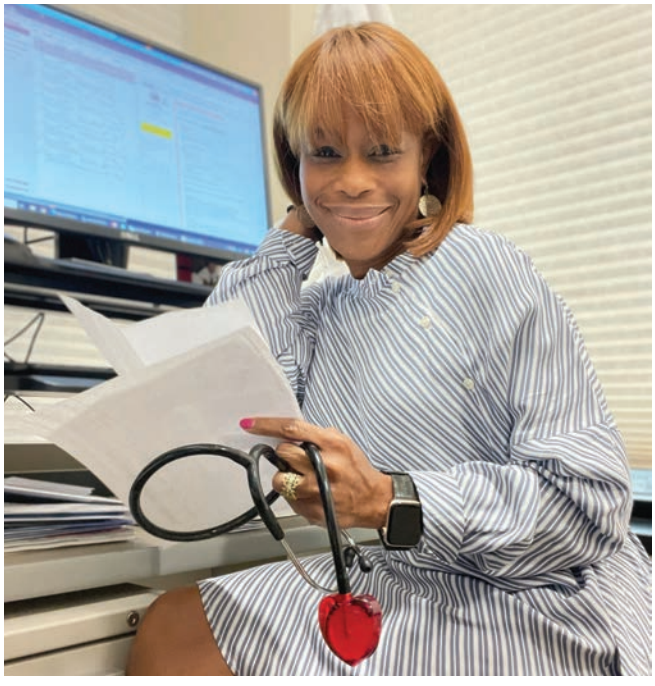
Dr. Jovita Oruwari's new book shares inspiring stories of successful black female physicians

By Jim Braibish, St. Louis Metropolitan Medicine

Breast surgeon and SLMMS member Jovita Oruwari, MD, FACS, of SSM Health DePaul Hospital wants to inspire more young African American girls to pursue careers in medicine.

To help show them what is possible, she has brought together a panel of 60 Black women physicians and surgeons from across the country to share their personal stories of succeeding in medicine. Their stories are contained in her newly published book *Black Girls in White Coats*.

"We need more Black physicians. *Black Girls in White Coats* provides encouragement for young Black girls dreaming of becoming doctors," Dr. Oruwari said. "This collection of narratives can be a guiding light for Black girls and help alleviate the stigma around health care in the Black community."



Dr. Jovita Oruwari

The idea for the book grew out of Dr. Oruwari's experience caring for patients during the COVID-19 pandemic. She was dismayed to see the number of Black patients in her North County practice who were skeptical of the COVID vaccines, despite the number of African Americans who were dying from the virus.

"Their hesitancy is rooted in years of mistrust of medicine," she explained. "With African Americans so under-represented among physicians, Black patients' experiences typically have been with doctors who don't look like them. Plus, abuses such as the Tuskegee experiments and Henrietta Lacks are still fresh in many minds."

According to the Association of American Medical Colleges, just 5.7% of U.S. physicians in 2021 were Black.[1] Just over half of Black physicians are women.[2] Blacks comprise approximately 14% of the U.S. population.

And this is a major reason why the incidence of health conditions such as cardiovascular diseases, obesity, asthma, disability from mental illness, and cancers is higher among African Americans. "Research has shown that health outcomes overall are better for African American patients when they are cared for by Black physicians," writes Dr. Oruwari in her introduction to the book.

Collecting the Stories

Dr. Oruwari drew on a range of contacts to gather contributors for the narratives.

"Over the past few years, I've become active in various physician social media groups and met a lot of good people whom I contacted. I also reached out to physicians I know in St. Louis and others with whom I trained," she recalled.

Each story covers two to four pages in the book. The physicians discuss their practices, how they became interested in medicine and the challenges they faced. They also describe the rewards they enjoy from a medical career, as well as how they integrate time for family and personal interests. While most of the narratives are from physicians and surgeons, the book also includes several dentists, a podiatrist and a psychologist.

Local doctors whose profiles appear in the book include:

- Bisi Ademuyiwa, MD, MPH, MSCI, medical oncologist at Washington University
- Teide Ehimare, MD, psychiatrist
- Denise Hooks-Anderson, MD, family practice physician in Philadelphia and formerly of Saint Louis University School of Medicine

- Jade James-Halbert, MD, MPH, ob-gyn with SSM Health DePaul Hospital
- Lannis Hall, MD, MPH, radiation oncologist at Washington University
- Kelechi Loynd, MD, psychiatrist
- Melba Ross Akinwande, DMD, Chesterfield Dentistry
- Leslie Scott, MD, ob-gyn

Also included is Dr. Oruwari's daughter, Ivrie, who is a second-year resident at the University of Missouri-Kansas City.

Each of the narratives describes their immense satisfaction with being a physician. "I can't tell you how many times it has warmed my heart to know that a patient sought me out as their dermatologist because I look like them," comments one. "I am the doctor who relieves pain in a patient who just had surgery or a woman in labor," said an anesthesiologist.

A challenge often cited by contributors from their time in medical school is "imposter syndrome," the feeling among African Americans that somehow they don't belong at the school, often fueled by indifference or lack of support from others in the school.

Besides their practices and families, many of the physicians have secondary careers or businesses such as writing or fitness. Contributor Nicole Swiner, MD, family medicine from Atlanta, has a publishing business and served as publisher of *Black Girls in White Coats*.

Showing family and personal interests is an important consideration for Dr. Oruwari in presenting the medical career to youth.

"A major mitigating factor for many young people in choosing a medical career is the amount of time and sacrifice involved. They are concerned about missing their youthful years," Dr. Oruwari said. "We wanted to show that once you are done with school, many opportunities open up. To marry, to have children, to travel."

Dr. Oruwari's Story

In her narrative in the book, Dr. Oruwari shares that she wanted to be a doctor for as long as she can remember. Born in Nigeria, her family emigrated to the U.S. when she was 10.

"My earliest recollection of patient care is sitting in my great grandfather's hut as a child and watching him minister to the sick with natural remedies. He was a traditional medicine man," she relates in the book. In the U.S., she always loved math and science classes.

She adds, "I had the good fortune that my family was very supportive and involved in fostering my dreams and interests in medicine."

Dr. Oruwari graduated from Rutgers New Jersey Medical School and completed residency at Rutgers University Hospital. She decided to specialize in breast surgery during clinical rotations after seeing a female attending breast surgeon as well as the chief resident who aspired to be a breast surgeon.

Following a fellowship at Brown University, Dr. Oruwari was recruited to St. Louis in 2001 to join the former St. Louis Cancer & Breast Institute and continued there after it became part of Mercy. In August 2020, she moved to SSM Health DePaul Hospital.

Dr. Oruwari is married to psychiatrist Patrick Oruwari, MD. Besides their daughter at UMKC, they also have a son.

"Girls who look like me should go into medicine because there are so few of us, yet there are so many of us (Black people) with illnesses. Representation matters."

Getting the Word Out

Black Girls in White Coats is for sale on Amazon and on her website, drjovitaoruwari.com. Dr. Oruwari also has distributed books at various schools in the St. Louis area, and plans to visit North County high schools this fall. A book signing event is planned for September 6 at the St. Louis County Library Florissant Valley Branch.

"Girls who look like me should go into medicine because there are so few of us, yet there are so many of us (Black people) with illnesses. Representation matters. I cannot tell you how many patients come in and once they see me, they relax because they feel that they are in the presence of someone who understands them," she noted.

Dr. Oruwari emphasizes the importance of mentors. "I believe 100% in mentorship. I wouldn't be where I am without mentors," she said.

"My advice to girls of color is: you can do whatever you set your mind to do. Do not let anyone tell you that you cannot. Only you can decide that." ◄

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Gender-Affirming Care in Adults: An Overview of the Interventions and Evidence

What is gender-affirming care? What do the studies show?

By Margo Kahn

Gender-affirming care (GAC) consists of "interventions designed to support and affirm an individual's gender identity," and encompasses a wide range of behavioral, psychological, medical and surgical approaches.[1] The state of Missouri requires a diagnosis of gender dysphoria (at least six months of distress associated with gender incongruence) to receive GAC.[2] However, it is important to note that variation in gender identity is a matter of diversity, not pathology. Not all transgender and gender-diverse individuals experience gender dysphoria, yet still may desire gender-affirming interventions.[3,4]

Major U.S. medical societies including the American Medical Association (AMA), American College of Physicians, and American Academy of Family Physicians support GAC for transgender and gender-diverse adults.[4,5,6] AMA policy "recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary."[5]

GAC in adults includes psychosocial support, gender-affirming hormonal therapy (GAHT), and gender-affirming surgery (GAS).

The Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People (Version 8) from the World Professional Association for Transgender Health (WPATH) is a useful resource for understanding the various aspects of GAC and its treatment indications. The WPATH is endorsed by the AMA as the "leading international, interdisciplinary professional organization devoted to the understanding and treatment"[7] of patients seeking GAC.

Margo Kahn

Margo Kahn is a student at Saint Louis University School of Medicine in the class of 2025. She is a student member of SLMMS. She can be reached at margo.kahn@health.slu.edu.

These standards of care will be delineated here to provide an overview of the practical application of GAC for adults in the U.S.

GAC in adults includes psychosocial support, gender-affirming hormonal therapy (GAHT), and gender-affirming surgery (GAS). GAHT regimens include estrogens and anti-androgens, along with progestins for feminization and testosterone for masculinization. GAS may include chest/breast surgery, genital surgery, and interventions to alter the face, voice, hair, etc. Patients seek varying combinations of these therapeutic options based on personal preference. While some patients pursue surgical interventions, many patients solely pursue social or hormonal interventions.[3] Further, it is important to note that many patients do not conform to a gender binary, and are not seeking a complete sex transition. Treatment therefore must be individualized to each patient's goals and values.

In most cases, adults in the U.S. may proceed with GAHT and/or GAS after being evaluated by a medical professional who determines if the treatment indications are met. These criteria include all of the following: "marked and sustained" gender incongruence, a diagnosis of gender dysphoria (in states where required), the exclusion of rare medical causes of gender dysphoria, and adequate control of any mental or physical health issues that may impact the outcomes of treatment.[3] Patients must have the capacity to consent to the intervention and to understand the potential impacts on reproduction. Additional criteria may be required depending on the patient's location and insurance coverage.

Data Supporting Utilization of GAC in Adults

Adults who receive GAC have associated improvements in gender dysphoria, body dissatisfaction, quality of life and mental health.[3] One meta-analysis of 28 observational studies including 1,833 adult participants showed "80% of individuals … reported significant improvement in gender dysphoria" after receiving GAC in the form of GAHT and/or GAS.[8] Another meta-analysis of three prospective cohort studies that looked at psychological outcomes 3-12 months after initiating hormonal therapy showed a "statistically significant reduction in depression, somatization, interpersonal sensitivity, anxiety, hostility and phobic anxiety/agoraphobia."[9] Improvement in

quality of life and reductions in gender dysphoria, anxiety, depression, and suicide attempts were found in a systematic review of 53 studies looking at GAS specifically.[10] Another study looked into the impact of states moving from excluding to including GAC in Medicaid coverage. Statistically significant improvements in mental health outcomes in low-income transgender patients were found with this switch in coverage.[11]

Levels of regret are low in adults who have received GAC. The percentage of individuals who experience regret with GAS is very low, between 0.3% and 3.8%, and detransitioning is rare.[3] Detransitioning is defined as an "individual's retransition to the gender stereotypically associated with their sex assigned at birth."[3] Individuals may detransition for a variety of reasons, including external factors such as stigma or lack of support, and internal factors including variation in gender identity over time. One cross-sectional study evaluated the factors that contributed to detransition in 2,000 adults, with 82.5% of subjects reporting at least one external factor and 15.9% reporting at least one internal factor.[12] This data supports the notion that very few individuals elect to detransition. Further, if they do, it is overwhelmingly due to external factors, unrelated to the individual's gender identity.

Adults who receive GAC have associated improvements in gender dysphoria, body dissatisfaction, quality of life and mental health.[3]

As a whole, evidence suggests that GAC is associated with positive impacts on mental health and quality of life, as well as low levels of regret.[3] Of note, data on this topic are largely non-randomized. Prospective controlled studies have been recommended to further evaluate the impacts of GAC, although this is limited by the unethical nature of randomizing patients to study arms that withhold indicated medical care. While this makes it difficult to draw conclusions on causality, there is general consensus in the literature that GAC is associated with positive outcomes.

Conclusion

GAC in adults is associated with positive outcomes in gender dysphoria, mental health and quality of life. This care is complex in nature and highly individualized in practice. It is vital for physicians to have an understanding of the various aspects of GAC and how it is practically applied in order to help guide patients and interact with the health care system as a whole. A complete understanding of current guidelines from various medical societies, as well as a grasp of the current legal implications, is vital to providing care to this patient population. ◄

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Sound Health Services Makes Additions

Sound Health Services added facial plastic surgeon andotolaryngologist **Robert T. Cristel, MD**, to its ENT Associates and Synergi Facial Surgery division at their offices in Chesterfield and O'Fallon, Mo. Two other recent additions at Sound Health Services are **Joseph Bradley, MD, FACS**, at its laryngology division in O'Fallon and **Andrew Skillington, MD**, at its Metro Ear, Nose & Throat division in south St. Louis County. ◄

New Black-Owned Pharmacy Advances Health Care in St. Louis Underserved Community

"Radically inclusive, culturally responsive" expresses desire to provide highest quality to all populations

By Dave Nowak

Marcus Howard, PhD, had a vision. Growing up in north St. Louis, he was fully aware of health inequities in the St. Louis Black community, and that its residents were underserved and disproportionately impacted by illness and chronic health conditions. He also noticed there was a lack of pharmacies providing services to underserved communities. Howard set out to change that, and in achieving his vision has made history as the CEO and founder of the first radically inclusive, culturally responsive pharmacy in the country.

GreaterHealth PHARMACY & WELLNESS

Last November, Howard opened GreaterHealth Pharmacy & Wellness in the Delmar DivINe at 5503 Delmar Blvd. in St. Louis. Located in the former St. Luke's Hospital (and later St. Louis Regional Medical Center), Delmar DivINe is a non-profit working to promote health, education and human service organizations in the St. Louis region.

Marcus Howard

Howard explains that the pharmacy's mission is to ensure all people experience greater health and a greater quality of life. "We'll achieve this mission by leveraging a community's demographic variables, psychological characteristics, health motivations and cultural behaviors to deliver inclusive care like never before," he noted. "Radically inclusive means that regardless of difference—race, gender, orientation, religion, country of origin, socioeconomic status—we provide the highest quality of care to anyone who walks into our pharmacy.

"GreaterHealth will also focus on collaborating with local health care providers, coordinating services across sectors, sharing data, and providing affordable care options to our target demographic," he continued. "Our north star is for all residents, specifically those from historically marginalized backgrounds, to achieve better health outcomes."

Howard earned an undergraduate degree from the University of North Carolina, spent three years as a teacher with Teach for America, and then earned a doctorate in human development from North Carolina State University. He had no previous pharmacy experience. But he had a friend operating a Black-owned pharmacy in Charlotte, N.C., and that helped him see the effects such a venture can have on a marginalized community, he explained. He noted that patients want to come to an environment where they feel seen and are represented.

Howard came home to St. Louis to establish his vision, a health care space for disenfranchised residents across all differences, including race, age, gender, sexual orientation, socio-economic status and disability. St. Louis entrepreneur Maxine Clark, founder of Build-A-Bear Workshop and the driving force behind the Delmar DivINe, helped him achieve it. Community partnerships began to emerge, and Howard received funding from the Missouri Foundation for Health for the pharmacy build-out.

"Our north star is for all residents, specifically those from historically marginalized backgrounds, to achieve better health outcomes."

SSM Health Express Clinic Opened

SSM Health has partnered with GreaterHealth to bring an Express Clinic to the Delmar DivINe community to serve the surrounding neighborhoods, and held its grand opening this past February. The clinic offers express care, physical exams, vaccinations, COVID testing and wellness care among its many services.

Research suggests culturally responsive pharmacies are important in communities of color because they help bridge trust in health care.

GreaterHealth Pharmacy & Wellness is addressing health inequities by meeting its target populations' unique needs. "We alleviate transportation challenges by providing free delivery to our patients," Howard explains. "We offer all patients medical therapy management, allowing the patient to build a strong and trusting relationship with their pharmacist. This includes educating patients, improving adherence, and mitigating risks.

"In addition, we have an in-store discount for those patients without insurance. The medication is not free, but is significantly discounted."

He noted that research suggests culturally responsive pharmacies are important in communities of color because they help bridge trust in health care. Building trust ultimately leads to better preventative care, which helps the community become healthier and reduces health care costs, he added.

The pharmacy has also partnered with the University of Health Sciences and Pharmacy to give pharmacy students experience in a community pharmacy. Other partnerships include with the St. Louis Community Credit Union to promote community wealth and health, and with the St. Louis Integrated Health Network to help coordinate referrals across community organizations.

GreaterHealth Pharmacy & Wellness recently announced its expansion to a second location, opening in early 2024 on South Grand Blvd. in the Holly Hills neighborhood of south St. Louis. It will be built in partnership with Novus Health in what is planned to be Novus' new headquarters. According to Howard, it will specialize in serving patients who are members of the LGBTQ+ community.

How Physicians Can Support GreaterHealth

Howard also seeks to collaborate with the St. Louis medical community, especially physicians. "They can help spread the word about our services to their patients and the larger medical community," he explained. "They can also create collaborative practice agreements with our pharmacy to support their patients, as well as help identify patients that would benefit from our unique and inclusive services. We welcome and encourage physicians and other health care professionals to visit our pharmacy to learn more about our purpose and mission."

In June, Howard's dedication to this mission was recognized by the St. Louis American Foundation as he was one of five recipients of the 23rd Annual Excellence in Health Care Awards.

To learn more about GreaterHealth Pharmacy & Wellness, visit www.greaterhealthpharmacy.com. Dr. Howard can be reached at marcus@greaterhealthpharmacy.com. ◄

SLMMS Alliance Installs 2023-24 Officers

Serving as co-presidents of the SLMMS Alliance for the 2023-24 year are Gill Waltman and Sandra Murdock, seated in photo. Also joining in the May 12 installation were, standing left to right, Zoe Cangas (Alliance member), Angela Zylka (vice president of health), Sana Saleh, president of the Missouri State Medical Association Alliance (installing officer), Sue Ann Greco (treasurer and membership chair), and Jo-Ellyn Ryall, MD (vice president of legislation). Gill also will serve as recording secretary. Not pictured: Jean Raybuck, corresponding secretary. ◄

Physician Family Day Picnic August 26

Get to know fellow SLMMS physician families, and join the SLMMS Alliance in celebrating physician families at Physician Family Day on Saturday, August 26, from 12 to 2 p.m. at Tilles Park, Litzinger and McKnight roads. Burgers, hot dogs and soda/water will be provided. There will also be a petting zoo and fun zone for the children. All physicians, residents, fellows and medical students are invited to attend along with their spouses, partners, children, parents or any other integral support person that is a behind-the-scenes hero. The national AMA Alliance established Physician Family Day to bring awareness to the importance of physician family health and the vital role that families play in supporting the health care system. The event is free, but registration is requested and space is limited. For information and registration, visit https://www.eventbrite.com/e/physician-family-day-tickets-677434212967 ◄

◄ WELCOME NEW MEMBERS ►

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

Clelland James-Henry Chatman, MD
901 Washington Ave., Unit 707 63101-1278
MD, Univ. of Arkansas, 2014
Born 1987, Missouri Licensed 2019 ► **Active**
Certified: Diagnostic Radiology

John P. Judd, MD
12 Carter Ct. 63132-2002
MD, Univ. of Texas Southwestern 2004
Born 1978, Missouri Licensed 2011 ► **Active**
Obstetrics & Gynecology

Mark A. Scheperle, MD
38 Rolling Rock Ct. 63124-1422
MD, Univ. of Missouri-Kansas City 1989
Born 1964, Missouri Licensed 2019 ► **Active**
Internal Medicine

Sarah L. Jensen, MD
1463 U.S. Hwy 61, Ste. B 63028-4160
MD, Saint Louis Univ., 2000
Born 1971, Missouri Licensed 2006 ► **Active**
Certified: Dermatology

Sino Mehrmal, DO
3942 Flad Ave., Apt 2D 63110-4115
DO, Midwestern Univ., Ariz. College of Ost. Med., 2021
Born 1992, Missouri Licensed 2021 ► **Resident/Fellow**
Dermatology

Nicole T. Shen, MD
40 Loren Woods Dr. 63124-1903
MD, Univ. of Missouri-Columbia, 2013
Born 1987, Missouri Licensed 2020 ► **Active**
Certified: Gastroenterology

Richard A. Blath, MD

Richard A. Blath, MD, a urologist, died March 16, 2023 at the age of 76.

Born in St. Louis, he earned his undergraduate degree from Miami University of Ohio and his medical degree from Washington University School of Medicine. He completed a residency and internship at Vanderbilt University Hospital in Nashville, Tenn., and a urology residency at Barnes Hospital and Washington University in St. Louis.

Dr. Blath achieved the rank of major in the U.S. Air Force and was chief of urology at Wright Patterson Air Force Base in Ohio. Dr. Blath joined St. Louis Urological Surgeons and served as managing partner for several decades. He was a past chief of surgery and chief of staff at Christian Hospital, and served on the board of directors of BJC HealthCare. He also completed a term as president of the Washington University Medical School Alumni Association. He joined the St. Louis Metropolitan Medical Society in 1975.

SLMMS extends its condolences to his wife Lory Adelson Blath; his children Lisa Crawford and Jeff Blath; and his five grandchildren. ◄

Richard D. Brasington, MD

Richard D. Brasington, MD, a rheumatologist, died April 30, 2023 at the age of 71.

Born in Asheville, N.C., he earned his undergraduate degree at Harvard and his medical degree from the Duke University School of Medicine. He completed his residency in internal medicine and fellowship in rheumatology at the University of Iowa Hospitals.

Dr. Brasington joined the faculty of Washington University School of Medicine in 1996. He served as director of clinical rheumatology for 15 years and rheumatology fellowship director for 23 years. He was recognized for his contributions as the inaugural recipient of the Richard Brasington, MD, Award for Excellence in Education and Mentorship of Rheumatology Fellows upon his retirement in 2019. He had recently returned to part-time community practice with Arthritis Consultants, Inc. He joined the St. Louis Metropolitan Medical Society in 2008.

SLMMS extends its condolences to his wife Kathleen Ferrell; his children Charles Brasington, William Bashert, Elizabeth Dueweke and Melissa Haralson; his six grandchildren; and his three great grandchildren. ◄

Nathan M. Simon, MD

Nathan M. Simon, MD, a psychiatrist, died July 4, 2023 at the age of 97.

Born in Wilmington, Del., he enlisted in the U.S. Army at age 17 during World War II. Following his discharge, he attended Yale University, where he earned both an undergraduate and a master of public health degrees. He received his medical degree from Washington University School of Medicine and interned at the former Jewish Hospital of St. Louis. He returned to Yale to complete his residency in psychiatry, and received his psychoanalytic training at the Institute for Psychoanalysis in Chicago.

Dr. Simon was affiliated with Barnes-Jewish Hospital for 35 years and was clinical director of the Department of Psychiatry. He later established a private practice at the St. Louis Psychoanalytic Institute, but he remained committed to medical education with appointments at both Saint Louis University School of Medicine and Washington University School of Medicine. Dr. Simon was also widely known for a number of groundbreaking studies in public health, and he was active in many local and national organizations including the ACLU and the American Psychoanalytic Association. He joined the St. Louis Metropolitan Medical Society in 1961.

SLMMS extends its condolences to his wife Barbara Simon; his children Benjamin Simon, Charles Simon, Philip Simon and David Simon; and his eight grandchildren. ◄

JOINS IN CLINICAL RESEARCH PARTNERSHIP

Urology of St. Louis has joined in a clinical research partnership with ObjectiveHealth, a Nashville-based integrated research and technology platform company. The joint clinical research center, Specialty Clinical Research of St. Louis, will offer access to innovative diagnostic tools, treatments and therapies aimed at improving health outcomes in urologic disease states. Urology of St. Louis has 27 practicing urology associates who are SLMMS members at 21 locations throughout St. Louis and the Metro East.

The site's work will focus on population-intensive urological disorders such as benign prostatic hypertrophy, kidney stone disease, urinary tract infections and overactive bladder, as well as bladder and prostate cancer. The research will include interventional cancer trials and predictive biomarkers in precision medicine diagnostics. ◄

Heal at Home – An Alternative to the Hospital

By George Mansour, MD

My phone rings a lot in the mornings, but this was not an ordinary phone call:

"Hi Jennifer!" I answered, recognizing a familiar number.

She said, "I have a patient to refer to the program."

Dr. Jennifer is one of the primary care physicians that refers patients to Heal at Home, a program of which I am the medical director. Launched in June of 2021, Heal at Home offers the services of physicians, nurses and other providers to care for patients with acute medical needs in the comfort of their homes. Heal at Home is now a program of CaSAnitas, which provides a full range of at-home services.

Remember when family doctors used to visit homes to check on the sick, how personalized and intimate that was? This is blossoming again in response to the pandemic—only with superior technological support and more efficient merchandise home delivery utilizing an Amazon-like model.

Jennifer pauses: "It's actually my daughter. She doesn't have the insurance you accept, but I am willing to pay cash to treat her at home."

Knowing that Jennifer's daughter has been battling cancer for the last year, I realized it would be a challenging admission. Also, since Heal at Home is for adults (18 and over), the fact that she was 17 last year at the onset of the illness did not allow us to help before. But now that she has turned 18, I accepted her for admission without hesitation once I learned more about the acute need.

Over the last couple of years, I have observed many patients and their families prefer to be treated at home, if possible, as opposed to being admitted to the hospital.

Dr. George Mansour

George Mansour, MD, is CEO of CaSAnitas and medical director of the Heal at Home program. He is a member of the SLMMS Council. For more information about Heal at Home, visit casanitasmd.com. From 2021 to 2023, Dr. Mansour was one of the medical directors of Safe Transitions. He can be reached at gmansour@casanitasmd.com.

Why Avoid the Hospital?

The question remains: Are hospitals sometimes worth avoiding?

Are they becoming bad news in the aftermath of the pandemic? Or is it that home is just, well, home?

Among the reasons people would like to avoid the hospitals are the restrictions during admission, concerns about sanitization, being away from your routine and loved ones, and financial reasons due to lack of proper insurance.

But the question above is not one with a solo answer. It is a combination of bad experiences with hospital admissions and the opportunity for more autonomy and perhaps dignity at home, that leaves patients with an easy decision to heal at home. It is also the effect of systematic overutilizing of hospitals that give patients the feeling they "didn't need to be there."

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Charles' Story

Some of the patients I have treated over the years are unforgettable. Charles was one of them. He was suffering from heart failure with extra pounds of fluids, his legs were very distended, and he had shiny, stretched skin when I saw him first. He was in respiratory failure secondary to his heart condition. He also had pain in his knees. Charles lives in a poor neighborhood; there is a nearby hospital that he knows well. When he heard of the possibility of getting treated at home, he wanted to try it.

"I am sick of going to the hospital," he stated, hoping this would be a better experience. After an extensive review of his records that day, hearing his concerns and examining him, we developed and initiated a good plan. By the third day, he felt so much better and commented:

"Doc, I want to tell you something."

"Sure, tell me anything Charles," I said.

"Before you guys came to treat me, I prayed to God to help me, and he sent you! I have been going to the hospital since 2019, and I never felt like a human. I always was treated like a number."

Charles sensed a personal touch that patients admitted to hospital at home frequently experience.

The Psychology of Treating Patients at Home

When a patient is admitted to the hospital, he or she surrenders many simple and important rights. Think of the fact that the patient wears a gown they typically do not like and that makes them look like everyone else in the hospital. They are given a limited food menu and often a semi-private room. If the patient does not "cooperate," they are non-compliant. If they ask for help "too much," they are labeled as needy.

For some patients, hospitals become more like a prison. But feeling they have no alternative, they eventually resign themselves to staying. Hospital advocates often cite the benefits of hospitalizations and the excellent work done at most inpatient facilities. This is true in many situations, but from the patient's perspective, we must be aware that they often feel a loss of freedom and control.

What if they can get similar results while staying at home?

For that reason, let's ask a couple of questions:

1. What is different in healing at home?
2. Can all acute issues be treated at home?

When a referral is accepted, everything starts with the patient giving consent to treat. This is different from the consent you give at a hospital. What this consent does is essentially extend an invitation for the team of medical professionals to visit the patient's home, where this team will experience the patient's memories, social and financial struggles, and more. This is true for the tidy, the old, the new, the hippie-looking, the messy, even the hoarders' homes. This invitation allows us to be new members of the patient's and family's inner circle.

Psychologically, these invitations make patients feel in control, as opposed to being controlled in the hospital. With control comes responsibility; patients become very responsible in helping you helping them to heal.

Often, this psychology of control encourages patients who typically are perceived as high maintenance when hospitalized, to act with unprecedented respect and trust.

The bottom line is that there is now a program—Heal at Home—where patients can resolve short-term issues without being admitted to the hospital.

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When do Patients Need to Go to the Hospital?

Having said all of this, we are aware of the fine line that separates a successful and safe home admission from one that is not. Hospitals are there for a reason, and we should not redirect patients away but rather rearrange the usage to be optimal.

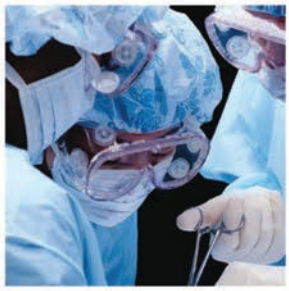
My advisor Rajiv Patel, MD, of Bluestone Physician Services, once said to a group of hospital-at-home leaders over dinner: *"I am not sure you can do the hospital work at home."* For a moment, that was quite shocking if not even insulting to a group of us who spent years battling to prove the worth of this concept.

But after taking a deep breath and thinking deep about his statement, I turned to my left where he sat and said: "I agree, the name hospital at home might be misleading. Hospitals are there for a reason, but patients can still be treated at home for exacerbations of chronic diseases. We can call it acute care at home or ***Heal at Home***."

Some patients do belong in the hospital. Stringent inclusion and exclusion criteria help identify who needs to be admitted to the hospital rather than heal at home. Having said that, even with good exclusion criteria a small percentage of patients end up being transferred to the hospital. Jennifer's daughter in fact was one of these. She ultimately went to the hospital for further investigation and support. Exclusion criteria helps triaging patients on admissions to Heal at Home, but a clinician must have the awareness to arrange for hospital transfer when needed.

Fortunately, Jennifer's daughter is the exception. The bright side is most patients can now heal safely and cost effectively at home. We are able to provide the services and staffing to render acute care to patients in the home setting, where they can benefit from greater dignity and comfort.

It Doesn't Take An Eye Doctor To See A Really Good Deal.



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