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Patient-Centered Medical Homes: Coming of Age

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How to Improve and Preserve Your Health

By Richard J. Gimpelson, MD

With the presidential election closing in on us, the people at this time seem to be leaning toward Donald Trump and Hillary Clinton. I have tried to find out the details of these two candidates' plans for improving our health through their specific health plans. The details are sparse. In fact, Trump claims he is going to scrap Obamacare and give all of us something fantastic and greater than ever before. On the other hand, Clinton is going to improve Obamacare and give us something even better than we have now. Not only is there no meat in either of their plans, there are not even any potatoes.

Since I cannot give you any details at this time, I surfed the Internet and came across "13 Strange but True Health Tips." These tips came from *Men's Health* magazine (these can apply to women also). You may refer to them as "Old Doc Gimpelson's Guide to Better Health:"

1. **Change your name:** Your initials may predict your future. People with positive initials like J.O.Y. or W.O.W. live



Dr. Richard J. Gimpelson

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

nearly 4-1/2 years longer than people with neutral initials. People with negative initials like D.U.D., B.A.D., I.L.L., and D.E.D live three or more years less than the neutral-initialed people.

2. **Use the first stall:** After analyzing 51 public restrooms, experts found the stall closest to the restroom door had the lowest bacteria levels and the most toilet paper. In addition, one should stand before flushing to avoid the fine mist that contains contagious bacteria.
3. **Splint a broken arm with a magazine:** Place wrist palm-down on a thick magazine. Roll the magazine in a u-shape and secure with duct tape, Ace wrap or long strips of material torn from a shirt. Don't forget to renew the subscription.
4. **Accuse others of taking your keys:** Young people tend to blame lost keys on someone else, while older people blame themselves. If you blame others, you will remain younger longer.
5. **Scratch the other limb:** For itchy skin under a cast, scratch the same place on the other arm and trick your brain into thinking you are scratching the real itch. This may work on any body part.
6. **Break a high fever.** Treat up to 102°F with increased fluids. For a higher temperature, put an ice pack under your arm or near the groin to cool the body's core. Then see a doctor.

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Harry L.S. Knopf, MD

ON LIFE

Life is like an inexpensive suit of clothes: It requires continual alterations to make it fit.

— (adapted from poem by David McCord, 1897-1997)

I think most of us desire a life that follows our wishes. Sure, the basics are always needed: food, shelter, money, love. But what about those things that are more intangible and unpredictable: "success," "admiration," "satisfaction." These things and other intangibles are not easy to come by. Many people work hard their entire lives without anyone ever noticing, except, perhaps, their loved ones. Are they worse off because they did not receive acclaim? If they provided well for their family, then they can claim satisfaction for a life well-lived. Good enough, don't you think? Each of us needs to find that "life garment" that fits. Perhaps it will need altering as our life changes (like our real clothes). But fear not! There is plenty of material, and sometimes more than enough for a **new** suit. ◀

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

David M. Nowak
Executive Editor
dnowak@slmms.org

James Braibish
Braibish Communications
Managing Editor
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Should Nurse Practitioners Be Allowed to Practice Independently?

By Samer Cabbabe, MD, FACS, Medical Society President



Medical Society President
Samer Cabbabe, MD, FACS

According to the AMA, only a handful of states require independently practicing NPs to submit information regarding their location of employment. Of those states, none keep track of the number of independently practicing NPs.

For several years, health-care experts have been concerned about an impending shortage of physicians. This concern accelerated in 2014 due to expanded health coverage available as a result of implementation of the Affordable Care Act. Policymakers have suggested that nurse practitioners (NPs) could fill this gap. They have argued that since their reimbursement is lower, nurse practitioners could also help reduce health-care costs.

Advocates for NPs note that they could fill the growing primary care shortage more quickly than physicians, since it takes NPs, on average, six years to complete their education and training, including undergraduate and graduate degrees, compared to an average of 11 to 12 years for physicians, including schooling and residency training.

Medicare pays NPs, practicing independently, 85 percent of the physician rate for the same services. Medicaid fee-for-service programs pay certified pediatric and family practice NPs directly, but these rates vary by state. Some states pay them the same rates they pay physicians for some or all services, but more than half of the states pay NPs a reduced fee. Health insurance plans have significant discretion to determine what services they cover and which providers they recognize. Some plans do not cover NP services, and many managed care plans require their enrollees to designate a primary care provider but do not always recognize an NP in that role.

Background and Training

In order to become a nurse practitioner, students with a high school diploma usually study for a Registered Nurse (RN) certification, or for a degree in nursing. These degrees include the Associate Degree

in Nursing (ADN) and the Bachelor of Science in Nursing (BSN) which can be completed in approximately two and four years, respectively. After the completion of a degree program, students must first obtain the RN certification and then enroll in a Master of Science in Nursing (MSN) program. The Master's degree in nursing is normally completed in about two years, but for enrollees who already have some work experience in a health-care-related field, the degree can be completed in as little as 18 months.^{1,2}

A new nurse practitioner, without any other nursing experience, acquires between 500 and 1,500 hours of clinical experience in a minimum of 1.5 years of post-graduate training, an equivalent of less than a third-year medical student. In contrast, a new family physician acquires more than 15,000 hours of clinical experience in a minimum of seven years post-graduate training. This amounts to a difference of at least 13,500 hours in clinical experience.³

Currently, there are 21 states where NPs have the statutory authority to practice without physician collaboration, supervision or oversight. The other 29 states require physician supervision for prescribing but have various requirements for physician involvement for diagnosing and treating.⁴ According to the AMA, only a handful of states require independently practicing NPs to submit information regarding their location of employment. Of those states, none keep track of the number of independently practicing NPs.⁵

Current Missouri law prohibits NPs from independently prescribing, diagnosing or treating patients without physician supervision or collaboration. Furthermore, Missouri NPs are governed by the Missouri

Board of Nursing and do not fall under the jurisdiction of the Board of Healing Arts.

Reports Debate Expanded NP Scope of Practice

In 2010, the Institute of Medicine (IOM) issued a report in conjunction with the Robert Wood Johnson Foundation, entitled “The Future of Nursing: Leading Change, Advancing Health.” The goal of this joint effort was to explore options to increase access to health care as a result of the passage of the Affordable Care Act. Their conclusion was that “Advanced Practice Registered Nurses (NPs) should be called upon to fulfill and expand their potential as primary care providers across practice settings based on their education and competency.”⁶ Of the 18 committee members, only two were physicians, one of whom was the chief medical officer for CVS Caremark.

The Council of Medical Specialty Societies (CMSS), which represents 34 societies with an aggregate membership of more than 650,000 U.S. physicians, believes that “non-physician clinicians are critical stakeholders in the health of our nation and that nurses are irreplaceable members of a high-performing, patient-centered health-care team.” In their rebuttal of the IOM report, CMSS states that “nurses, within the context of the physician-led medical home, are ideally suited to help deliver these newly covered preventive services.”⁷

The American Medical Association (AMA) acknowledges that non-physician practitioners, including NPs, can provide essential patient care, but that such care is “most appropriately provided as part of a physician-led team.”



Existing studies of the geographic distribution of NPs in the United States show that they are more concentrated in urban areas than are physicians: 85 percent of NPs work in metropolitan counties and only 5.5 percent of NPs practice in remote rural counties.^{2, 8} Furthermore, according to CMSS, the IOM report “lacks detail concerning the necessary clinical and educational standards which would undergird such an expansion, and does not give sufficient attention to the cost ramifications associated with its recommendations.” The CMSS points out, in criticizing the IOM report, that a recently graduated NP with only 500 hours of clinical experience would be permitted to legally admit patients to a hospital or hospice, lead the patient-care team, and receive the same level of reimbursement as a physician.⁷ Other studies have shown that NPs tend to order more laboratory and diagnostic tests than physicians, defying the concept of reducing health-care cost.^{9, 10}

The American Medical Association (AMA) acknowledges

that non-physician practitioners, including NPs, can provide essential patient care, but that such care is “most appropriately provided as part of a physician-led team.” In addition, the AMA states that “nurses are critical to the health-care team, but there is no substitute for the education and training of physicians. With a shortage of both nurses and physicians, increasing the responsibility of nurses is not the answer to the physician shortage. Research shows that in states where nurses can practice independently, physicians and nurses continue to work in the same urban areas, so increasing the independent practice of nurses has not helped solve shortage issues in rural areas. Efforts to get health-care professionals in areas where shortages loom must continue in order to increase access to care for all patients.”¹¹

In conclusion, we all desire excellent patient care but must remember that physicians are indisputably the most educated and trained to lead the health-care system. We must not confuse accessibility with quality in health care by allowing NPs to practice without physician supervision. ➔

References

1. Vanderbilt University Family Nurse Practitioner Program information. http://www.nursing.vanderbilt.edu/msn/fnp_plan.html, and the Vanderbilt University School of Nursing Handbook 2009-2010, <http://www.nursing.vanderbilt.edu/current/handbook.pdf>.
2. American Academy of Family Physicians, Primary Health Care Professionals: A Comparison. <http://www.aafp.org/dam/AAFP/documents/news/NP-Kit-FP-NP-UPDATED.pdf>.
3. <http://www.tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf>.
4. AK,AZ,CO,CT,HI,IA,ID,MD,ME,MN,MT,ND,NE,NH,NM,NV,OR,RI,VT,WA and WY.
5. AMA Independent Nursing Practice Brief, 2015, <https://download.ama-assn.org/resources/doc/arc/x-pub/independent-nursing-practice-issue-brief.pdf?cb=1456756548&retrieve=yes>.
6. Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: National Academies Press, 2010. <https://iom.nationalacademies.org/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>.
7. <http://cmss.org/wp-content/uploads/2016/02/IOM-FON-Report-CMSS-Response.pdf>.
8. Lin GE, Burns PA, and Nochajski TH. “The Geographic Distribution of Nurse Practitioners in the United States.” *Applied Geographic Studies* 1 (1997): 287–301.
9. A comparison of diagnostic imaging ordering patterns between advanced practice clinicians and primary care physicians following office-based evaluation and management visits. *JAMA Internal Medicine*. January 2015, Vol 175, No 1.
10. American College of Physicians, A Comparison of Resource Utilization in Nurse Practitioners and Physicians. <http://ecp.acponline.org/novdec99/hemani.htm>.
11. AMA Responds to IOM Report on the Future of Nursing, Oct. 5, 2010. <http://www.msv.org/DocumentVault/PDFs/101410-AMA-response-to-IOM-report-PDF.aspx>

St. Louis County Enacts Prescription Drug Monitoring

Responding to a stalemate in the Missouri Legislature, St. Louis County on March 2 enacted a program for monitoring the sale of prescription drugs, including opioids that can lead to addiction and heroin abuse. Missouri is the only state in the nation without a prescription drug monitoring program (PDMP).

The measure was sponsored by SLMMS member and St. Louis County Councilman Sam Page, MD, an anesthesiologist and former state representative. Dr. Page said, "The prescription drug monitoring program helps the physician and patient make better decisions about whether a narcotic pain medication is right for each patient. I am pleased that St. Louis County could move ahead so the medical community can have this needed tool."

Dr. Page said he hopes other counties will join St. Louis County in the program.

The St. Louis County Department of Public Health will administer the database and anticipates having it operational by the end of 2016, said Sarah L. Patrick, MPH, PhD, deputy director. They currently are consulting with other state PDMPs, drafting a request for proposals for vendor assistance, and working on hiring a project manager. They also are utilizing technical assistance from the Brandeis University Center of Excellence on Prescription Drug Monitoring.

According to the Centers for Disease Control, 44 people in the United States die every day as a result of prescription opioid overdose. —

Muny Season Ticket Discount for SLMMS Members

It's hard to imagine a St. Louis summer without The Muny, and SLMMS members can enjoy the entire season at a discounted rate. Enjoy great outdoor musical theater under the stars when you purchase season tickets through The Muny Corporate Advantage Program. With a discount of more than 10% on season tickets, combined with the savings compared to purchasing single tickets, SLMMS members can receive the equivalent of three shows free. It's the lowest price you'll find on Muny season tickets to seven great musicals. This year's lineup includes Muny favorites such as "Fiddler on the Roof," "Music Man" and "The Wizard of Oz" as well as The Muny premieres of



"Mamma Mia" and "Young Frankenstein."

The discount is easy to obtain. Use the special promo code (**SLMMS16CA**) when ordering your tickets by phone, online or in person at The Muny box office. The code is good on new season ticket subscriptions only when purchased between April 4 and May 8, and is not retroactive to prior season ticket purchases or renewals, and may not be used for individual ticket purchases. Corporate Advantage season tickets are limited to Terrace A and Terrace B seats only.

Visit www.muny.org to see the complete 2016 lineup of shows, dates and ticket prices. If you have questions about the discount program, contact Bill Borger at The Muny at 314-595-5762 or bborger@muny.org. —

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Recent postings include:

- SLMMS member Luis Giuffra, MD, discusses medication-assisted treatment for opioid addictions on FOX2 News
- Photos of SLMMS Alliance Valentine's dinner
- HHS announces commitments to increase EHR interoperability



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7. **Skip antibacterial soap:** The AMA claims there is no solid evidence that antibacterial soap is better than regular soap, and it may actually create resistant organisms. Note that the AMA supported Obamacare.
8. **Straighten your drive:** Sit with your shoulders back and spine straight while driving. Good posture reduces that old age curvature.
9. **Disinfect a wound with honey:** Put a dab of honey on a cut before covering it with a bandage. Honey has powerful antibacterial properties.
10. **Call Dr. Pepper:** If you nick yourself in the kitchen, run cold water over the wound and use soap. Then sprinkle black pepper on the wound and apply pressure. This stops the bleeding. Black pepper is supposed to have analgesic, antibacterial and antiseptic properties and does not sting. Warning! Do not use this for nosebleeds unless you like sneezing profusely.
11. **Shave your 'stache and sniff less:** If you are prone to seasonal allergies and have a mustache, wash it twice a day with liquid soap to get rid of stuck pollen grains. One study found a reduction of antihistamine and decongestants in men who did this. I assure you, if a woman has a mustache, this will work for her also.
12. **Pet away high blood pressure:** To lower risk of heart attack and stroke, get a dog. Many studies show that petting a dog keeps blood pressure under control when stressed.
13. **Flush away trouble:** Before you go to bed, put small strips of toilet paper and a pencil in the bathroom. In the morning take a seat and write the names of all the people or situations that are causing you angst. Then throw them in the bowl and flush. This will make you feel great. Don't forget to stand (see tip #2).

I do not guarantee that any of the tips work, but at least I have a plan for improving and preserving your health.

So take that, Trump and Clinton. Show us your plans. Old Doc Gimpelson has just slapped both of you with latex-free gloves. ➤



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Huge Fines Await Physicians Who Are Non-Compliant With HIPAA

Having strong policies and procedures, and completing a comprehensive risk analysis, are essential in preparing for an OCR or HHS audit

By Kyle J. Haubrich and J. Thaddeus Eckenrode, Eckenrode-Maupin, Attorneys at Law

Last September, a radiation oncology practice with 13 physicians paid \$750,000 to settle a claim that they were non-compliant with HIPAA regulations after a laptop was stolen from an employee's car.¹ In another incident, a hospital in Massachusetts agreed to settle HIPAA violation claims for \$850,000 because a laptop was stolen from an unlocked treatment room.² Likewise, Affinity Health Plan was fined over \$1.2 million for returning photocopiers without erasing the internal hard drives.³

As shocking as these figures may be, they reflect fines and settlements that are actually within the average range for HIPAA violation claims. Health-care providers need to be aware of the substantial risk they face, in these modern times of computers, social media and information technology, of being assessed fines by the government in the seven-figure range. Unfortunately, that risk—and the challenges posed to practicing physicians—is not going away. In fact, it will only become more difficult. The government anticipates increasing the number of audits they do in the coming months and years, and all physicians and medical practices must be prepared for that.⁴ Unfortunately, this is not something that can be addressed with a quick coat of paint.

Background

As all health-care providers likely know, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁵ establishes certain rules and guidelines for the use, dissemination and communication of protected health information (PHI), and

those laws are enforced by the U.S. Department of Health and Human Services (HHS) and Office for Civil Rights (OCR).

In the case referenced above involving the radiation oncology group (Cancer Care Group, P.C.), the OCR found that Cancer Care was in widespread non-compliance with the HIPAA Security Rule.¹ Cancer Care had not conducted an **enterprise-wide risk analysis** when the breach occurred in July 2012; nor did Cancer Care have in place a **written policy** specific to the removal of hardware and electronic media containing ePHI (Electronic Protected Health Information) into and out of its facilities, even though this was common practice within the organization. OCR Director Jocelyn Samuels stated, "Organizations must complete a comprehensive risk analysis and establish strong policies and procedures to protect patients' health information."¹

When Lahey Hospital and Medical Center in Massachusetts agreed to settle the alleged HIPAA violations, they not only had to agree to the \$850,000 settlement noted above, but also to adopt a robust corrective action plan to address deficiencies in its HIPAA compliance program.² The OCR investigation concluded that the hospital had:

1. Failed to conduct a thorough risk analysis of all its ePHI;
2. Failed to physically safeguard a workstation that accessed ePHI;
3. Failed to implement and maintain policies and procedures regarding the safeguarding of ePHI maintained on workstations utilized in connection with diagnostic/laboratory equipment;
4. Lacked ... a unique user name for identifying and tracking user identity with respect to the workstation at issue in this incident;
5. Failed to implement procedures that recorded and examined activity in the workstation at issue in this incident; and
6. Made impermissible disclosure of 599 individuals' PHI.²

So, what does all this mean to the average physician who hangs out his own shingle, or to a group practice that doesn't have its own in-house legal team working full-time to keep the practice updated and in compliance with the various nuances of these



J. Thaddeus Eckenrode



Kyle J. Haubrich

J. Thaddeus Eckenrode is the managing partner of Eckenrode-Maupin, Attorneys-at-Law, a St. Louis based insurance defense firm practicing in Missouri and Illinois. He focuses on defense of complex tort litigation, most notably in the areas of medical malpractice, wrongful death, nursing homes and product liability. Kyle J. Haubrich is an attorney with Eckenrode-Maupin and is experienced in health-care law. They can be reached 314-726-6670, or jte@eckenrode-law.com or kjh@eckenrode-law.com. The firm's website is www.eckenrode-law.com.

rapidly changing laws? Unfortunately, it makes such practice groups or individuals prime targets for an audit by HHS, and such an audit is likely to find HIPAA violations, leading to the assessment of fines, often for significant or astronomical amounts, for not being in absolute compliance with HIPAA's Privacy, Security, and Breach Notification rules.

What Is Required to Be HIPAA-Compliant?

Most physicians simply want to practice medicine, and that's what they trained to do. Very few have the time to learn the details of what the law requires under HIPAA, and as a result, most doctors' offices fail to do the basic things required by the HIPAA law. They are not purposefully non-compliant, but they just don't grasp the significance of the law's requirements, and tend to hand off the responsibility to an office manager or staff member who is already swamped with work themselves. Most of the time the office manager or staff member who is given this responsibility is not an attorney and, when faced with a set of voluminous laws that read like Egyptian hieroglyphics, the staff struggle to fully understand the law and to comprehend the minutia and details that are actually required to keep the practice in compliance. Therefore, it begs the question, "What does HIPAA require in order to be compliant with the law?" In short, a covered entity must:

- Have **written** policies and procedures in place to protect a patient's protected health information (PHI) or his/her ePHI.

- Conduct training for all staff on these policies and procedures and the law itself, **at least twice a year** (although doing so quarterly will be viewed more favorably by HHS).
- Conduct risk analysis walkthroughs to ensure compliance with the privacy and security rules of HIPAA and to see where the office might be lacking in compliance with these rules.
- Assure that all documents, forms, letters and other information-gathering documents be in HIPAA-approved format and are easy enough for the patient to understand the manner in which their PHI is used, and to what they are agreeing, etc.⁶

1) Written Policies

HIPAA requires that all covered entities, such as hospitals, physician practices, pharmacies and clinics, must have policies and procedures in place to protect PHI from being unlawfully used or disclosed.⁷ Basically, every covered entity should work with their office manager, officers and physicians to draft a **practice-specific** HIPAA manual that includes policies and procedures on everything from disaster recovery of medical files to how to respond if a patient's personal representative requests a copy of the patient's medical record. Some medical offices think they're in compliance because they have pulled a generic sample of "policies" off the Internet but never took the

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time to formulate and revise those policies to meet their specific practice needs. As noted below, all medical staff personnel must be trained on the practice's specific HIPAA policies and procedures, and must strictly adhere to those requirements.⁷ An entity cannot comply with that requirement and effectively train its staff on their policies and procedures for HIPAA if they don't have a policy manual or if it is generic or outdated. The fines, as noted above, can be hefty if a practice simply fails to have such written policies and procedures in place.

2) Training

HIPAA **requires** that all covered entities train their staff on the specific expectations for each staff member when it comes to complying with HIPAA, and the detailed policies and procedures in the office for HIPAA compliance.⁸ This is where most medical practices tend to drop the ball and expose themselves to sanctions. They either do no training at all, or the training they do is inadequate for the staff to fully understand how to comply. For example, if all an office did concerning training on HIPAA was to have its staff read a brief pamphlet every few months and then take a quiz right after reading the pamphlet, chances are good that the practice would not be in compliance with this part of the law. Because the law is so complex, training should consist of a presentation of the material the law requires the medical staff to know and understand concerning HIPAA, followed by several practice scenarios to help reinforce what was taught. Inadequate staff training may lead to a practice being heavily fined, sometimes to the tune of \$50,000 or more for this deficiency alone.⁸

3) Risk Analysis

Most medical offices have never done a "walkthrough" of the office to see where they may be out of compliance with HIPAA or identify vulnerabilities that may lead to a breach of PHI. Such walkthroughs should be done at least twice a year to identify these vulnerabilities and to ensure that progress is being made to correct any identified deficiencies. Failure to conduct these risk analysis walkthroughs can also expose a practice to fines of hundreds of thousands of dollars.^{1,2} Your walkthrough should be performed as though **you** are the HHS auditor. Be very detailed and tough on yourself and your practice, and ask yourself the questions an auditor might raise: "Can I see patients' names on the computer at the front desk if I were a different patient and making an appointment?" "How easy is it for one patient to look at another patient's medical record?" Conducting your walkthrough with someone who knows what to look for as possible vulnerabilities may save headaches and expense in the future.

4) Documentation

Professional documents and forms need to be in HIPAA-compliant format as well.⁹ These include all business associate contracts, documents for the release of medical records, letters

denying or approving changes to medical records, and the list goes on and on. Most practices have a lot of these forms already. Unfortunately, many of these forms, especially those found on Internet websites or other such "examples" that one might obtain, can be outdated or inaccurately worded. Properly drafted and up-to-date forms and documentation help your staff comply with the policies and procedures required by HIPAA and reduce the risk of huge fines for findings of non-compliance.

What all physicians and practice managers should understand is that when the government comes in to audit your practice, they are looking for a **paper trail** showing that you have done everything required of you to comply with HIPAA. The more detailed your paper trail the less likely you are to be found out of compliance.

Will I Be Audited? If So, How Soon Could I Expect an Audit?

According to recent reports, the director of HHS has announced that more audits, which are required under the HITECH Act, will begin in early 2016.⁴ They have found with the audits conducted in 2014 that almost 95 percent of all covered entities, when audited, **failed** the audits.¹⁰ "After conducting a study to assess OCR's oversight of covered entities' compliance with the HIPAA Privacy Rule, the Office of Inspector General issued a report finding that OCR should strengthen its oversight of covered entities and made several recommendations. Specifically, OIG recommended that OCR:

1. Fully implement a **permanent** audit program;
2. Maintain complete documentation of corrective action;
3. Develop an efficient method in its case-tracking system to search for and track covered entities;
4. Develop a policy requiring OCR staff to check whether covered entities have been previously investigated; and
5. Continue to expand outreach and education efforts to covered entities."⁴

The OCR responded to this report by stating that "it is **moving forward with a permanent audit program** and will launch Phase 2 of that program in early 2016." This "Phase 2" will "target common areas of noncompliance ..." It will also "... test the efficacy of the combination of desk reviews of policies as well as onsite reviews." Therefore, private practice physicians, hospitals, clinics and even pharmacies, should be "reviewing their HIPAA policies and practices and developing a plan for working with OCR in onsite reviews."⁴

It is clear from this report that every covered entity should **expect** an audit of its practice within the very near future. Be prepared for OCR to review everything you and your practice have ever done toward HIPAA compliance. Unfortunately, if

you do not have good documentation of all of the actions and steps you've taken—even if you have been faithful in doing all of the work necessary to comply—you may not be able to prove it, and the fines assessed could be massive.

In light of these developments, each physician and/or practice manager should ask themselves these questions:

1. Do we conduct training on HIPAA at least twice a year?
2. Do we have documentation showing that we have conducted training, who attended that training, what topics the training covered, and other required documented items?
3. Have we done our risk analysis/walkthroughs? Are they documented? Can we show that we have made progress in correcting any identified lapses in our security of PHI?
4. Do we have a HIPAA manual? Is our HIPAA manual up to date? Have our employees been trained on our policies and procedures from that manual?
5. Are all of our documents, forms, letters and other required information for patients and/or their respected personal representatives up to date and in HIPAA-compliant format?

If you can't confidently answer these questions in the affirmative, then your risk of a bad outcome from an OCR audit of your practice is substantial. The fines that may be levied against your practice will likely depend on the extent of the issues found in the audit, but even for the most nominal findings of non-compliance, fines of hundreds of thousands of dollars are possible.

Conclusion

To summarize, the Department of Health and Human Services and the Office for Civil Rights are ramping up audits of covered entities to ensure that they are complying with HIPAA's Privacy, Security and Breach Notification Rules. Every covered entity must be able to show that it has policies and procedures in place to protect a patient's protected health information (PHI) or the electronic version of the patient's information. The covered entity must show that it has conducted trainings on its policies and procedures concerning HIPAA.

Training must be documented and the covered entity must have that documentation handy and ready to show an auditor. All of the covered entity's documents must be current and in HIPAA-required format.

Failure to have any of these things as required by HIPAA, or simply having them in an inadequate form, will likely result in fines being imposed by HHS and OCR following your audit.

The auditors are coming. It is no longer a question of *whether* you will be audited, but only a question of *when*. The government is expediting the implementation of its auditing program. ***The time to make sure you are in compliance is now, not when the auditor shows up.*** ◀

References

1. <http://www.hhs.gov/about/news/2015/09/02/750,000-dollar-hipaa-settlement-emphasizes-the-importance-of-risk-analysis-and-device-and-media-control-policies.html>.
2. <http://www.hhs.gov/about/news/2015/11/25/hipaa-settlement-reinforces-lessons-users-medical-devices.html>.
3. <http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/examples/health-plan-photocopier-breach-case/index.html>.
4. <http://www.natlawreview.com/article/hipaa-phase-2-audits-to-start-early-2016-ocr-states-response-to-oig-recommendations>.
5. <http://thomas.loc.gov/cgi-bin/query/z?c104:H.R.3103.enr>:
6. HIPAA Security Standards §164.306 & §164.308.
7. HIPAA Security Standards §164.308(a)(1)(i).
8. HIPAA Administrative Requirements §164.530 (b)(1).
9. HIPAA Administrative Requirements §164.530.
10. <http://www.modernhealthcare.com/article/20130423/NEWS/304239958/audits-find-organizations-unaware-of-new-data-privacy-rules>.



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Patient-Centered Medical Homes: Coming of Age

Practices see positive results in converting to PCMH as they prepare for value-based payments

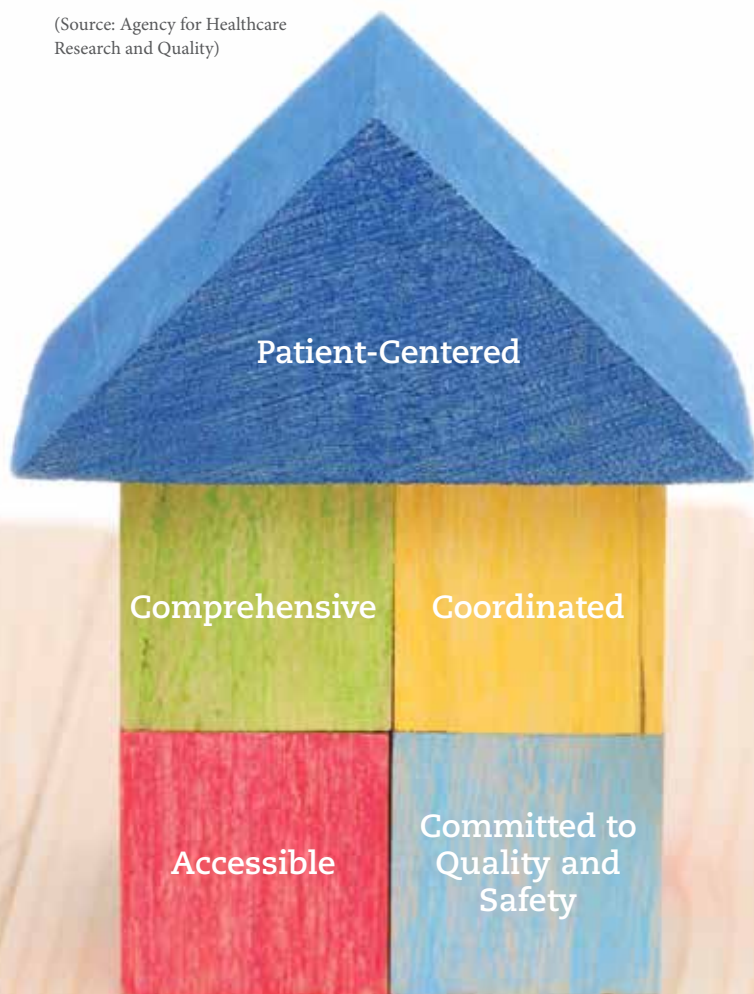
By Jim Braibish, St. Louis Metropolitan Medicine

As Medicare and insurers move toward value-based reimbursement, more primary care practices in St. Louis and across the nation are converting to the Patient-Centered Medical Home model. The PCMH takes a proactive approach to helping patients manage their health, by utilizing a care team and monitoring the health of its patient population.

More than 90 practices in St. Louis City, St. Louis County and St. Charles County with nearly 340 physicians are certified as Patient-Centered Medical Homes, according to an unofficial

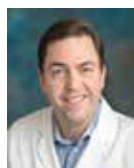
Five Core Attributes of the Patient-Centered Medical Home

(Source: Agency for Healthcare Research and Quality)



study of listings on the website of the National Committee for Quality Assurance (NCQA), the largest of several PCMH national and state certification programs.

BJC Medical Group and SSM Health Medical Group have converted all of their primary care practices to PCMH. Other major PCMH operators in the area are Esse Health and the various federally qualified health centers. SLUCare also has several certified practice locations.



Dr. Douglas Pogue

“We realized that the Patient-Centered Medical Home concept represents better medical care. The PCMH wraps around the patient to make sure they get the services they need to stay healthy,” said Douglas Pogue, MD, vice president and chief medical officer of BJC Medical Group.

“Several years ago, insurance companies began talking about changing how they pay, and in 2012 we launched our Accountable Care Organization (ACO). To be successful in these programs, we realized we had to change how care is delivered in the office.”

BJC’s primary care practices, including internal medicine, family medicine and pediatrics, became PCMH certified in 2013 and 2014 at Level 3, the highest NCQA level. BJC currently has 70 practice locations certified across St. Louis and eastern Missouri, with 259 physicians serving 284,000 patients. Of those, 65,000 are in value-based contracts where BJC assumes risk for patient health outcomes.



Dr. Thomas Hanley

At SSM Health, they had been providing the components of the PCMH since 2010, said Thomas Hanley, (MD), (SLMMS), vice president of medical affairs for the primary and specialty groups. “We had been doing team-based care and managing to the triple aim. But by the beginning of 2013, it became obvious to us that changes were coming. The Centers for Medicare and Medicaid Services was heading in the direction of the value-based programs we now have seen enacted for Medicare, and commercial payers were introducing performance metrics. We realized the world was changing, and in mid-2013 we made the decision to apply for formal recognition of all of our sites.”

SSM Health now has 31 practice sites Level 3 certified, with 150 physicians serving about 300,000 patients in internal medicine, family medicine and pediatrics.

Defining the Patient-Centered Medical Home

The PCMH concept originated with the American Association of Pediatrics in the 1960s. The model was further advanced by the World Health Organization in the 1970s and by the Institute of Medicine in the 1990s, with each further refining the PCMH definition. The goal of the PCMH is the “triple aim”—better patient experience, improved population health outcomes, and reduced cost of care.

“The PCMH is a model and philosophy of advanced primary care that embraces the relationship between a primary care team and patients, families and caregivers,” according to the Patient-Centered Primary Care Collaborative (PCPCC), a national consortium of employers, health-care provider associations, payers, patient/family advocacy groups, and others advocating for widespread adoption of the PCMH model.

The five core attributes of the PCMH as set forth by the Agency for Healthcare Research and Quality, are:

- **Patient-centered:**

The PCMH supports patients in learning to manage and organize their own care based on their preferences, and ensures that patients, families, and caregivers are fully included in the development of their care plans. It also encourages them to participate in quality improvement, research, and health policy efforts.

- **Comprehensive:**

The PCMH offers whole-person care from a team of providers that is accountable for the patient’s physical and behavioral health needs, including prevention and wellness, acute care, and chronic care.

- **Coordinated:**

The PCMH ensures that care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services, and long-term care supports.

- **Accessible:**

The PCMH delivers accessible services with shorter waiting times, enhanced in-person hours, 24/7 electronic or telephone access, and alternative methods of communication through health information technology (HIT).

- **Committed to Quality and Safety:**

The PCMH demonstrates commitment to quality improvement and the use of data and health information technology (HIT) and other tools to assist patients and families in making informed decisions about their health.

The PCPCC notes in its *Annual Review of Evidence 2014-2015* report, “While the goals or attributes for PCMH practices are often similar, the PCMH model is not ‘one size fits all.’ PCMH

practices differ in terms of their implementation, measurement and performance, and the term ‘medical home’ is not well understood by the public.”

THE PCMH TRIPLE AIM

- **Better patient care**
- **Improved population health**
- **Lower costs**

Team-Based Care

A key component of PCMH practices is the team-based approach to care. Nurses and other professionals take on additional roles in helping the physician to care for the patient. Dr. Hanley of SSM said, “Staff and physicians work at the top of their licenses. For example, medical assistants are trained to do medication reconciliation, and check for gaps in care that might be noted in the EHR, such as a person over 50 needing a colonoscopy. They screen patients for such things as fall risk and depression. This frees the physician to focus on medical decisions and the relationship with the patient.”

BJC’s Dr. Pogue noted, “Practically, this works out as a joint approach. Nurses review patient conditions. They check for gaps, and whether the patient is up to date on preventive measures. The care teams—including the physicians, nurses and nurse practitioners—huddle in the morning to review what the day’s patients will need, so they are working proactively instead of just reacting.”

Part of the PCMH approach is care managers who follow up with patients between visits. These are usually nurse practitioners or registered nurses. SSM has 18 RN care managers. “They will track the most complex five percent of our cases, such as diabetes, and contact patients to see that they are maintaining diet and wellness,” Dr. Hanley said. “Overall, the response from patients has been overwhelmingly positive.”

Another function of the care managers is to help manage the handoff from the hospital when patients are discharged. “The hospital care manager will contact the practice care manager to ensure the patient continues to receive follow-up. The goal is to prevent relapse and readmission,” Dr. Hanley added.

The care management team can include additional professionals such as social workers. Dr. Pogue said, “Our outpatient care manager team includes nurse care managers, social workers and health coaches such as dietitians. They support patients to make sure they get the care they need. A social worker can help patients overcome challenges such as getting transportation to appointments.”

continued on page 14

EHR and Population Management

To track the health of an entire population of patients, a robust electronic health records system is essential. BJC has a population health department that uses a data analytics engine to provide periodic reports to the practices, Dr. Pogue said. This can include patients who haven't been seen for a while, or with certain conditions that require regular screening and follow-up. SSM has tools in its Epic software to track patient health, plus an additional tool that overlays EHR data with adjudicated claims information. Dr. Hanley said, "We can run reports on any user-designed question, such as patients in target age groups without a mammogram, or identify patients with atrial fibrillation who may be subject to blood clots. This can be done in each office by the RN or medical assistant. They can then do outreach to these patients before admissions happen."

Payer Incentives



Dr. Kate Lichtenberg

Blue Cross and Blue Shield plans across the country have made a commitment to supporting the Patient-Centered Medical Home. Anthem Blue Cross and Blue Shield in St. Louis pays a monthly risk-adjusted coordination fee to its members connected with PCMH practices, said Kate Lichtenberg, DO, (SLMMS), physician director of Anthem's Enhanced Personal Health Care initiative.

"Our intent with the care coordination fee is to encourage practices to do care coordination. This is especially important with higher-risk patients who need extra touches. It could be a call from a nurse or medical assistant, just to make sure they are doing ok," Dr. Lichtenberg said.

"The PCMH has a whole-person orientation. It takes into account medical problems, but also the family and social situation. It follows patients with special conditions. Care coordination dollars help support this extra service," she commented.

Anthem also has a program to share savings when practices meet or exceed pre-determined cost targets. Currently, Anthem works with about 2,000 primary care providers in Missouri, for about 187,000 Anthem members who see those physicians. "In the end, we believe the savings achieved by the PCMH will offset the added cost of its services," she added.

A major expansion of value-based reimbursement is coming to Medicare as a result of the Medicare Access and CHIP Reauthorization Act (MACRA) enacted last year. Starting in 2019, physicians will choose between the alternative payment model (APM) track and the Merit-Based Incentive Payment System (MIPS) track. As this is implemented, the Centers for Medicare and Medicaid Services will define PCMH certification for the purpose of payment incentives, the PCPCC noted.

PCMH practices continue to operate in a mix of compensation models, with many patients remaining fee-for-service.

"BJC has made a commitment that during the transition to value-based care, we will have costs that are not reimbursed," Dr. Pogue said.

Dr. Hanley said, "The PCMH benefits all of our patients, whether or not they are fee-for-service. PCMH and value-based payment are the direction of the future."

Is the PCMH Achieving Results?

Nationally, many studies are tracking whether the PCMH is achieving its triple aim of better care, improved health and lower costs. A compilation of 30 studies published between October 2014 and November 2015 was presented in February by the Patient-Centered Primary Care Collaborative in its fifth *Annual Review of Evidence*. Of these, 21 of 23 studies reporting on cost measures found reductions in one or more measures, and 23 of 25 studies that reported on utilization measures found reductions in one or more measures. Among the studies included in the February 2016 report:

- A study of Veterans Health Administration Patient Aligned Care Teams found an 8.61% reduction in hospitalizations and a 7.54% drop in specialty visits, coupled with a 10.79% increase in primary care visits (*Journal of Health Care Quality*, November 2014).
- A Pennsylvania chronic care initiative achieved higher performance in four examined measures of diabetes care, a 7.75% increase in primary care visits, a 1.7% drop in hospitalizations and a 4.7% drop in emergency visits (*JAMA Internal Medicine*, June 2015).

In interpreting the findings, PCPCC President & CEO Marci Nielsen, PhD, MPH, noted that the medical homes that have been around the longest showed the most improvement. "Investments take time, sufficient resources and collaboration to pay off," she said.

Some remain skeptical. PCMH detractors cite a 2011 study of 21 Minnesota primary care practices published in the *Annals of Family Medicine* that found the rate of increase on performance quality measures was no different from other area medical groups.

Locally, BJC and SSM are seeing positive results. Dr. Pogue said, "Our quality scores have gone up, and our ACO scores are in the top quartile of the country. Our readmission rate is also 40% less for BJC as a system than just a few years ago. Long-term vaccination rates for pneumonia and other illnesses have gone way up, and hospitalization rates are down."

Patient satisfaction with the care managers is very high, he added. "The care manager gives the patient better access to

the doctor. They have someone who is easy to talk to.”

Since SSM converted to the PCMH, patient satisfaction has risen to 88% from 83% rating their experiences at the 9-10 level, Dr. Hanley said. Congestive heart failure readmissions have dropped to 12%, compared to the national average of 17%.

In addition, “Physicians are very impressed with the team-based approach. It relieves physicians from many mundane tasks, enabling them to focus on the critical task of maintaining patient health,” Dr. Hanley noted.

The Future of the PCMH

Dr. Lichtenberg said Anthem continues to recruit new practices to its Enhanced Personal Health Care initiative. “We would love to have every primary care provider in the state,” she said.

She noted that small practices can find overwhelming the cost and effort of becoming a PCMH. A recent RAND Corporation report pinpointed the annual cost of becoming a PCMH at \$147,000 per year. A 2013 Medical Group Management Association study found PCMH practices have much higher staff-to-patient ratios, but also have higher per-physician revenue.

Dr. Pogue sees primary care and the PCMH continuing to evolve. “Many of the things the PCMH is trying to do will become the way we operate every day. Some groups around the country are looking at building larger wraparound service into the PCMH.”

The expansion of the PCMH is inevitable as value-based compensation grows. Dr. Hanley said, “It has to become more widespread. As the reimbursement structure changes, doctors will be held more accountable for patient outcomes. The PCMH provides the necessary platform for this.”

For more information

Go to www.slmms.org or Facebook [saint.louis.metropolitan.medical.society](https://www.facebook.com/saint.louis.metropolitan.medical.society) for links to these resources:

- Patient-Centered Primary Care Collaborative, *Annual Review of Evidence 2014-2015*. <https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015>.
- National Committee for Quality Assurance, Patient-Centered Medical Home Recognition. <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>.
- American Medical Association, Understanding how MACRA will impact physicians. <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page>.
- Anthem Blue Cross Blue Shield Enhanced Personal Health Care Program. https://www.anthem.com/wps/portal/ahpprovider?content_path=provider/oh/f1/s0/t0/pw_e185951.htm&label=Enhanced%20Personal%20Health%20Care%20Program&state=oh. ➔

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Engaging Staff in the Patient-Centered Medical Home Process



By Kathleen McCarry

The medical practice manager plays a key role in leading a practice through the Patient-Centered Medical Home certification process and maintaining that status. Recognizing this, organizations such as the Medical Group Management Association (MGMA) offer a continually updated abundance of resources, many at no charge, to assist a practice manager with every step. For example, a recent search of “PCMH” on the MGMA website produced useful results such as a free PCMH program comparison tool, which would be helpful to a practice researching how to get started and which program to pursue for PCMH accreditation. Other materials include policy and procedure development guidebooks, cost/benefit analysis research reports, and tools to help increase patient and staff engagement. In fact, patient-centered care was featured in the March 2016 edition of *MGMA Connection* magazine, with seven great articles on the subject.

Staff Acceptance is Critical

While it is essential that the practice manager gains a strong working knowledge of patient-centered care, this is only the first step. The entire staff must understand and appreciate the importance of patient-centered care in providing better results for the patient, and that they are indeed joining in the future direction of the health-care system. In this new scenario, each staff member plays a crucial role as a member of the care team. If the practice manager doesn’t clearly understand or embrace patient-centered care, or has difficulty communicating it effectively, achieving staff “buy-in” will be particularly challenging.

In her role as director of practice management with SSM Health Medical Group-South, MGMA of Greater St. Louis member Ben Kramer, MHA, manages five primary care practices with a total of 24 providers. As SSM is one of several St. Louis-area PCMH Level 3 organizations listed

on the National Committee for Quality Assurance (NCQA) website, I contacted Ben recently to get her insight about being a PCMH practice manager.

Ms. Kramer described a patient-centered practice as one in which staff members are in positions which allow them to function at the top of their credentials. Furthermore, they understand they are part of a team which is serving all of a patient’s needs, both inside and outside of the practice’s walls. In addition to being “right for the patient,” she firmly believes that everyone, including physicians, non-physician providers and administrative staff, benefit from working in a patient-centered environment. To help bring her staff to that place, she provides basic and continuous education about Patient-Centered Medical Homes, sharing materials to which staff can refer as questions occur.

Celebrate the Wins

In addition to staff education, Ms. Kramer has found that providing relevant data in easy-to-read formats, such as dashboards, is an excellent way to engage staff in patient-centered care. Providing evidence of care protocol efficacy, as well as benchmarking, is helpful to the clinical staff. When data shows progress, these wins should be celebrated.

Challenges Remain

While there are many benefits to achieving PCMH certification, challenges remain. For example, while an individual practice might be certified, actually providing truly patient-centered care requires easy collaboration across the continuum of care. In addition, there are financial challenges. The extra costs of providing this quality of care are not reimbursed by many payers, leaving practices to absorb these expenses. —



Kathleen McCarry

Kathleen McCarry is vice president of practice advocacy for MGMA of Greater St. Louis. She is also a senior health care consultant with Anders CPAs + Advisors. Questions about the article can be directed to Kathleen at 314-518-0713 or kmccarry@anderscpa.com.

SLMMS has established a partnership with the Medical Group Management Association of Greater St. Louis (MGMA), including sharing of information across publications, across websites, through organizational committees, and via joint educational programs. For more information on MGMA, visit www.mgmastl.org.

Physician News

- **Timothy J. Eberlein, MD, (SLMMS)**, head of the department of surgery at Washington University School of Medicine, has been elected a member of the Board of Regents of the American College of Surgeons (ACS).
- **Paul Pfeiffer, DO**, has been named director of the department of emergency medicine at SSM Health St. Mary's Hospital. He has been on the medical staff at St. Mary's since 2014, serving as assistant director of the department.

Hospitals

- **Mercy Virtual** has signed a partnership with the University of North Carolina Health Care (UNCHC). Initially, Mercy will virtually monitor patients in 28 intensive care unit (ICU) beds for one of UNCHC's hospitals. The partnership will expand over time to include additional facilities and programs. Beyond elevating quality, access and efficiency for patients served by UNCHC, Mercy and other Mercy Virtual partners, UNCHC will leverage Mercy's decade of telemedicine experience. Likewise, Mercy will benefit from UNCHC's medical research experience and a sophisticated delivery network of clinical expertise, according to Mercy's news release. Mercy has become a national leader in remote delivery of health-care services, monitoring patients using high-speed data and video connections.
- **St. Luke's Hospital** has announced an affiliation with Cleveland Clinic's Sydell and Arnold Miller Family Heart & Vascular Institute. Combining the academic, clinical and research components of Cleveland Clinic with St. Luke's, the affiliation will enable the two to collaborate to continue best practices in quality and patient safety. St. Luke's patients will also get greater access to new treatments, clinical trials and second opinions.
- **SSM Health** named **Steven Burghart** as the new president of Cardinal Glennon Children's Hospital and **Travis Capers, FACHE**, as president of St. Mary's Hospital. Burghart previously served as chief executive officer for Holtz Children's Hospital and The Women's Hospital at the University of Miami/Jackson Memorial Medical Center. Capers was chief executive officer for Ochsner Medical Center, part of Ochsner Health System, a not for-profit health-care system in New Orleans; he previously was chief operating officer for Southern Hills Medical Center, part of the HCA health system.

Research

- **Health Benefits of Five Percent Weight Loss:** For patients with obesity trying to lose weight, the greatest health benefits come from losing just five percent of their body weight, according to a new study at **Washington University School of Medicine**. Researchers found that the relatively small weight loss markedly lowered patients' risk for diabetes and cardiovascular disease and improved metabolic function in liver, fat and muscle tissue. The results were published online Feb. 22 in the journal *Cell Metabolism*.
- **Two Genes Linked to Cardiovascular Health:** A new study by **Washington University School of Medicine** and other institutions has identified two genes that, when altered in specific ways, either promote or undermine cardiovascular health. The findings may help guide efforts to design new preventive drugs, similar to the way statins now are prescribed to lower "bad" cholesterol to reduce the risk of heart disease. The study, published online March 2 in *The New England Journal of Medicine*, analyzed genetic data from more than 190,000 people.

CALENDAR

APRIL

- 12** SLMMS Council, 7 p.m.
- 23** Physician Leadership Institute Session 5, Leadership Skills, 8:30 a.m. - 2:00 p.m.

MAY

- 10** SLMMS Council, 7 p.m.
- 30** Memorial Day, SLMMS office closed

JUNE

- 11-15** AMA Annual Meeting, Chicago
- 14** SLMMS Executive Committee, 6 p.m.

JULY

- 4** Independence Day, SLMMS office closed
- 12** SLMMS Executive Committee, 6 p.m.
- 16** MSMA Council Meeting

AUGUST

- 9** SLMMS Executive Committee, 6 p.m.

Outsourcing IT, Revenue Cycle Management and Accounting Can Complement Staff Skill Sets, Improve Efficiencies and Drive Growth

Evaluating the best option for your practice

By Brian D. Rapp, CPA, Anders CPAs + Advisors

In the rapidly changing landscape of the health-care industry, medical practices are expected to change with it in order to survive. Whether it be due to the changes in the workforce, reimbursement, technology or any number of other possible factors, practices are faced with tighter budgets and a growing list of new tasks to complete. And in no one area are these changes more far-reaching than for staff members, which makes outsourcing an increasingly viable solution.

While many practices have asked their staff to adapt and take on new responsibilities, we are now seeing that the specialization required in this new age of patient care is causing more work and less efficiency. It is nearly impossible for your current staff to be equipped to not only handle the transition to value-based reimbursement models, but to utilize the technological advances, all the while continuing to provide quality patient care.

Evaluating practice operations, including human resources, can help determine whether your non-physician staff are working at the highest level warranted by their education and experience.



Physicians are often approached by consultants promising that outsourcing various tasks will reduce costs and increase efficiencies. The tough decision is to determine which of these

services, if any, are right for your practice. While every practice seems to have those employees that can seemingly “do it all,” it is likely there are still holes, particularly in the areas of information technology, revenue cycle management and accounting. If you are able to find employees that have the skills demanded in these specialized areas, it is likely they will demand premium salaries. Fortunately, advancements in technology, cloud-based computing in particular, have made it easier than ever to obtain these specialized services on an outsourced basis.

Analyze Needs for Outsourcing

Before you can decide if outsourcing is right for your practice, you must first identify the greatest opportunities to increase revenue and decrease costs. An operational assessment, which is a thorough review of all or part of your practice’s operations to identify areas needing improvement, is an important starting point, and can either be done by an outside consultant or internally.

As part of the assessment, benchmarking—which is utilizing industry data to compare various aspects of your practice to your peers—can be very helpful. For example, via benchmarking, you can determine if you have employed the right number of people in the right areas, and whether you are paying market salaries. You can also see how your practice compares in the areas of provider productivity, revenue cycle and overhead.

Evaluating practice operations, including human resources, can help determine whether your non-physician staff are working at the highest level warranted by their education and experience. This can also show the scope and efficiency of your information systems, and help you identify areas of weakness. Areas to review can include billing and collections, patient satisfaction and/or access to care, employee satisfaction and/or productivity, compliance and technology, as well as areas of opportunity, and establishing related goals. Once the goals are identified, you can then consider whether or not outsourcing would be the most effective way to achieve them.

If the specialized areas of information technology, revenue cycle management or accounting are services among those



Brian D. Rapp

Brian D. Rapp, CPA, is manager of tax services in the Health Care Services Team at Anders CPAs + Advisors. He assists medical practices with compensation modeling, revenue cycle acceleration, operational effectiveness and profitability. He also works with individual physicians and their practices on addressing their tax needs. He is a member of the American Institute of Public Accountants (AICPA) and the Missouri Society of Certified Public Accountants (MSCPA), the League of Healthcare Experts and MGMA. He can be reached at 314-655-0224, brapp@anderscpa.com.

needing improvement, take the factors below into account as you make the decision to keep internal or outsource.

Information Technology: While technology has enabled us to make great advances in the way practices are run, it is not without risks. Often, smaller physician practices do not have the resources on site to protect the security of patient data. Your practice should understand its vulnerabilities when it comes to the way patient information is transmitted, security of the computers and servers, and disaster recovery. At the very core is to ensure your practice is compliant with HIPAA's security regulations, including performing at least an annual security risk assessment. In addition to security, other benefits of outsourcing IT services include assuring that your systems are up to date and running as efficiently as possible, which will increase both staff productivity and satisfaction. While most practices outsource at least some part of the information technology component, it should be determined whether your current IT services vendor has the adequate expertise and resources to handle the requirements of the medical field.

Revenue Cycle Management: With the movement toward value-based reimbursement, the implementation of ICD-10, and the increase in self-pay and high-deductible plans, practices will be challenged more than ever to maintain collection levels and timeliness. By outsourcing some or all of the revenue cycle management functions—such as insurance eligibility and benefit verification, pre-authorizations, appointment reminders, coding, as well as insurance and patient billing and collections—your practice might see improvements in payment per procedure, reduction in the number of days to collect, denial reduction, collectability and better cash flows.

Accounting: Accurate and timely financial records are critical for medical practice viability, so it is crucial that the accounting process be efficient and accurate. Advances in technology have vastly improved the accounting process. The movement is towards a paperless environment, where banking, billing, payroll and accounts payable data are able to update seamlessly into the accounting software. It includes applications, like the ones on your mobile device, that are being created at an incredible pace that will help to make the accounting process faster and more convenient.

With the ability to import bank activity, scan and approve invoices remotely, and to make those payments electronically, the accounting function has become streamlined and something that can be outsourced quite easily.

The Right Outsourced Solutions for Your Practice

With other available services such as human resources, credentialing and payer contract negotiation, the opportunities for outsourcing are numerous. While a cost-benefit analysis is crucial in determining which services to outsource, it is important to remember the subjective pros and cons as you make your decision.

Outsourcing brings a team of experts on board who must stay abreast of:

- best practices
- current laws and regulations
- compliance requirements

Not only can you benefit from this expertise, you will also see your risks minimized. Think about how much time would it take your employee to develop and maintain these skill sets, and outsourcing begins to look much more advantageous.

The team approach to account management is also a benefit, as your account will continue to be serviced despite staff vacations and sick time. Outsourcing also brings economies of scale and with it, access to the best software and systems which likely would not make sense for you to purchase on your own.

While outsourcing bears a cost, which is difficult to swallow during these times of financial uncertainty, if you've carefully chosen your outsourcing partner, the investment will likely improve your practice's performance while allowing you and your staff to focus on your area of expertise: caring for your patients. ➤



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Adam Hammer, MD

The St. Louis physician who made the first-ever diagnosis of coronary thrombosis and acute myocardial infarction in a living patient

By Arthur Gale, MD

St. Louis physician Adam Hammer was the first doctor to consider that a blocked coronary artery could cause an acute myocardial infarction in a living patient. He confirmed his diagnosis with an autopsy. His originality and his enormous achievement in the understanding of the pathology and physiology of heart attacks are largely unknown.



Adam Hammer

During a visit to Vienna in 1876, Hammer made his landmark diagnosis. His patient was a 34-year-old man who had collapsed and died 19 hours later. The patient's symptoms were atypical. He did not have angina pectoris. He developed a very slow heart rate which probably represented complete heart block. Hammer suggested to a colleague that a completely occluded coronary artery might have caused death of heart muscle and the death of the patient. Although angina pectoris had been previously described, the diagnosis of infarction had never previously been made or even thought of.

Hammer's diagnosis was confirmed at autopsy. A coronary artery was completely occluded by a thrombus caused by a vegetative aortic endocarditis. Atherosclerosis of the coronary arteries was not mentioned. The area of the heart that the artery supplied was a pale yellow-brown, signifying infarction.

The case was published in a German medical journal. Prominent physicians in both the United States and in Germany had never heard of the disease and were unaware of any similar cases. Considering the prevalence of myocardial infarction, it is astonishing that no one before Hammer ever thought that an occluded coronary artery could be the cause of this serious common disease. Hammer hoped his case "would

stimulate interest among clinicians who might also recognize the condition before the death of the patient." He also hoped that experimental pathologists would study the case and conduct further research.

Hammer was born in Germany in 1818. The profession of medicine was in its infancy. He received an excellent medical education in Germany, where medical training was far more advanced than it was in the United States. He took part in the revolution of 1848, which aimed to bring democracy and a republican form of government to Germany. The revolution failed, and many participants including Hammer were wanted by the authorities. Like many Germans who sympathized with this democratic uprising, Hammer immigrated to the U.S. They were known as the "48ers."



Location of the Humboldt Institute founded by Adam Hammer near Tucker Boulevard and Lafayette Avenue and across from the former St. Louis City Hospital.

After leaving Germany, Hammer settled in St. Louis. He was anti-slavery. He was an admirer of Abraham Lincoln and joined the Republican Party. During the Civil War, he joined the Union army as a medical officer and rose to the rank of lieutenant colonel.

As a practicing physician, Hammer was a well-respected general surgeon and ophthalmologist in St. Louis during the mid and late 19th century. An astute clinician and tireless reformer of medical education, he founded two medical schools in St. Louis, both of which eventually failed.

Hammer believed that the medical curriculum should last 16 months not the four and one-half months that the existing two St. Louis medical schools as well as Harvard required. He lost that battle.



Seal of Adam Hammer's medical school, the Humboldt Institute.



Dr. Arthur Gale

Arthur Gale, MD, is a past president of SLMMS and frequent contributor to *St. Louis Metropolitan Medicine* and *Missouri Medicine*. His writings over the past five-plus years have been compiled into a new book, *A Doctor's Perspective on Medical Practice in the Twenty-First Century*, available on Amazon.com. Dr. Gale can be reached at agalemd@yahoo.com.

He was a pioneer in the study of surgical pathology. He served as a professor at the Missouri School of Medicine. He founded a hospital for poor people in St. Louis, where eye operations and other types of surgeries were carried out free of charge. He was altruistic and promoted many philanthropic causes. He was a member of the St. Louis Medical Society, ultimately serving as its president.

Hammer had a prickly personality, which caused him to come into conflict with physicians both at the medical educational facilities with which he was affiliated, and also at the Medical Society. He filed a civil suit against his foes, which he won. Eventually he resigned from the Medical Society.

The renowned 19th century St. Louis physician William Beaumont—who with the aid of his famous patient Alexis St. Martin was the first to document and describe the process of gastric digestion—had a similar independent prickly personality. Like Hammer, he too served as president of the St. Louis Medical Society and because of conflicts with other members, he too subsequently resigned from the society.

Hammer died in 1879, one year after he permanently moved back to Germany. At the time of his death, the St. Louis Medical

Society issued the following ambivalent obituary:

Dr. Hammer had his friends and his enemies; but what man of talent has not? Now that he is dead, let us forget his faults and cherish his memory as that of one whose first and last love was for his profession; one whose great mind and good deeds entitle him to be enrolled among the benefactors of mankind; one whom the members of the medical profession of St. Louis will ever be proud to acknowledge as their companion and compeer.

It would be fitting for the St. Louis Metropolitan Medical Society, the Missouri History Museum or the City of St. Louis to find a way to honor Hammer as well as that other great 19th-century physician William Beaumont for their original and landmark contributions to medicine. ➡

References

1. Rebok, Sandra. "Adam Hammer and the Reform of Higher Medical Education in the United States: The Creation of the Humboldt Institute in St. Louis." In *Immigrant Entrepreneurship: German-American Business Biographies, 1720 to the Present*, vol. 2, edited by William J. Hausman. German Historical Institute. Last modified April 29, 2015. <http://www.immigrantentrepreneurship.org/entry.php?rec=235>.
2. Nuland, Sherwin B., *How We Die*, Vintage Books, 1993.
3. Gale, Arthur H. MD, "Dr. William Beaumont: Founding Father of Gastroenterology," *St. Louis Metropolitan Medicine*, October 2011.

➡ OBITUARIES ➡

George E. Thoma, Jr., MD



George E. Thoma, Jr., MD, an internist and former longtime vice president of Saint Louis University Medical Center, died Jan. 31, 2016, at the age of 93.

Born in Dayton, Ohio, Dr. Thoma received his undergraduate degree from the University of Dayton and medical degree from Saint Louis University School of Medicine. He completed his internship at SSM Health St. Mary's Hospital and his residency at SSM Health Saint Louis University Hospital.

He served in the U.S. Air Force Medical Corps as a flight surgeon from 1951 to 1954, attaining the rank of major.

Dr. Thoma spent all 35 of his years in academic medicine at Saint Louis University. As vice president of Saint Louis University Medical Center from 1973 to 1986, he served as dean of the School of Medicine, and also oversaw the University's schools of nursing, allied health professions, graduate department of orthodontics, Center for Health

Care Ethics and Saint Louis University Hospital. He was a professor in the department of internal medicine in the School of Medicine. The medical center experienced a period of extensive growth and development under Dr. Thoma's tenure, including construction of a doctors' office building, a \$56-million expansion of the hospital, a learning resource center and the School of Nursing.

A pioneer in the field of nuclear medicine, Dr. Thoma was the founding editor of the *Journal of Nuclear Medicine*. He also served as the medical director for the St. Louis Metropolitan Police Department.

Dr. Thoma joined the St. Louis Metropolitan Medical Society in 1948 as a Junior member, and became a Life Member at his retirement in 1993.

Dr. Thoma was preceded in death by his first wife, Jennifer Biega Thoma. SLMMS extends its condolences to his wife, Eugenia Benoist Bryan Thoma; his children; Lee Cornish, Mary Ann Dowling, Christie Dennison, Skee Thoma, Larry Thoma, Lisa Savel, Mark Thoma and Nellie Ross; his 17 grandchildren and 10 great-grandchildren. ➡

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Movie Fundraiser, Advocacy and More

By Gill Waltman, SLMMS Alliance

A favorite Alliance program is the annual classic movie fundraiser. Alliance members and friends gathered at the Hi-Pointe Theatre on Jan. 30 for a special screening of *Two for the Road* starring Audrey Hepburn and Albert Finney.

Led by Angela Zylka, the event raises funds to provide scholarships to graduating medical students selected in a Match Day drawing. Those entering primary care or family medicine are favored. Additional donations were contributed by Southside Comprehensive Medical Group, Cabbabe Plastic Surgery, West County Radiology, and Ophthalmic Plastic and Cosmetic Surgery, Inc. These monies support student expenses as they make plans to begin their residency programs, often in another state. The Alliance also gives out gifts of luggage. The national Residency Match Day for 2016 was held March 18 (see the June *St. Louis Metropolitan Medicine* for details of this year's Match Day events).

Funds from the movie event also support the Alliance programs for middle school students at Loyola Academy of St. Louis.

Valentine's Dinner and Doctor of the Year Award: The annual event was held on Friday, Feb. 19, at the Hilton St. Louis Frontenac Hotel. This year's recipient was George Hruza, MD



Among the attendees at the Alliance Valentine's Dinner: SLU medical student Robert Hieger; Alliance co-president and medical student liaison Millie Bever; guest speaker Stuart Slavin, MD; SLU medical student Amanda Waltos; Alliance medical student liaison Angela Zylka.

(see accompanying article). Sue Ann Greco organized the event. Stuart Slavin, MD, associate dean for curriculum and professor of pediatrics at Saint Louis University School of Medicine, gave an inspiring talk on ways to decrease stress among medical students. Student representatives from the medical school were also invited guests.

Advocacy Day: Several Alliance members traveled to Jefferson City Feb. 23-24 to attend the MSMA Alliance winter board meeting and Day at the Legislature. Before the Alliance members began their visits to legislators' offices, MSMA lobbyists briefed them on pending legislation. These included support of the Prescription Drug Monitoring Program (HB 1892 and SB 768), APRN Collaborative Practice (HB 1866, HB 1697, HB 1465), and opposing Helmet Repeal (SB 851 and HB 1464.)

Awarded: Congratulations to Alliance member Sandra Murdock on being honored as an Ageless Remarkable St. Louisan by St. Andrew's Resources for Seniors. Besides the Alliance, she is active in a number of community volunteering efforts including science education and health care for the underprivileged. ➡



At the Valentine's Dinner, Alliance members Millie Bever, Angela Zylka, Jean Raybuck, Sue Ann Greco, Gill Waltman, Carrie Hruza, Sandra Murdock and Kelly O'Leary.

Upcoming

SLMMS Alliance Officer Installation Luncheon

MAC West – Des Peres
Friday, May 13, 2016

Contact Kelly O'Leary for reservations, kellyoleary20@gmail.com

Become an Alliance Member!

For membership information,
contact Membership VP Angela Zylka,
angelazylka@gmail.com.

George Hruza, MD, Named 2016 Alliance Doctor of the Year

By Gill Waltman, SLMMS Alliance

George J. Hruza, MD, board-certified dermatologist and fellowship-trained Mohs surgeon, has been a strong advocate for physicians and an active supporter of organized medicine. For his service, he was selected to receive the Alliance Doctor of the Year Award presented on Feb. 19 at the annual Valentine's Dinner. Dr. Hruza accepted the award accompanied by his wife and Alliance member Carrie Hruza, OD; family members and colleagues.

The recipient of this award must be an active member of the St. Louis Metropolitan Medical Society, an advocate for the profession of medicine, an advocate for quality health care, a role model for future physicians, and a supporter of the Alliance. Previous recipients include Erol Amon, MD; Edmond Cabbabe, MD; Jeffrey Thomasson, MD; Sam Hawatmeh, MD; and Ravi Johar, MD.

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

He has continued to practice, teach and be an active participant in organized medicine, advocating on behalf of the profession at the local, state and national levels.

Active in SLMMS, Dr. Hruza was president in 2008 and served on the Council from 2002 to 2009. He received the SLMMS President's Award in January 2015 in recognition of his advocacy work in response to insurance companies narrowing their provider networks and terminating many physicians from Medicare Advantage programs. At the state level, he has been a councilor and treasurer of the Missouri State Medical Association. Dr. Hruza is a Diplomate of the American Board of Dermatology.



Alliance Co-President Gill Waltman; MSMA Alliance President and event chair Sue Ann Greco; George Hruza, MD; Carrie Hruza, OD; Alliance Co-President Millie Bever.

He has held numerous offices in his specialty, including as president of the American Society for Dermatologic Surgery (ASDS) and the American Society for Lasers in Medicine and Surgery (ASLMS). He currently serves on the board of directors of the American Academy of Dermatology, and previously was on the American College of Mohs Surgery board of directors. His academic achievements are many: he serves on five dermatology journal editorial boards and has published more than 140 scientific articles and book chapters and three textbooks on laser surgery, and has lectured on dermatologic surgery and laser surgery on four continents!

A graduate of New York University School of Medicine, he obtained his MBA from Washington University and completed his residency in dermatology at New York University Medical Center. He took a fellowship in laser surgery at Harvard Medical School and a second fellowship in Mohs and dermatologic surgery at the University of Wisconsin-Madison.

He enjoys snow skiing (including helicopter skiing!), bicycling, hiking and yoga. George and Carrie were married in 2009 and have four children aged 16-22. The Alliance congratulates Dr. Hruza for all his accomplishments. ➡

Common Sense Investing – Part Two

Use diversification to manage market fluctuations

By Bill Bender, CPA, PFS, MS

In part one of “Common Sense Investing” (*St. Louis Metropolitan Medicine*, February 2016), we discussed the need to have patience, be properly diversified, and simplify your investments. In this article, we will discuss how to set up your investments to protect against market fluctuations.

Someone who retired at the start of 2008 was going to suffer through a very difficult time period with their equity investments versus someone who retired at the start of 1982—prior to the start of a 17-year bull market. The financial plans that we prepare make very conservative assumptions, so if you retire at the start of a bad year, this will not ruin your financial plan. It is wise to have a substantial amount in a cash bucket or a short-term bond ladder when you retire because the last thing you want to do is become a forced seller of stocks after they have fallen in value.

From the start of the year 2000 to the end of 2009, the S&P 500 lost 9.1 percent. This is compared to the period from 1980 to 1999, when the S&P 500 was up almost 18 percent per year. The period from 2000 to 2009 was referred to as a lost decade, but it was only a lost decade for the S&P 500. In the accompanying Chart 1, you will see that only the S&P 500 lost money during this decade while all of the other asset classes had good returns. This reemphasizes the need to be properly diversified.

From 1991 to 2014, a diversified index of commodities slightly outpaced the return of cash with much higher risk. Commodities are said to have a negative correlation with the stock market, meaning that when the stock market goes down, the price of commodities will go up. Ben Carlson, author of *The Wealth of Common Sense*, believes that commodity prices only increase if we have higher inflation. Commodities are very volatile and are typically not a part of our investment plan.



Bill Bender

Bill Bender, CPA, PFS, MS, is co-founder of Clarity Financial Planners LLC, representing the well-respected Dimensional Funds. SLMMS has a special partnership with Clarity, which offers SLMMS members a discounted advisory fee and access to these highly sought funds with a lower minimum investment than commonly offered. For more information, email bill.bender@clarityfinancialplanners.com, or call Clarity at 314-548-2260, or visit www.clarityfinancialplanners.com.

Chart 1: Investment Performance 2000-2009

Asset Class	Total Returns	Annual Returns
S&P 500	-9.1%	-1.0%
Emerging Markets	162.0%	10.1%
Small-Cap Value	158.6%	10.0%
Mid-Cap	84.2%	6.3%
REITs	169.0%	10.4%
Equal-Weighted Portfolio	112.9%	7.2%

Chart 2: Percentage of Funds Underperforming Benchmark

Fund Category	1 Year	3 Years	5 Years
All U.S. Stock Funds	60.2%	85.9%	73.6%
Large-Cap Stock Funds	59.4%	83.4%	89.9%
Small-Cap Stock Funds	72.1%	87.6%	90.6%
International Stock Funds	70.0%	75.6%	74.2%

We find that successful people and highly intelligent people are more prone to investing errors because they are so intelligent; and therefore, overconfident in their ability to pick stocks. Individuals who recognize their limitations typically have more long-lasting success in the markets. If you are a physician recommending prescription medicine from various companies such as Merck or Pfizer, this does not mean that you have more knowledge of those companies than other investors. I have seen this mistake made many times in my life. Knowing about a product does not make the manufacturer of that product a good investment.

Having low-cost mutual funds is a key determinate in their performance. In Tony Robbins' newest book, *Money, Master the Game: 7 Simple Steps to Financial Freedom*, he states that 96 percent of active funds lose to their benchmark over a 10-year-period. He states that the best funds to purchase, among those with low fees and based on a passive index or asset class funds, are those offered by Vanguard or Dimensional

Fund Advisors, the fund family that we primarily use. Chart 2 shows what percent of all funds underperform their benchmark over a one-, three- and five-year period.

History shows that the funds that do outperform the market, win by a much smaller percentage than the amount of the loss incurred by the losers. Picking a single active mutual fund that can beat an index fund is very difficult. Picking an entire portfolio of active funds versus a portfolio of index funds is even more difficult.

Asset Allocation

Over 90 percent of a portfolio's performance can be explained by its asset allocation. Time in the market is very important. You will see in Chart 1 that U.S. stocks and foreign stocks have flip-flopped their performance over the last five decades. This is the reason why we add international investments into a diversified portfolio. We have tended to keep 30 percent of the equity portion in the international sector. Even though over half of the world's gross national product comes from foreign companies, the fact that so many of the larger U.S. companies do business overseas gives them international exposure.

With asset allocation comes diversification. Diversification is worthless without rebalancing. We sell winners and buy losers or put new money into the categories that are underperforming. This has been proven to add a small additional return to your portfolio.

The past year has not been good for the markets. Most indices are down for early 2016, and throughout 2015 they were just close to break-even, or slightly negative. Being diversified, using low-cost asset class funds, rebalancing with new money, or rebalancing without new money, is the proper strategy.

When a strategy does not work all of the time, it does not mean that you should give up on the strategy. No one can control the short-term outcomes in the market, so it does not pay to worry about the daily volatility. Ben Carlson makes the comment that educational and emotional coaching from a financial advisor is more important than portfolio management. I believe the two go hand in hand.

In conclusion to common sense investing, remember that less is more. Minimize the number of funds or stock holdings that make up your portfolio. We typically have no more than 8-10 mutual funds in a client's portfolio. Focus on what you can control—have a comprehensive investment plan with a reasonable asset allocation, and understand your individual risk tolerance and time horizon. Stick with your strategy through good years and bad years.

A passive, repeatable investment strategy is the best option for most investors. So few active managers outperform the markets that the probability of finding that manager in advance is virtually impossible. Asset allocation, diversification, periodic rebalancing, and the discipline to stick with your plan may not be exciting but are some of the best risk controls you can have as an investor. Stay patient. You cannot expect to make money in the stock market if you do not occasionally lose money in the stock market.

There are many words of wisdom contained in this article. Most of what I have had to say I have said before, but in the book *A Wealth of Common Sense* by Ben Carlson, he brings all of the pieces together. This has certainly been one of the better books that I have read and would recommend it to those of you who need reinforcement on the way to investing your money. —

Obituaries — continued from page 21

Jack Hartstein, MD



Jack Hartstein, MD, board certified in ophthalmology, died March 12, 2016, at the age of 91.

Born in St. Louis, Dr. Hartstein received his undergraduate degree from Southern Methodist University and medical degree from the University of Cincinnati. He completed his internship and residency at Saint Louis City Hospital. He served in the U.S. Navy from 1943 to 1945.

He was a clinical professor of ophthalmology at Washington University School of Medicine, and on staff at St. Luke's Hospital, Missouri Baptist Medical Center, Mercy Hospital St. Louis, SSM Health St. Mary's Hospital, Barnes-Jewish West County Hospital and Des Peres Hospital.

Dr. Hartstein joined the St. Louis Metropolitan Medical Society in 1956 as a Junior member. He became a Life Member at his retirement in 2003.

Dr. Hartstein was preceded in death by his wife, Merle Hartstein. SLMMS extends its condolences to his children, Anne Pace, Dr. Morris Hartstein and Larry Hartstein; and his eight grandchildren. —

WELCOME NEW MEMBERS

Pooja M. Dorward, MD

1001 Chesterfield Pkwy. 201-E, 63017-2167
MD, Washington Univ. 2005
Born 1979, Licensed 2009 — Active
Cert: Dermatology

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