ST. LOUIS METROPOLITAN
MEDICINE
VOLUME 39, NUMBER 3 JUNE/JULY 2017

Population Health Management

Will it Achieve Better Health and Lower Costs?

Page 2

Population Health Management

Inside

ONE

STEADY·PARTNER

As the medical practice landscape continues to shift from changing regulations, new types of risk and the coming and going of insurance companies, MPM-PPIA is your one steady partner. We were here when you first needed us. Now, as we begin our 15th year, we still offer physicians the same quality coverage at the same affordable price.

Dr. Karl Stark
Kansas City

Dr. Carrie Carda
Poplar Bluff

Dr. Kevin Threlkeld
St. Louis

www.mpmppia.com | 314.587.8000
287 N. Lindbergh Blvd., St. Louis, MO 63141

ST. LOUIS METROPOLITAN
MEDICINE

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

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

St. Louis Metropolitan Medicine (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society, 680 Craig Rd., Ste. 308, Saint Louis, MO 63141-7120; (314) 989-1014, FAX (314) 989-0560. Annual Subscription Rates: Members, $10 (included in dues); nonmembers, $45. Single copies: $10. Periodicals postage paid at St. Louis, MO. POSTMASTER: Send address changes to: St. Louis Metropolitan Medicine; 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120.

Advertising Information: www.slmms.org/magazine, or editor@slmms.org or (314) 989-1014. Online copies of this and past issues are available at www.slmms.org/magazine.

Printed by Messenger Print Group, Saint Louis, MO 63122.
Graphic design by Lisa Troehler Graphic Design, LLC.

ST. LOUIS METROPOLITAN
MEDICAL SOCIETY

www.slmms.org

Facebook: saint.louis.metropolitan.medical.society
Twitter: STLMedSociety

◄ **VOLUME 39 | NUMBER 3 | JUNE/JULY 2017** ►

Cover Feature: Population Health Management

Features

Columns

News

Departments

President's Page

Population Health Management and ACOs: Will They Achieve Their Goals of Better Health and Lower Costs?

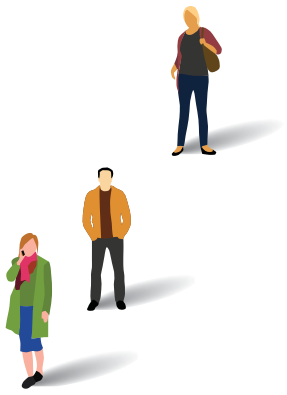
What are the elements of a successful population health management program?

What results have been reported for ACOs to date?

By J. Collins Corder, MD, FACP, Medical Society President

Medical Society President
J. Collins Corder, MD, FACP

Whether we like it or not, we are entering this phase and must attempt to improve the quality of care and reduce cost at the same time.



Having been in practice for over 36 years, I have seen many technological advances in the diagnosis and management of diseases; much has been taken for granted. We have seen the dissolving of a code of medical ethics that opposed advertising and solicitation of patients, replaced by a system of so-called free-market competition, clinical integration, and the right of insurers and hospital systems to choose their own providers. During this managed care revolution, we have seen reforms that have actually increased costs and are responsible for much of the frustration and anxiety that is so prevalent today among practicing physicians and many patients as well. One thing that remains constant is the patient in need of a competent and compassionate physician who can spend the time to listen to their complaints.

We are entering another era of change in medicine reimbursement as the concepts of population management and Accountable Care Organizations (ACOs) enter the picture. Many feel this is a continuum of what started with the HMOs in the 1990s failing to control costs. The U.S. has by far the highest health care cost of any Western industrialized nation without any discernible improvement in life expectancy or other measures of health care. Many say this is the result under managed care with the formation of hospital and insurance company monopolies, which like all monopolies, bring increased costs. Whether we like it or not, we are entering this phase and must attempt to improve the quality of care and reduce cost at the same time. I will define what population management is and the desired role of ACOs in trying to achieve the goal of delivering "value-based payment (VBP)."

Value-based care (VBC) or VBP has been broadly adopted in the private market by both commercial insurance payers and employers. According to the Catalyst for Payment Reform's 2014 Action Scorecard, about 40% of payments by private plans to health care providers were based on quality and performance measures. This represented a significant increase in adoption from 2013, when a scorecard found that only 11% of payments were value-based. In addition, if MACRA regulations as expected are not substantially altered, VBP will soon be implemented in some form for nearly all Medicare reimbursement, regardless of what happens to the Affordable Care Act.

MACRA has two payment tracks, MIPS and the advanced alternative payment models (APMs). Both tracks meet the broad definition of VBP. This means that by the end of 2017—absent regulatory changes due to administration or congressional action—all Medicare Part B services will be reimbursed

through value-based payment of some sort. By the end of 2018, the Department of Health & Human Services has a goal of devoting 50% of Medicare spending toward value-based reimbursement. However, Kaiser reports most physicians are not participating in risk-based contracts, but I suspect this will increase as the number of ACOs grows. Medicare payment reform gives preferential treatment to the APMs created by the ACA Innovation Center and the Centers for Medicare and Medicaid Services (CMS), who have made changes to allow more participants to qualify as advanced APMs.

The development of ACOs in response to the transition of payments to the VBP model is the central piece necessary for population health management to be implemented. The Medicare Shared Savings Program (MSSP) was established by the ACA to facilitate improved care and reduce unnecessary costs.

There are three types of ACOs: physician-led, hospital-led, and hybrids, which include both physician and hospitals. A study published in the *New England Journal of Medicine*, as well as one from KPMG, found that ACOs led by independent primary care groups typically saw greater savings than hospital-led ACOs. "ACOs have shown an ability to reduce hospital admissions and health care spending, which is why Congress specified ACOs to be part of MACRA and why CMS has given them a prominent role in achieving its overall goals," says Tim Gronniger, deputy chief of staff at CMS.

The ACO program has evolved in the last five years, and all the changes have been based on feedback resulting in moving from 6 models to 10 in MACRA proposed rules for 2018.

Defining Population Health Management

Health care reform is feeling the shift away from fee-for-service models toward pay-for-performance, VBP paradigms. And in order for health care organizations to successfully transition, there is an acute need for actionable analysis of data from individual patients and populations.

Multiple definitions for population health management abound. Some feel population health management should be defined the same way public health was defined years ago by C.E. Winslow, founder of the Yale Department of Public Health, as "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."

Eighty percent of what affects health outcomes is associated with factors outside the traditional boundaries of health care delivery—health behaviors (tobacco use, sexual activity), social and economic factors (employment, education, income), and physical environment (air quality, water quality). When health care delivery systems expand their interactions with patients to these territories—now the purview of the public health system—outcomes will improve.

Population health management (PHM) is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. The ultimate goal is to improve the health outcomes of the group by monitoring and identifying individual patients within that group, using a business intelligence tool to aggregate data and provide a comprehensive clinical picture of each patient. This allows the tracking of these patients and focusing on the sickest (such as those with diabetes, vascular disease, COPD, hypertension, heart failure or coronary disease), which hopefully will improve the clinical outcomes of these patients while lowering the cost.

Eighty percent of what affects health outcomes is associated with factors outside the traditional boundaries of health care delivery—health behaviors, social and economic factors and physical environment.

EMR systems currently on the market are designed for a fee-for-service world, running entirely on encounter-based medicine. This makes it difficult to manage the health of populations of patients—and difficult to understand the cost of care. Fundamentally, in a population health environment, a health system is managing to margins on a per-member, per-month (PMPM) basis. And in this environment, everyone has to be aware of the cost of care at the point of care. This is not possible without major changes to current EMR software.

Elements of a Successful Population Health Management Program

A successful and well-developed PHM program will give real-time insights to both clinicians and administrators that allow them to identify care gaps within the patient population. This is the key to better outcomes in cost savings, especially in the population with chronic disease. A critical component of PHM is care management; while the objectives of care management can vary from organization to organization, they tend to revolve around improving patient self-management, improving medication management, and reducing the cost of care—such as admission rates to hospitals. In VBP, there is greater financial reward in preventing illness than there is in treating disease. Reducing expenditures can be accomplished by identifying preventable hospitalizations, ED visits, and preventable readmissions. This idea was recently put to the test in the Pioneer ACO program, which scored high for preventative health care measures, generating $147 million in total savings for these initiatives.

continued on page 4

President's Page *continued from page 3*

All of this leads to population health management in new form. To get there, the industry has to be smart about accelerating development of the right areas and manage expectations about what can be achieved.

For one, the industry needs to do a better job of collecting true patient outcomes data, rather than proxies for care. For example, it inherently does not matter if a patient with diabetes has had a foot exam—but it matters very much if that foot exam discovers an open wound that will not heal or a severe neurovascular deficit identified to work on ways to prevent the ulcer from developing.

Additionally, organizations must also understand cost at a granular, patient level instead of guessing at costs by looking at the average cost for all patients. That approach is almost meaningless when managing margins.

The Population Health Equation and Return on Engagement

The fundamental, traditional Health Care Value (HV) equation is defined by the Quality of Care (QoC) plus Experience (E) divided by the Cost of Care (CoC), or HV = (QoC+E)/CoC. The fundamental equation of population health is the calculation of Return on Engagement (ROE): the Clinical Outcome Achieved (COA) divided by the Total Patient Investment in a Patient's Health by the Health Care System (TPI), or **ROE = COA/TPI**.

RETURN ON ENGAGEMENT (ROE)	=	CLINICAL OUTCOME ACHIEVED (COA)/ TOTAL PATIENT INVESTMENT IN A PATIENT'S HEALTH BY THE HEALTH CARE SYSTEM (TPI)

Described otherwise, "How much does it cost our population health management system to increase a patient's clinical outcome by one unit of measure?" This is why the understanding of costs and patient outcomes is so fundamentally critical to the success of population health.

The motive behind a care management system—services and software—is to reduce the investment (TPI) necessary by the health care system to achieve a unit of improvement in clinical outcomes (COA) by engaging patients in both the numerator and denominator of their own health.

As provider groups assume more financial risks, there are ACO constraints by the Medicare legislation which limit the ability for patients to choose to exclusively use an ACO, as well as what can be done with regard to benefit redesign. A rogue patient that smokes and eats whatever one wants and does not care about BMI or blood sugar basically ties the physician's hands when it comes to quality measures. Since a Medicare ACO beneficiary is "not captive" as in private insurance, they can choose to seek care anywhere outside their assigned ACOs. This places that ACO at the mercy of overspending at another facility not involved in the ACO. Until patients have a monetary stake in their health or penalties if they go outside the ACO system, ACOs will be unable to maximize their results in quality and cost savings.

Evaluating ACO Success

Whether ACOs are living up to the lofty expectations of health care executives and federal policymakers is a matter of rising debate. Saving money while raising the quality of health care has been the central focus of the health care industry—from providers to health insurance carriers—since the arrival of the ACA. Yet, the initial costs of these programs were substantially more than the government anticipated. Kaiser Health News reported that 45% of ACOs cost more than anticipated, and in 2014, MSSP had a net loss of $2.6 million. Some 40% of the participating sites ended their involvement in the program after the first year, they said.

Proponents contend that the early evidence points to increased care quality. But detractors counter that ACOs have failed to produce adequate cost savings and efficiencies, according to commentaries published in the *Journal of the American Medical Association*.

Kevin Schulman, MD, of Duke University School of Medicine and Harvard Business School, and Barak Richman, of Duke University School of Law, said they aren't impressed with the early findings, pointing to a trio of published evaluations that suggest less-than-ideal efficiencies generated by ACOs.

- The first, a comprehensive evaluation of Pioneer ACOs, showed savings in the cost of care to the CMS in 2012 of 1.2%. But after accounting for bonus payments, net savings to CMS were a paltry 0.4%, and 40% of the participating sites ended their involvement in the program after the first year, they said.
- A second analysis by CMS showed smaller increases in total Medicare expenditures for ACO-aligned beneficiaries, but the result was substantially reduced by the second year of the program and didn't include incentive costs to ACO participants.

- The third report, an evaluation of the CMS Medicare Shared Savings Program, found that the 2012 ACO cohort showed a lower cost of care but triggered CMS bonus payments that exceeded those savings. Then, the 2013 cohort didn't save money at all.

Furthermore, none of those evaluations, Schulman and Richman said, considered the costs to implement the ACO. They concluded that of the several iterations of ACOs, none have meaningfully reduced the cost of care, which begs the question whether the ACO concept itself is sound. This is an important consideration, they said, because ACOs carry a substantial cost to those outside Medicare.

In their view, the ACO model has also accelerated the trend of hospitals acquiring physician practices, enhancing their market power.

Since this results in a lack of negotiating power on the part of private health plans, Schulman and Richman said that two strategies have emerged to maintain affordability in the health insurance market: high-deductible health plans, and narrow-network health plans with significant cost sharing. Co-payments for care under these offerings are often unaffordable, leading the authors to conclude that the ACO model may have weakened the financial protection that is the core purpose of health insurance, while undermining the ACA's goal of expanding coverage.

Schulman and Richman suggested paying physicians and physician-led groups to keep patients away from and out of hospitals, away from costly facilities and tests, and use inpatient services only when other low-cost mechanisms are not effective.

In their view, the ACO model has also accelerated the trend of hospitals acquiring physician practices, enhancing their market power. Consolidation is responsible for sharp price increases across markets within states, they argue, with monopoly hospitals, those that dominate a local market with no real competition, showing 15.3% higher prices than hospitals in competitive markets.

Seeing the matter differently are Zirui Song, MD, of the Department of Medicine at Massachusetts General Hospital, and Elliott Fisher, MD, of the Dartmouth Institute for Health Policy and Clinical Practice. With limited evidence of the effects of ACO contracts, and most studies containing fewer than two years of follow-up, they said, reversing course so early in ACOs' lifespans would be a mistake—particularly since evidence on quality has been promising.

continued on page 6

President's Page *continued from page 5*

Quality improved in both process and outcomes in the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, they said, with similar gains for Medicare beneficiaries in ACOs. For example, process measures included adherence with guidelines for screening for colorectal or breast cancer, and follow-up testing for patients with diabetes or coronary artery disease; outcome measures included the proportion of patients with diabetes achieving target blood pressure, lipid levels, or hemoglobin A levels. In both populations, bonuses for ACOs were highly contingent on achieving gains in quality.

Medicare beneficiaries also reported better access to care, and for those with multiple chronic conditions, much higher subjective ratings of the overall quality of care. That evidence, Song and Fisher contend, is grounds for "cautious optimism."

What's Next?

CMS is developing "refinements" to overcome these ACO early failures, culminating with the new APM models of higher levels of financial risk and reward to the providers. They maintain that opportunities for making the model more attractive involve supporting a gradual transition to reasonable risk-bearing that offers greater financial rewards for physicians. I would advocate a transition to enterprise liability, wherein the ACO, not the individual physician, would be liable for malpractice claims.

More clarity is needed to determine ACOs' efficacy, be it failure or success, and the only thing that can deliver that clarity is time.

These models focus not on historic performance but more on current performance efficiency at managing care, not for "picking low-hanging cost-cutting fruit." Physician behavior must change in this approach to care, and hopefully not physician practice to deliver the best of care.

Will these "modern" pay-for-performance models support previous failed studies in England and the U.S. that cost, efficiency, and quality are not improved? Are they the same old wine in new bottles? Will they be rejected again as the "gatekeeper" perception was in the 1990s? Will the Medicare Advantage Plans continue to be more costly and more cuts to providers occur in the future as the insurance companies continue to take their 15% cut? Should the patient be part of "cost responsibility" when they do not lose weight, continue to smoke, fail to take medication, ignore ACO guidelines in utilization of the ACOs services, or utilize their PCP first before needless ER visits?

The Physician's Foundation survey continues to show physicians are demoralized and dispirited in a dysfunctional health care delivery system. Policymakers might benefit from consulting and listening to those who actually treat the patient, the practicing physician, and not solely to those like the Dartmouth Group.

References

Gale, Arthur H. MD, *A Doctor's Perspective on Medical Practice in the Early 21st Century*, 2015.

Taufen, Amber, "Grading ACOs. Are ACOs Passing or Failing." *Benefits PRO*, March 14, 2016. http://www.benefitspro.com/2016/03/14/grading-acos

Shyrock, Todd, "Is the success of physician-led ACOs sustainable?" *Medical Economics*, Feb. 25, 2017. http://medicaleconomics.modernmedicine.com/medical-economics/news/success-physician-led-acos-sustainable

Rectoris, Mary, "Are ACOs and the Medicare Shared Savings Program Working?" Becker Associates, Mar. 21, 2016. http://www.beckersasc.com/asc-coding-billing-and-collections/are-acos-the-medicare-shared-savings-program-working-5-key-points.html

"Population Health Management: Systems and Success," Health Catalyst. https://www.healthcatalyst.com/population-health/

Beard, Mason, "Top 10 Strategies to Succeed Within Value Based Care," Phillips Wellcentive, May 11, 2016. https://www.wellcentive.com/blog/top-10-strategies-to-succeed-within-value-based-care/

HARRY'S HOMILIES©

Harry L.S. Knopf, MD

ON SECOND THOUGHTS

Colors seen by candlelight
Will not look the same by day.

Elizabeth Barrett Browning

"Oh I wish that I had given that a bit more thought …" How many times have you said this? (I myself am guilty: Witness some of these writings. And what about those emails or tweets you sent in haste?) Whenever you make plans for a project, no matter how trivial it seems, it is never a bad idea to give it a second look. "Sleep on it," some say. You've also heard other writers opine on the subject, e.g. "Measure twice, cut once." Ms. Browning was a little more poetic about her advice, but it is still the same: Take your time. Tighten up your grammar. Check those measurements. Go over your itinerary, again. What you thought was terrific after a long night's work may appear less so by the light of day. Some recipes need a little seasoning.

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.

Provider Enrollment Open for St. Louis County PDMP

Physicians can access prescription records from pharmacies in four area counties

By Sam Page, MD

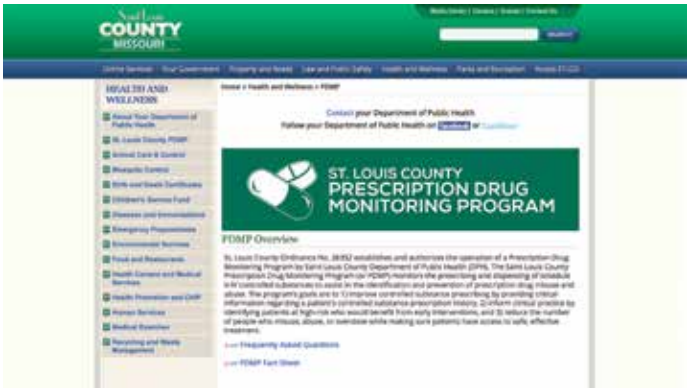
Physicians and other patient advocates watched with dismay and disappointment the end of the Missouri Legislative session. In spite of strong leadership by House sponsor Rep. Holly Rehder (R-Sikeston), Missouri remains the only state in the union without a statewide Prescription Drug Monitoring Program (PDMP).

The good news is that the St. Louis County Council passed legislation to create a county-based PDMP last year, and the County Health Department has implemented rules and has contracted with APPRIS, the PDMP administrator in 25 states, to create a PDMP in St. Louis County.

The St. Louis County PDMP is now live! Hopefully you have registered and have created a user ID and password. It is a simple process that can be completed in a minute or two. Before prescribing opioids to new patients or as an additional tool in caring for patients receiving chronic opioid therapy, it may be prudent to check the PDMP to determine if other physicians are also providing opioid analgesics to your patients. If so, this warrants further conversation and discussion, as the potential for opioid misuse syndrome exists in some patient populations and has contributed to our current opioid epidemic. In addition, liability may exist in certain settings when opioids have been prescribed, a PDMP is available, and the clinical scenario warrants further investigation prior to prescribing. This in no way discourages prescribing opioid analgesics in the appropriate clinical scenario, or limits safe and effective treatments.

The registration is completed through **www.Missouri.PDMPaware.net**. Physicians (or your staff) can upload medical licenses and register for access. In recognition of the reality of patient workflow in the emergency room or outpatient setting, the PDMP allows the concept of a delegated user. Physicians may select individuals to delegate access, allowing someone in their office to query the PDMP and print PDMP reports and have them readily available for review in the medical record when the patient is seen.

Sam Page, MD, is a physician anesthesiologist at Mercy Hospital St. Louis and a SLMMS member since 1996. He is a member of the St. Louis County Council representing the 2nd District. He served in the Missouri House of Representatives from 2003-2009.



The St. Louis County ordinance requires pharmacies in this county to report Schedule II-IV prescribing data to an electronic database that is accessible to prescribers. St. Charles County, Lincoln County and St. Louis City have joined, merging data from pharmacies in these areas. Several Kansas City-area jurisdictions also are participating.

Our program in St. Louis County is designed to allow other counties (and in some cases large municipalities) to contract with us and join our county-based PDMP. Currently, over half of the state population is covered by this program, essentially creating a statewide PDMP based in St. Louis County. We anticipate renewed interest in subscribing to our program now that the legislative session has closed without a statewide program.

Registration details, information on delegated users, and FAQs can be found at **www.Stlouisco.com/HealthandWellness/PDMP**.

The St. Louis Metropolitan Medical Society and the Missouri State Medical Association have recognized the critical roles physicians have in identifying opioid misuse, overdose and addiction and referring these patients to the proper care and treatment. The PDMP is an important first step. Please join the house of medicine in incorporating this new tool into your clinical practice.

LEARN MORE AND REGISTER

www.stlouisco.com/HealthandWellness/PDMP

Program information | Training videos | FAQ

SLMMS Members Advocate for Positive Change Through Resolutions

By David M. Nowak

Executive Vice President David M. Nowak

We are most grateful to the physicians and medical students who drafted, introduced and debated resolutions this year. Leading change by influencing policy is perhaps the greatest benefit of organized medicine.

The 159th annual convention of the Missouri State Medical Association (MSMA) convened March 31-April 2 in Kansas City. Thank you to the SLMMS members who journeyed across the state and served as delegates, participated in lectures, or attended gatherings of their specialty societies over the three days.

Once again, SLMMS was well represented advocating for positive change in the practice of medicine in our state. The MSMA reference committees invited comments in reviewing a total of 14 resolutions this year, seven of which were authored by SLMMS members and supported by your Medical Society. Six of the seven were recommended for adoption, and the remaining resolution was referred to the MSMA Council for further study. Following is a summary of the seven SLMMS-sponsored resolutions:

Comprehensive Review of CME Process, written by Ravi Johar, MD, calls for MSMA to request that the American Medical Association do a comprehensive review of the CME process on a national level, with the goal of decreasing costs and simplifying the process of providing CME. The resolution was recommended for adoption with no modifications.

Certified Translation Services, written by Samer Cabbabe, MD, resolves that MSMA, in collaboration with the American Medical Association, work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act. Following a slight change in wording recommended by the reference committee, the resolution was adopted.

Peer to Peer Reviews, also submitted by Samer Cabbabe, MD, asks that MSMA support legislation to require insurance companies to have an actively practicing physician, who is board certified in the same specialty as the patient's physician, participate in the peer-to-peer stage of the Missouri utilization review appeals process. Again, following a slight change in wording, this resolution was adopted.

Claim Payment Adjustments, also submitted by Samer Cabbabe, MD, calls for MSMA to work with appropriate parties to require each insurance claim to be independently evaluated. The reference committee recommended this be referred to the MSMA Council; however, the resolution as written was approved and adopted by the House of Delegates.

Medicaid Coverage for Dental Conditions, written by Mary Klix, MD, resolves that MSMA continue to support MO HealthNet coverage for the treatment of dental conditions that complicate or exacerbate systemic medical disease. Following testimony, the reference committee recommended the proposal be adopted with a substitute resolution clause; however, following debate in the House of Delegates, the substitute resolution was referred to the MSMA Council for further study.

Insurance Contract Revisions Requiring Opt-in Agreement, sponsored by SLMMS and authored following discussion in the annual SLMMS delegates briefing, directed MSMA to work with the Missouri Department of Insurance and other appropriate parties to require that unilateral alterations to an insurance contract be sent by certified mail, and that the physician must opt-in to agree to any changes or additional networks. Again, the reference committee recommended adoption with a modified

resolution clause, but the House of Delegates voted to adopt the original resolution as submitted.

Decreasing Screen Time and Increasing Outdoor Activity to Offset Myopia Onset and Progression in School Children, was authored by SLMMS medical student member Shannon Tai from Saint Louis University. The resolution was co-authored by Ingrid Hsiung, a University of Missouri-Kansas City medical student, and jointly sponsored by SLMMS and the Kansas City Medical Society. The resolution calls for MSMA to support the efforts of the American Academy of Pediatrics and the American Academy of Ophthalmology to educate, promote public awareness, and promote guidelines to reduce the incidence and burdens of myopia to physicians, public health agencies and schools, and to encourage the American Medical Association to do likewise. The resolution was recommended for adoption as written.

We are most grateful to the physicians and medical students who drafted, introduced and debated resolutions this year. Leading change by influencing policy is perhaps the greatest benefit of organized medicine. If you have an idea for a resolution, please contact me, and we will file it to consider for presentation to the 2018 House of Delegates. Meanwhile, the SLMMS office will continue to keep members apprised of further developments concerning all of this year's resolutions.

Also at this year's convention, SLMMS past president Ravi Johar, MD, concluded his year as 2016-2017 MSMA President with his farewell address at the Presidential Inauguration. Please join me in thanking Dr. Johar for his year of service to the state association and ably representing the Third District.

Several SLMMS members assumed statewide roles at the convention. The MSMA Council elected George Hruza, MD, as council vice chair for the coming year, and David Pohl, MD, was re-elected as MSMA treasurer. Robert Brennan, Jr., MD, and Michael Stadnyk, MD, were re-elected to two year terms on the MSMA Council, and Inderjit Singh, MD, was appointed to complete a term as District 3 vice councilor. Our delegation nominated William Huffaker, MD, to another term as an AMA delegate from Missouri, and he was re-elected. Best wishes to these physicians and all who work to improve the practice of medicine locally, statewide, and across the nation.

I invite you to join them by becoming more involved in leadership of the St. Louis Metropolitan Medical Society. The SLMMS Nominating Committee will be meeting this summer to identify the slate of officers and councilors for leadership in 2018. Please refer to the article on page 10 to learn how you can become more involved in your Medical Society not only as a council member, but by serving on a committee or as an MSMA delegate.

SLMMS Seeks Nominees for Council and Committees

Effective leadership is necessary for SLMMS to continue to fulfill our mission to support and inspire member physicians to achieve quality medicine through advocacy, communication and education, and achieve our vision of physicians leading health care and building strong physician-patient relationships. To sustain our impact, your Medical Society needs volunteer leaders willing to help move our organization forward.

The SLMMS Nominating Committee will meet in July to consider candidates for leadership roles beginning in 2018. We need physicians from all specialties and practice settings to serve. Available positions include SLMMS councilors, delegates to the Missouri State Medical Association annual meeting, and appointments to SLMMS committees.

Your Medical Society recognizes that the time commitment is a concern many have when asked to serve. Please know that SLMMS leadership does its best to keep meetings to a minimum, and meet virtually or via an email conversation when possible.

As physicians are challenged and threatened from all directions, there are even more reasons to represent your interests. We know physicians are busier than ever, but please consider the social and networking opportunities that also come with SLMMS leadership. Organized medicine benefits you, your profession, your practice and your patients.

To be considered as a potential council nominee or for a committee role, please contact Ravi Johar, MD, chair of the Nominating Committee, at rkjohar@att.net or David Nowak, executive vice president, at the SLMMS office at 314-989-1014, ext. 108 or email dnowak@slmms.org no later than July 1. If you wish to nominate another member for a leadership position, please check with them first to confirm their willingness to serve. All recommendations will be given thorough consideration.

Per the Society's bylaws, the Nominating Committee will present its slate of officers and councilors at a General Society meeting on Tuesday, Sept. 19, at 7 p.m. to be held at the Society office on Craig Road. All members are welcome to attend the meeting.

Candidates for office will be profiled in the October/November issue of *St. Louis Metropolitan Medicine*, and the annual election will take place online during the month of November.

This is a prime opportunity to provide leadership and direction to the Society to which you belong. It is also a chance to positively influence the future of medical practice. Thank you to those who are willing to consider serving and representing your fellow physicians and your profession.

Returning This Fall – The 2017 Physician Leadership Institute

Mark your calendars! The 2017 Physician Leadership Institute returns this fall. Emphasizing leadership skills and the business side of medical practice, the course is open to physicians only, and is sponsored by Anders Health Care Services, Maryville University and SLMMS.

The course will meet over six Saturday mornings from September through November. Classes will be held at Anders' educational facilities in their offices at 800 Market Street, Suite 500, in downtown St. Louis. Up to 21 CME hours will be awarded for completion of the entire curriculum. Tuition is $900, discounted to $600 for SLMMS members. Group discounts will also be available.

Registration will open later this summer. Watch for e-news updates and announcements on slmms.org. Full curriculum details will be included in the August/September issue of *St. Louis Metropolitan Medicine*.

Contact the SLMMS office for more information.

The 2017 Physician Leadership Institute

- September 16
  September 23
  October 7
  October 21
  November 4
  November 11
- 8:30 a.m. – 12:15 p.m.
- Anders Headquarters
  800 Market St., Suite 500
  St. Louis, MO, 63101
- Up to 21 CME hours will be awarded
- Tuition: $900 for six sessions ($600 for SLMMS members)

SLMMS Council Approves New Member Benefit: Multiple Employer 401(k) Plan

At its May meeting, the SLMMS council voted to approve sponsorship of a new member benefit that will become available this summer—a Multiple Employer 401(k) Plan. Sponsorship of this plan will allow SLMMS members to take advantage of the economies of scale that come from being a part of a large organization.

The plan was designed for the Medical Society by Rich Fitzer of Triad Financial Group, SLMMS' approved provider of financial services. Fitzer has brought together top service providers including MassMutual, Benefit Plans Plus, Envestnet, and Roland-Criss to offer a combination of local personalized service, plan design expertise, and top quality fiduciary protection.

This arrangement provides practices of any size with cost-effective access to a high-quality, institutional level retirement plan. "As we learn of more lawsuits filed against 401(k) plan sponsors, as well as an ever-increasing level of scrutiny from the Department of Labor, we feel it is important to provide a benefit option for our members that is not only cost-effective but also provides protections that are normally not found in stand-alone plans," explained Dave Nowak, SLMMS executive vice president.

The Multiple Employer Plan is available to practices with an existing retirement plan in place as well as to those practices looking to start a plan for their owners and employees. "SLMMS is excited to sponsor a 401(k) plan that may greatly reduce our members' fiduciary liability and administrative responsibility," Nowak continued. "In most cases it will also lower the ongoing costs for both the practice and its plan participants."

Due to the size of the SLMMS organization, Fitzer and his team were able to secure pricing that is very competitive for our members, starting with the initial groups that convert their existing plans in the Multiple Employer Plan. The pricing structure is designed to benefit both smaller and larger practices and will further improve as the plan grows.

"While we want to help SLMMS members lower their costs, reduce their liability, and remove much of their administrative burden, we also realize that you each run unique practices," said Fitzer. "Therefore, this plan still allows each of you to design your plan in the manner that best suits your practice. Your practice will still determine your level of contribution matching, profit sharing, vesting, and other plan design features."

Watch for more information, including member information sessions, to be scheduled later this summer. To learn more about this opportunity please contact the SLMMS office at 314-989-1014 or Rich Fitzer directly at 314-392-6812 or rcfitzer@triadfinancialgroup.net.

Securities and advisory services offered through Commonwealth Financial Network®, member FINRA/SIPC, a Registered Investment Adviser.

2017 MSMA Insurance Conference

Thursday, July 20, 2017

8:30 a.m. - 4:30 p.m. *(Registration begins at 8:00 a.m.)*

Renaissance St. Louis Airport Hotel
9801 Natural Bridge Road, St. Louis

Problems with your practice's cash flow? Fixing those issues can boost your bottom line! Register to attend MSMA's Annual Insurance Conference, open to physicians and their office staff.

Again this year, eight different payers including MO HealthNet (Medicaid) will be present to help answer your questions. They'll provide updates and address concerns about eligibility, coding, consults and prior authorizations. Presentations, followed by Q & A, will cover common errors resulting in claims denial, changes in coverage, ICD-10 and electronic claims processing.

Visit www.msma.org to download the registration form. The conference fee is $75 per person, and reduced rates are available for multiple attendees from the same office. You may forward any questions for the insurance companies in advance of the conference to pmills@msma.org. *The program has the prior approval of AAPC for 6.5 Core A continuing education units.*

Seeking Enhanced Patient Care Outcomes

Better evidence-based care from IT-driven population health management

By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA and Todd A. Zigrang, MBA, MHA, FACHE, ASA

Population health may be defined as "*…the health outcomes of individuals within a specified group based on geography and other characteristics, and the social distribution of those outcomes, their determinants and the interventions and policies that link the two.*"[1] *The origins of population health stem from the discovery over two centuries ago of the connection between sanitary conditions and the spread of disease, as well as the realization that the upper echelons of society were far less afflicted by epidemics than those in the lower socio-economic classes.*[2] *These determinations have driven the understanding that population health "depends heavily upon social, cultural and economic determinants and not solely upon the delivery of medical care."*[3]

The need for ***population health management*** has been well documented in the canon of professional literature, as evidenced by the fact that the United States spends more on health care per person than any country in the world, but ranks poorly on numerous health indicators, including infant mortality rates and life expectancy.[4] Health indicators are inconsistent across the U.S., with "healthy" counties experiencing "lower rates of poverty, unemployment and preventable hospital stays than unhealthy counties." At a more delineated level, individuals with lower incomes have "shorter lives, poorer physical and emotional health and more chronic disease."[4] These differences in health indicators across graphic subdivisions and sub-populations cannot be explained solely by clinical indicators, e.g., "genes and biology…health behaviors (such as tobacco use and physical activity)," as they only account for 30% of an individual's health status. The other 70% is determined "by social and physical environmental factors such as access to adequate housing, education, income, healthy food and safe places for social and physical activity."[5]

Population health management efforts have occurred through various initiatives in both the public and private sectors, on national and local levels.

Numerous stakeholders have a significant interest in population health management as a means to improve the health of ***all*** Americans, including: individual patients and their families; the health providers who care for them; the communities in which these individuals live and work;[6] commercial entities; and, public policymakers.[7] An understanding of the current state of population health management from the perspectives of these stakeholders informs the discussion the potential evolution of these endeavors going forward.

Population health management efforts have occurred through various initiatives in both the public and private sectors, on national and local levels. The federal government has attempted to approach population health management through several different initiatives, including but not limited to:

1) **Implementation of Emerging Healthcare Organizations (EHOs):** Through health care reform, the federal government has facilitated the creation and implementation of EHOs such as Accountable Care Organizations (ACOs) and bundled payment models to incentivize providers to provide better care to a defined population at a lower cost, and, consequently address other, nonmedical needs of patients in an effort to yield cost savings.[8]

Robert James Cimasi

Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, is chief executive officer of Health Capital Consultants, a nationally recognized health-care financial and economic consulting firm headquartered in St. Louis, serving clients in 49 states since 1993. His professional focus is on the financial and economic aspects of health-care service sector entities.

Todd A. Zigrang

Todd A. Zigrang, MBA, MHA, FACHE, ASA, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices and other health-care enterprises. Their website is https://www.healthcapital.com.

2) **The Partnership for Sustainable Communities:** An Obama Administration initiative, the Department of Housing and Urban Development, the Department of Transportation and the Environmental Protection Agency have partnered to "align cross-agency investments and policies to improve [200] communities [across the U.S.] … through more efficient spending of taxpayer dollars," to advance "economic opportunity and mobility through the support of transportation connections and promotion of fair housing, all through the lens of helping communities adapt to a changing climate."[5]

3) **Healthy Food Financing Initiative (HFFI):** Created in 2010 and modeled after a public-private collaboration in Pennsylvania, HFFI works "…to bring grocery stores and other healthy food retailers to ['food deserts,' i.e.,] underserved urban and rural communities across America" that typically rely on fast food restaurants and/or convenience stores that only sell processed food. This effort seeks to utilize the expertise (and funding) of the Department of Health and Human Services, the Department of Agriculture and the Department of the Treasury, to "give stakeholders a full range of tools to increase access to healthy foods."[9]

In the private arena, efforts to further population health management through cross-sector partnerships and collaborations have "grown in frequency and depth in recent years."[5] While the need for these alliances has been well established, there is a dearth of studies regarding the success of these initiatives. Examples of these partnerships include:

- **Culture of Health Initiative:** This national initiative, developed by the Robert Wood Johnson Foundation (RWJF), consists of four action areas: making health a shared value; fostering cross-sector collaboration; creating healthier, more equitable communities and strengthening services and systems.[10] In the pursuit of building a "culture of health," RWJF tracks three metrics in determining the effectiveness of their various action areas: increased individual and community well-being, managed chronic disease and, reduced health care costs. RWJF is monitoring efforts in these action areas across 30 "Sentinel Communities" throughout the U.S.[11]
- **The Communities That Care Coalition:** This local partnership in Franklin County, Mass., led by a community action group and a community group for teenagers, was formed to combat high rates of substance abuse by young people in the area. The partners engaged community stakeholders such as the local government, schools, charges and parents, as well as teenagers, to plan and participate in task forces and activities to educate and provide resources to teenagers and their families and, over a nine-year period, reduced alcohol use for the younger age segment by 37%, cigarette smoking by 45% and marijuana use by 31%.[12]
- **The Healthy Library Initiative:** This partnership between the University of Pennsylvania and Philadelphia's public library system aims to "integrate evidence-based health efforts" throughout the library system's 54 branches and support a new Community Health and Literacy Center, which houses a "health-focused library branch, public and private health clinics and a recreation center," and hosts numerous programs and job fairs.[13]

Going forward, future population health management initiatives will need to overcome current challenges.

In addition to these specific initiatives, a number of population health management initiatives are utilizing information technology (IT) to serve previously underserved populations. One such innovation is CommunityRx, an IT infrastructure that was integrated with EHR platforms and "enabled clinicians to e-prescribe community resources for basic, wellness and disease self-management needs" during the patient visit. Implemented at over 30 federally qualified health centers and other participating clinical sites in Chicago, the system, in contrast to many initiatives that target only one population or health factor, "was designed to serve people of all ages … for the management of a wide range of social and medical conditions."[14]

Going forward, future population health management initiatives will need to overcome current challenges, such as scalability, as well as the difficulty in determining a causal relationship among numerous nonmedical factors generating health outcomes, e.g., social determinants of health (e.g., race/ethnicity, household resources and familial structure).[3] To address these challenges, stakeholders will likely seek to leverage evidence-based care through the utilization of IT to analyze aggregated data from sources such as government-collected data and empirical research.

One potential application may be through the utilization of big data to analyze patient segments. Also known as population segmentation, this application divides a general patient population into distinct, more homogenous groups through data analysis, which can aid providers in developing targeted interventions and care models to effectively provide care to these sub-populations.[15] Another potential application is through the utilization of a computer simulation model, such as the ReThink Health Dynamics Model, which can represent the population of a U.S. subdivision and, through the analysis of over a dozen sources of empirical data, simulate "…changes in population health, health care delivery, health equity, workforce productivity and health care costs by quarter year increments from 2000 to 2040."[16] Utilization of this model, or other similar models, may allow stakeholders to appropriately plan future

continued on page 14

Patient Care Outcomes *continued from page 13*

population health management endeavors by determining the most effective interventions for a particular population, as well as the level of financing required to fund the initiative.

Although population health management has rapidly improved over the past several years through an increased number of federal government initiatives and private cross-sector partnerships, as well as with the advent of IT to support these endeavors, the health of the U.S. population is still significantly fragmented, with minorities and impoverished individuals experiencing lower life expectancies and poorer overall health. The increased use of IT algorithms and models to identify these populations and determine the most effective health interventions (both medical and nonmedical) will potentially serve to improve health indicators across the population and consequently lessen health costs on those highest utilizers of care.

References

1. Kindig, David, and Stoddart, Greg, "What Is Population Health?" *American Journal of Public Health*, Vol. 93, No. 3 (2003), p. 380–383.
2. Szreter, Simon, "The Population Health Approach in Historical Perspective," *American Journal of Public Health*, Vol. 93, No. 3 (2003). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449802/pdf/0930421.pdf (Accessed 5/1/17), p. 421.
3. Dubowitz, Tamara, "Creating Healthier, More Equitable Communities by Improving Governance and Policy," *Health Affairs*, Vol. 35, No. 11 (November 2016), p. 1970.
4. "Why We Need a Culture of Health" Robert Wood Johnson Foundation, March 2016, http://www.rwjf.org/en/library/research/2016/03/why-we-need-a-culture-of-health.html (Accessed 5/1/17).
5. Towe, Vivian L., et al., "Cross-Sector Collaborations And Partnerships: Essential Ingredients to Help Shape Health and Well-Being," *Health Affairs*, Vol. 35, No. 11 (November 2016), p. 1964.
6. Plough, Alonzo L., "Building a Culture of Health: A Critical Role for Public Health Services and Systems Research," *American Journal of Public Health*, Vol. 105, No. 52, supp. 2 (2015), p. S150.
7. "Culture of Health" Datagraphic, *Health Affairs*, Vol. 35, No. 11 (November 2016), p. 1948.
8. Fraze, Taressa, "Housing, Transportation and Food: How ACOs Seek to Improve Population Health by Addressing Nonmedical Needs Of Patients," *Health Affairs*, Vol. 35, No. 11 (November 2016), p 2109. "Accountable Health Communities Model," Centers for Medicare and Medicaid Services, April 12, 2017, https://innovation.cms.gov/initiatives/ahcm/ (Accessed 5/1/17).
9. "Healthy Food Financing Initiative," Office of Community Services, Administration for Children & Families, U.S. Dept. of Health & Human Services, Feb. 14, 2017, https://www.acf.hhs.gov/ocs/programs/community-economic-development/healthy-food-financing (Accessed 5/1/17).
10. "Taking Action," Robert Wood Johnson Foundation, http://www.cultureofhealth.org/taking-action/ (Accessed 5/1/17).
11. "Sentinel Communities: How Communities Work Toward Health," Robert Wood Johnson Foundation, http://www.cultureofhealth.org/what-were-learning/sentinel-communities/ (Accessed 5/1/17).
12. "Communities That Care Coalition," Franklin Regional Council of Governments, 2014, http://frcog.org/boards-committees/communities-that-care-coalition/ (Accessed 5/1/17). "Collective Impact Case Study: Franklin County Communities that Care Coalition" FSG, Sept. 10, 2013, http://www.issuelab.org/resources/15787/15787.pdf (Accessed 5/1/17).
13. Morgan, Anna U., et al., "Beyond Books: Public Libraries as Partners for Population Health," *Health Affairs*, Vol. 35, No. 11 (November 2016), p. 2030. "CHOP and the city of Philadelphia break ground on health and literacy center," Children's Hospital of Philadelphia, Sept. 18, 2014, http://www.chop.edu/news/chop-and-city-philadelphia-break-ground-health-and-literacy-center (Accessed 5/1/17).
14. Lindau, Stacy T., "CommunityRx: A Population Health Improvement Innovation That Connects Clinics to Communities," *Health Affairs*, Vol. 35, No. 11 (November 2016), p. 2021.
15. Vuik, Sabine I., et al., "Patient Segmentation Analysis Offers Significant Benefits for Integrated Care and Support," *Health Affairs*, Vol. 35, No. 5 (May 2016), p. 769-770.
16. Homer, Jack, "Combined Regional Investments Could Substantially Enhance Health System Performance and Be Financially Affordable," *Health Affairs*, Vol. 35, No. 8 (August 2016), p. 1436.

VALUE-BASED CARE: ADVICE FOR PHYSICIANS

What are some steps physicians can take to prepare for value-based care and population health management? Cora Butler, JD, RN, CHC, president and CEO of HealthCore Value Advisors, and consultant Kathleen McCarry, offer these suggestions:

- **Physicians should monitor their scores in the various Medicare quality measures.** "This data is going to be posted on websites available to the public. Whether you're part of a group or independent, data that produces actionable clinical and business intelligence is power," McCarry said.
- **Review your practice operations and workflow to identify opportunities to optimize performance and capture additional revenue.** "Practices that become more pro-active in preparation and follow-up of patient visits have an opportunity to transform those encounters from a single-issue visit to one focused on management of existing chronic conditions," Butler said. Much pre- and post-visit work including care coordination can and should be handled by members of the office workforce other than the physician.
- **Think about documentation.** "Continually evolving reimbursement models such as those used by ACOs and Medicare Advantage plans adjust patient care budgets on the basis of risk. If you are treating a chronic disease population, make sure to adequately document clinical status to support accurate and complete clinical coding so you can get the most appropriate risk adjustment," Butler added.
- **Consider the patient's social determinants of health.** "An emergency room visit may occur because the patient did not adhere to a medication. Maybe they can't afford it or don't have transportation to the pharmacy," Butler noted. Care navigators in the practice can help patients connect with community resources to assist with these needs.

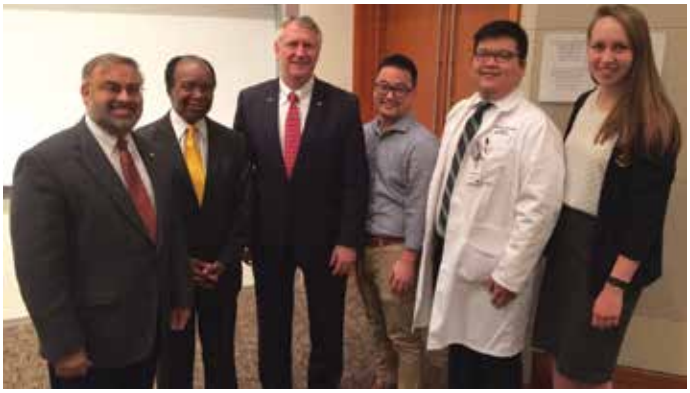
Value-based care is not going away, Butler said. "It addresses the reality of the situation today. Baby boomers are growing older and have different expectations about their wellness and activity. We can't afford to keep doing things the way we are now."

AMA President-Elect Visits Local Medical Schools

American Medical Association president-elect David O. Barbe, MD, MHA, of Mountain Grove, Mo., spent the day in St. Louis on Tuesday, May 2 visiting both Washington University and Saint Louis University Schools of Medicine. Dr. Barbe met with medical students, physicians, faculty and staff and presented a keynote address on the American Medical Association and the future of medicine at both institutions. He answered medical students' questions and offered perspective on the changes from "volume to value" in reimbursement, and the current state of health system reform.

Several SLMMS members attended Dr. Barbe's presentations, including Drs. Ravi Johar and Nat Murdock at Washington University, and Drs. Elie Azrak, Edmond Cabbabe, Jo-Ellyn Ryall, and Chris Swingle at Saint Louis University. Many SLMMS medical student members were in attendance as well.

Dr. Barbe will be inaugurated as AMA president in June at their annual meeting in Chicago. He is the first AMA president from Missouri in 90 years. He has already confirmed he will return to St. Louis to meet with SLMMS members and deliver the annual Hippocrates Lecture this fall.



At Washington University, SLMMS members from left, Ravi Johar, MD, Nathaniel Murdock, MD, and resident member Daniel Young, MD, join Dr. Barbe and medical students.

Dr. Barbe, back row center, with Saint Louis University medical students. He is joined by SLMMS members Elie Azrak, MD; Jo-Ellyn Ryall, MD; Christopher Swingle, DO; and Edmond Cabbabe, MD.

Six ACOs Now Serve the St. Louis Area

Programs report cost savings, increase in preventive care

By Jim Braibish, St. Louis Metropolitan Medicine

More Medicare beneficiaries in the St. Louis area are receiving care through an Accountable Care Organization (ACO). The number of local ACOs has doubled from three in 2014 to six in 2017.

Nationally, there are 480 ACOs recognized by the Centers for Medicare and Medicaid Services with nine million beneficiaries. Data for 2015, the most recent year available, showed Medicare ACOs generating more than $466 million in total program savings.

For more discussion of studies analyzing the success of ACOs to date, see the article by J. Collins Corder, MD, starting on page 2.

Following is an update on St. Louis-area ACOs.

BJC HealthCare ACO

Start Date: July 1, 2012

Physicians: 558

Members: 42,458

Website: www.bjcaco.org

The BJC HealthCare ACO reports important successes in its first four years. In 2015, the ACO achieved a quality score of 97.66%, and saved Medicare $3.5 million, said Nathan Moore, MD, ACO medical director. The BJC ACO has the lowest per-beneficiary cost in the St. Louis area, he added.

"Our ACO is focused on providing exceptional and high-value health care to our patients," Dr. Moore said. "We have a team of nurses, social workers and care coaches that work one-on-one with our patients and assist them with chronic care management, socioeconomic barriers to care and disease education. Our ACO team works closely with our partners in primary care, specialty care, hospitals and skilled nursing facilities to ensure that care is coordinated and well-managed across all sites.

"BJC is the only ACO in St. Louis that has qualified as a CMS Advanced Alternative Payment Model ACO," he says. "This allows us to do more for our patients than ever before."

Dr. Moore noted that BJC is proud to partner with independent medical practices to assist them with resources to improve the lives of their Medicare patients. "This way, the health of our whole community rises together."

Mercy ACO | Mercy Health ACO

Start Date: Jan. 1, 2013 and Jan. 1, 2015

Physicians: 1,900

Members: 120,000

Geography: Mercy Health ACO (started 2015) includes St. Louis and Washington, Mo., as well Joplin, Mo., Oklahoma, Kansas and Arkansas. Mercy ACO (started 2013) covers the Springfield, Mo., area.

Website: www.mercy.net/accountable-care-organization

Mercy has attained over 90% composite scores for ACO quality measures in its two ACOs spanning portions of Missouri and three other states. The ACOs also are seeing a slower rate of increased expenditures compared to the national fee-for-service Medicare population, according to Tracy Riordan, MD, clinical vice president-employer health solutions.

A particular success has been an 11% increase in breast cancer screening over three years at one ACO. Combined, the ACOs are experiencing a 20% higher rate than the national Medicare ACO average on diabetic eye exams.

"Our tools, strategies and infrastructure investments have allowed us to close gaps in care and deliver higher quality of care," she said. "We are applying population health management to reach out to patients before illnesses occur. We pursue getting these patients any needed health screenings to aid in disease prevention or early detection. At the same time, we also identify high-risk patients and work with them in a variety of ways."

Via telemedicine, patients with chronic conditions can be proactively cared for and monitored from home, she added.

SSM Health ACO

Start Date: Jan. 1, 2014

Physicians: Almost 500

Members: 23,000

Website: www.ssmhealth.com/aco

The SSM Health ACO reports improvements in quality, cost and patient experience in its three years of operation. The ACO is performing at 95% of Medicare's 33 ACO quality measures, according to Peter Schoch, MD, vice president-value based care

delivery and payment for SSM Health St. Louis.

"Our greatest success to date is our quality and our goal is to appropriately reduce the cost of care while maintaining high quality scores," Dr. Schoch said. "From a standpoint of cost, we saw savings in the first year, and over the past couple of years have put significant infrastructure and processes in place to see improvements in both quality and cost over the next year or two."

He added, "We also have adopted a health information exchange program to give us a line of sight into the health of patients outside the walls of our clinics. This allows us to make more informed medical decisions from a more complete record and shorten the runway to making decisions about their clinical care. It also enables a more focused approach to closing gaps in care which improves the overall health of the community we serve."

About the patient experience, Dr. Schoch explained, "Patients for the most part don't realize they are part of an ACO. What patients perceive is value of a patient-centered model that provides the highest quality of care through the coordination of information and care across the network. They are looking for access to their primary care doctor, when they need it, where they need it and with assistance in navigating the system."

St. Louis Physician Alliance ACO

Start Date: Jan. 1, 2015
Physicians: 412
Members: More than 19,400
Website: www.stlouisphysicianalliance.com/aco

The St. Louis Physician Alliance, an independent clinically integrated network formed in 2013, operates the SLPA ACO. It achieved $1.5 million in cost savings in its first year and was the only ACO in St. Louis to achieve significant savings in 2015, according to Executive Director Amy Sullivan. Other results include development of a high quality post-acute care network that is helping patients return to their homes and families more quickly.

"We successfully implemented a population health technology platform to connect clinical and financial performance data across our largest practices on disparate electronic medical record systems," Sullivan said. "We can stratify patients for targeted interventions, and identify high-cost/high-need patients and route them to appropriate providers. In addition to better coordinating care, we leverage our technology to drive improvements in quality and share best practices across our network."

SLPA fills a unique role among ACOs. Sullivan pointed out, "By providing the infrastructure to support independent providers, SLPA helps to keep a vibrant and competitive health care delivery environment in the St. Louis area. Sustaining this ecosystem helps keep attention focused on providing the best care at the lowest cost to the community."

MissouriHealth+

Start Date: Jan. 1, 2016
Physicians: 176
Members: 14,500
Website: www.missourihealthplus.com

Just entering its second year, MissouriHealth+ comprises 19 Federally Qualified Health Centers across Missouri. Among participating local centers are Affinia Healthcare, Betty Jean Kerr People's Health Centers, Family Care Health Center and Myrtle H. Davis Comprehensive Health Centers.

While 2016 performance data is not yet available, CEO Danny O'Neill said the ACO already has shown benefits.

"Participating in the ACO program has expanded the scope of value-based contracts that MissouriHealth+ has entered into," he said. "By aligning efforts across Medicaid, commercial and Medicare lines of business, our FQHCs and their providers are shielded from external differences to focus on what they do best, provide access to high-quality primary care services."

MissouriHealth+ has created a population health collaborative, a setting in which providers and care managers come together every other month to learn about business arrangements with payers, get involved with the development of population health management infrastructure and exchange ideas and best practices.

"Our ACO is providing high-quality, low-cost care, in a setting that is designed to provide access to care to all, regardless of their ability to pay," O'Neill concluded.

Aledade ACO

Start Date: Jan. 1, 2017
Physicians: 60 (Missouri)
Geography: Aledade Missouri is one of 15 ACOs operated nationally by Aledade, Inc., encompassing almost 300 primary-care physicians in 11 states (NY, MD, WV, KS, MS, TN, LA, MO, AR, FL, UT)
Website: www.aledade.com/about-us/where-we-are/missouri

The Aledade Missouri ACO, the area's newest, focuses on partnering with independent primary care practices. Local members include Robert Tague, MD, (SLMMS), Family Medicine, South County; David Stansfield, DO, (SLMMS), Family Medicine, Hillsboro; RIA Medical in Wentzville; and Jefferson County Internal Medicine.

Aledade member practices benefit from data analytics and regulatory expertise already developed through Aledade's work in other states.

continued on page 21

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

Herman K. Beebe, III, DO
12345 West Bend Dr., #300, 63128
DO, Lincoln Memorial Univ., Tenn., 2009
Born 1985, Licensed 2015 ► **Active**
Internal Medicine

Sean M. Breit, MD
15 The Boulevard Saint Louis, 63117
MD, Ohio State Univ., 2002
Born 1976, Licensed 2006 ► **Active**
Cert: Ophthalmology

Karen S. Cowan, MD
915 N. Grand Blvd., 63106
MD, Univ. of Missouri-Columbia, 1988
Born 1956, Licensed 1994 ► **Active**
Psychiatry

B. Sophia Ford-Glanton, MD
3635 Vista Ave., 3FDT, 63110
MD, Stanford Univ., CA, 2002
Born 1976, Licensed 2007 ► **Active**
Cert: Urological Surgery

Richard E. Gestring, MD
555 N. New Ballas Rd., #220, 63141
MD, Amer. University of Antigua, 2009
Born 1981, Licensed 2014 ► **Active**
Cert: Psychiatry

Katherine L. Glover-Collins, MD
660 S. Euclid Ave., #8109, 63110
MD, Meharry Medical College, 2009
Born 1978, Licensed 2015 ► **Active**
Cert: Surgery

Virginia M. Herrmann, MD
11155 Dunn Rd., #202N, 63136
MD, Saint Louis Univ., 1974
Born 1949, Licensed 2014 ► **Active**
Cert: Surgery

Diane M. Hood, MD
121 St. Luke's Center Dr., #504, 63017
MD, Univ. of Missouri-Kansas City, 2002
Born 1978, Licensed 2006 ► **Active**
Cert: Internal Medicine

Benjamin D. Kozower, MD
660 S. Euclid Ave., #8234, 63110
MD, Univ. of Rochester, 1997
Born 1971, Licensed 2016 ► **Active**
Cert: Thoracic Surgery

Sara A. Lander, MD
121 St. Luke's Center Dr., #504, 63017
MD, Univ. of Missouri-Columbia, 1999
Born 1971, Licensed 2003 ► **Active**
Internal Medicine

Sarah A. Lord, MD
121 St. Luke's Center Dr., #504, 63017
MD, Univ. of Missouri-Columbia, 2010
Born 1983, Licensed 2013 ► **Active**
Cert: Internal Medicine

Katharine H. Mikulec, MD
121 St. Luke's Center Dr., #504, 63017
MD, Columbia Coll. of Physicians & Surgeons, 1997
Born 1969, Licensed 2004 ► **Active**
Cert: Endocrinology

Kimberly G. Perry, DO
232 S. Woods Mill Rd., 63017
DO, A.T. Still Kirksville Coll. of Osteopathic Med., 1991
Born 1965, Licensed 1992 ► **Active**
Emergency Medicine

Tara Ramachandra, MD
6400 Clayton Rd., #405, 63117
MD, Stanford Univ., 2009
Born 1982, Licensed 2016 ► **Active**
Cert: Otolaryngology

Gayathri V. Raman, MD
3009 N. New Ballas Rd. #100B, 63131
MD, Univ. of Missouri-Kansas City, 1998
Born 1973, Licensed 2001
Family Practice

Chris R. Reeves, DO
450 N. New Ballas Rd., 63141
DO, Kansas City Univ. of Medicine and Biosciences, 1999
Born 1968, Licensed 2013 ► **Active**
Cert: Orthopedic Surgery

Herbert N. Shapiro, MD
617 Brookmont Lake Ct., 63017
MD, Univ. of Missouri-Columbia, 1960
Born 1935, Licensed 1960 ► **Active**
Cert: Surgery

Bradley W. Stockmann, MD
1 Memorial Dr., Alton, IL 62002
MD, Saint Louis Univ., 2004
Born 1976, Licensed 2008 ► **Active**
Cert: Diagnostic Radiology

Robert W. Thompson, MD
4921 Parkview Pl., Ste 8A, 63110
MD, Univ. of Michigan, 1983
Born 1957, Licensed 1992 ► **Active**
Cert: Vascular Surgery

William C. Wetzel, DO
5000 Manchester Ave., 63110
DO, Kansas City Univ. of Medicine and Biosciences, 1963
Born 1953, Licensed 2000 ► **Active**
Emergency Medicine

Stephen A. Wexler, MD
15 The Boulevard Saint Louis, 63117
MD, Univ. of Michigan, 1982
Born 1956, Licensed 1986 ► **Active**
Cert: Ophthalmology

Robert J. Wlodarski, MD
11133 Dunn Rd., 63136
MD, Rush Medical College, 2010
Born 1983, Licensed 2016 ► **Active**
Cert: Vascular & Interventional Radiology

Erica L. Yalavarthi, MD
121 St. Luke's Center Dr., #504, 63017
MD, Univ. of Missouri-Kansas City, 2001
Born 1977, Licensed 2004 ► **Active**
Cert: Family Practice

WELCOME STUDENT MEMBERS

Saint Louis University School of Medicine

John D. Bireley
Jordan R. Feltes
Mobolaji H. Fowose
John Galatowitsch
Heather L. Gladfelter
Jason W. Greenberg
Chyleigh J. Harmon
Ellen J. Kim
Lauren N. Mackie
Chase Pribble
Macy May Walz
Haley Wartman

Washington University School of Medicine

Mitchell Anthony Lynn

Advice on Issues You May Encounter in Your Practice

By Jessica Flora, PHR, Research and Solutions Analyst, AAIM Employers' Association

Q How many steps should be included in the disciplinary process before terminating an employee?

Answer There is no correct answer to this. This should be assessed based on your organization's needs. What is important is to remain fair and consistent. Fairness and consistency will weigh heavily in court if ever challenged. Also, employers should ensure all disciplinary actions are clearly documented. This can help when contesting unemployment claims.

Q What are my obligations as an employer regarding benefits for an employee who is on FMLA leave?

Answer Employers must maintain employees' group health insurance benefits for the entire duration of FMLA leave, as long as the employee continues to make any required premium payments, and must reinstate coverage when the employee returns from leave on the same terms as before the leave begun.

If the employee normally pays a share of the insurance premiums, he or she may be required to continue doing so to the same extent as if there were no leave. An employer must tell an employee in advance and in writing about any requirements to make payments to keep health plan coverage during FMLA leave, and the terms and conditions required for making payment as well as the consequences of not making timely payments.

To receive payment, you can require the employee to pre-pay benefits, make payments throughout the leave, or make payments when returning from leave. Whichever method the employer chooses, it must be communicated in writing to the employee.

Jessica Flora

AAIM Employers' Association is an association of over 1,600 member organizations in the St. Louis region and throughout Illinois. AAIM provides tools for its members to foster organizational growth and develop the potential of individual employees. For more information about AAIM, call 314-968-3600 or visit www.aaimea.org.

Q Can I provide Form I-9 to an employee before their first day?

Answer Yes, only if the employee has been provided and accepted an offer of employment with the company.

Q Do you have to provide an employee a pay stub?

Answer The Fair Labor Standards Act does not require an employer to provide employees pay stubs. However, there is a Missouri statute that requires, with each paycheck, employers must "furnish the employee at least once a month a statement showing the total amount of deductions for the period." (MO Rev. Stat. Sec. 290.080).

Q If an employee puts in their two week notice, do I have to keep them employed the entire two weeks?

Answer Missouri and Illinois are both "employment-at-will" states. So, you may terminate them earlier than their requested last day. Ensure your company policies are up to date and you remain consistent. Also consider if these employees are exempt or non-exempt. Each will be paid differently depending on when you terminate the employee.

Boomers Becoming Seniors

Need for home care services will increase significantly as the boomer population ages

By Mike Roberts, Home Care Assistance of St. Louis

The year 2030 is just 13 years away and a tipping point.

Between now and then, every single day, 10,000 Americans will turn 65. By 2030, one in five will be 65 or older and the number of those 85 or beyond will be well on the way to tripling, growing from 5.8 million in 2010 to 19 million by 2040.

While this generation will outlive its parents, it is also likely to struggle more with obesity and, as a consequence, diabetes, hypertension and higher cholesterol. Almost 20 million Americans over 65 are expected to have a disability by 2030.

The weight of providing needed care will come at no small cost and fall on increasingly fewer shoulders.

Today, an estimated 40 million family members spend some portion of their days, nights or both looking after a loved one, who is usually a family member, helping them with any, most or all of their daily living activities—including bathing, dressing, medications, incontinence and more. It's estimated some 60 percent of those doing this hard work for family members lose time at work either through missed days, arriving late or leaving early, and this amounts to an estimated $300,000 in lost wages and income over the span of their careers.

In 2015 there were seven caregivers for every person needing it; by 2030 that ratio will be closer to four to one.

These numbers tell an important story about how the need for home care and related services will grow. So, it comes as no surprise that the in-home care business for aging boomers is, well, booming. In the St. Louis metropolitan area alone there are more than 300 providers.

In-home care is not the same as in-home health care. In-home health care offers skilled nursing, palliative care, physical, occupational and speech therapy and, in some cases, some help with daily household needs. The goal is to provide medical care at home at the same level as what would be offered at a hospital or skilled nursing facility.

In-home care, on the other hand, provides a caregiver or team of caregivers who help the family member or loved one in need—and bring relief to exhausted family supporters—by handling incontinence issues, bathing, dressing, grooming, cooking, running errands and driving to doctor appointments. Help can be provided on anywhere from an hourly or daily basis, to overnight, live-in or 24/7. Home care services are tailored to fit the need so it really becomes a dynamic process that will evolve as those needs inevitably change. In-home care often serves those dealing with late-life issues but not exclusively. It also helps those rehabilitating after surgery or the many and varied journeys from hospital to home.

The goal of those in the home care industry is to ensure the home continues as the almost sacred space where 90 percent of us would like to finish our lives (and 80 percent assume they will) … and that it indeed will be the place where those nearing the end of life do remain.

It's estimated some 60 percent of those doing this hard work for family members lose time at work either through missed days, arriving late or leaving early, and this amounts to an estimated $300,000 in lost wages and income over the span of their careers.

Mike Roberts

Mike Roberts, Emmy-winning former longtime broadcast meteorologist in St. Louis, made a career change in 2016. After many years as a hospice volunteer, he is now director of client services with Home Care Assistance of St. Louis, LLC. He can be reached at 314-863-8989 or mike.roberts@hcamo.com. The company website is www.stlouishomecare.com.

But might this family have been gifted with just a little bit more time together had in-home help been suggested earlier?

Making Decisions About Care

On Super Bowl Sunday, I met with a family looking for help caring for their 91-year-old father. A World War II veteran, he came home, got married, became a teacher and then an assistant principal at a large local high school while helping his wife raise their family. On this day he was lying in bed with a card from his late wife's funeral on a stand next to him and his wallet close by (but only after his daughter insisted he take it out of his back pocket). The week before, he'd told his Sunday school class that his 50-plus year journey there had come to an end and he would not be coming back because he could no longer drive himself to church alone. His oldest daughter, now in her 50s, so loved watching her father teach bible study that she still went and sat in on his lessons every Sunday.

It had been a hard week for all of them and a particularly sad Sunday for Dad. One of the daughters lived at home as caregiver and the other with her family not far away. Their father could no longer get up and down the stairs without significant effort. I explained how a chair lift could be put in and that our caregivers could help him get to and from church so he could continue teaching, and help with all the daily needs from bathing to cooking to grooming. We even prayed together. But, he said he really was ready to die. It was no surprise when, shortly after our meeting, he did.

I really think this kind, gentle father, husband, teacher and community leader was just ready to "go home," and once his heart felt that way his soul obliged the desire. But might this family have been gifted with just a little bit more time together had in-home help been suggested earlier?

All corners of the elderly care world follow the lead of the physician. They are the quarterbacks of care and any recommendations must, first and foremost, be the doctor's decision, made only after lengthy assessments. But the boomers have always been large in number, and over the next decade this will dictate their next need and, this time, it will be for help at home. The hospital to home journey will have to include expert, in-facility medical advice and support and when possible, skilled home health … and in-home care.

Each physician's team will have to have on their roster trusted in-home care resources.

I remember watching an interview with Paul McCartney, who was asked how it felt to be getting a little older. He said, "You know, when I turned 40, the years just started to fly by and now they just go faster and faster." Well, the next decade and half is likely to come and go with increasing speed as the largest senior population in our history ages. For many, that will mean "A Hard Day's Night," so it's a comfort to know they can get by "With a Little Help From Their Friends"… and family.

But if more help is needed than the strongest and most loving families can provide, in-home care can allow staying in the home to go from being a possibility to a reality and in the process, who knows, maybe even re-kindle a few fond memories … of "Yesterday."

References

Kaiser Family Foundation (http://www.kff.org) analysis. Original data and detailed source information are available at http://facts.kff.org/JAMA_082813

"Geriatrics Interest Group," AMSA.org, http://www.amsa.org/AMSA/Homepage/About/Committees/Geriatrics.aspx

https://www.census.gov/prod/2010pubs/p25-1138.pdf

"The Boomer Challenge," H&HN.com, Jan. 14, 2014, https://www.census.gov/prod/2014pubs/p25-1140.pdf

"Families Caring for an Aging America"http://www.nationalacademies.org/hmd/Reports/2016/families-caring-for-an-aging-america.aspx

---

Six ACOs Now Serve *continued from page 17*

Nick Bartz, Aledade Missouri executive director, said, "Our boots-on-the-ground support for practice transformation is already beginning to have an impact on our practices' bottom lines. On average, Aledade Missouri practices have billed 30% more fee-for-service revenue in Q1 of 2017 vs. Q1 of 2016."

Bartz noted other benefits seen in Aledade ACOs:

- Real-time alerts when patients are admitted, discharged or transferred into and out of acute-care facilities, and when they visit the emergency room
- State of the art chronic-care management software, at no extra-charge
- Dedicated on-site support every week from experienced practice-transformation specialists

Annual MSMA Alliance Meeting in Kansas City

Members of the SLMMS Alliance were recognized at this year's MSMA Alliance annual meeting in Kansas City March 30-April 1:

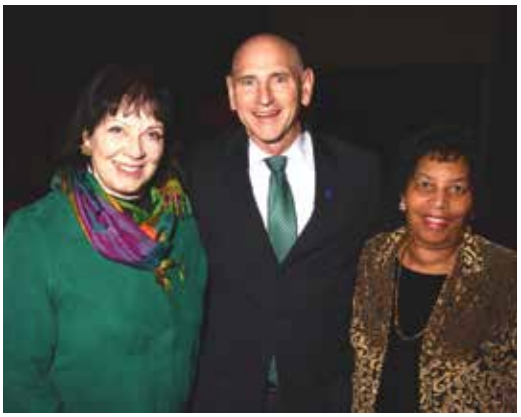
- **Sandra Murdock** received the Jean Wankum Spirit of the Alliance Award for her many contributions to the community outside the Alliance.
- **Kelly O'Leary** received the Jean Duensing Journalism Award for her presentations at the national, state and local levels on opioid abuse which claimed her son's life (see *St. Louis Metropolitan Medicine* Dec. 2016). Kelly also presented to the Missouri Psychiatric Association workshop organized by Jo-Ellyn Ryall, MD.
- The entire **SLMMS Alliance** received a recognition certificate for its role in organizing a Drugs Are Not for Me competition at Loyola Academy of St. Louis; Loyola's winners also swept the state awards.
- **Gill Waltman** was recognized for generating an increase in Holiday Sharing Card donations for the AMA Foundation and the Missouri State Medical Foundation.

2017-18 Officers Installed

Congratulations to SLMMS Alliance 2017-18 officers installed on May 11: From left, installing officer MSMA Alliance president Marsha Conant from St. Joseph; James Conant, MD; Alliance incoming co-presidents Sue Ann Greco and Sandra Murdock; president-elect and treasurer Kelly O'Leary; vice president-health Angela Zylka; vice president-foundations and recording secretary Gill Waltman; corresponding secretary Jean Raybuck; vice president-legislation and parliamentarian Jo-Ellyn Ryall, MD; community outreach director Claire Applewhite; and special projects Nancy Marino. Not pictured: vice president-membership Gail Thomasson; and special projects Dianne Joyce, Ph.D.

Alliance Supports Graduates on Match Day

Alliance members from across Missouri attended Match Day events in March to lend their support to medical school graduates on this critical day when they learn their residency locations. The Alliance provides pizza and gifts to the graduates. Pictured at the Saint Louis University Match Day event are Alliance members Angela Zylka, left, and Sandra Murdock, right, with Kevin E. Behrns, MD, the new dean of the SLU School of Medicine.



NEIMAN MARCUS FASHION SHOW AND FUNDRAISER

Thanks to those who supported the Alliance fashion show and luncheon on April 29 at Neiman Marcus. Organized by Kelly O'Leary and Sandra Murdock, it was a great success raising funds for Alliance community health programs.

Physician News


George M. Bohigian, MD

George M. Bohigian, MD, SLMMS past president, received the Presidential Award from the St. Louis Ophthalmological Society. The award is presented for distinguished contributions and service to the ophthalmic community local and worldwide." Dr. Bohigian is a professor of clinical ophthalmology in the Department of Ophthalmology and Visual Sciences at Washington University School of Medicine.


Leslie Scott, MD

Leslie Scott, MD, (SLMMS), chair of the Department of Obstetrics and Gynecology at SSM Health DePaul Hospital, received the *St. Louis American* Excellence in Health Care Award. **Jacqueline Turner, MD**, was named a *St. Louis American* Stellar Performer; she practices with West End Ob/Gyn, part of BJC Medical Group.


Thomas Olsen, MD

Thomas Olsen, MD, has been awarded Mastership in the American College of Physicians (ACP), the national organization of internists. He is a professor of internal medicine at Saint Louis University, where he has taught and practiced medicine since completing his residency in 1984.


Matthew Mutch, MD

Matthew Mutch, MD, chief of the Section of Colon and Rectal Surgery at Washington University School of Medicine, has been named the Solon and Bettie Gershman Chair in Colon and Rectal Surgery at Barnes-Jewish Hospital. He has served as colon and rectal surgery chief since 2015. The chair previously was held by Ira Kodner, MD, (SLMMS), professor emeritus of surgery.


Kimberly S. Quayle, MD

Kimberly S. Quayle, MD, has been named director of the Division of Emergency Medicine in the Department of Pediatrics at Washington University School of Medicine. She also will serve as the Dana Brown Chair for Emergency Medicine at St. Louis Children's Hospital.

OBITUARIES

Eli R. Shuter, MD

Eli R. Shuter, MD, a board-certified neurologist, died April 6, 2017, at the age of 81.

Born in Brooklyn, N.Y., Dr. Shuter received his undergraduate degree from Cornell University and medical degree from Washington University. He completed his internship at New York Hospital; his residencies were completed at Massachusetts General Hospital and Cleveland Metropolitan General Hospital. He completed a special post-doctoral fellowship with the National Institute of Neurological Diseases and Blindness at Barnes-Jewish Hospital. He served in the U.S. Army from 1962-1964.

In private practice, he also served as an associate professor of neurology at Washington University School of Medicine. He was on staff at Christian Hospital, Barnes-Jewish Hospital, SSM Health DePaul Hospital, Alton Memorial Hospital and the former St. Louis Regional Hospital. He founded the St. Louis Neurological Institute at Christian Hospital, where he also served as chief of staff.

Dr. Shuter joined the St. Louis Metropolitan Medical Society in 1966, and became a Life Member in 2010.

Dr. Shuter is predeceased by his wife, Renni Shuter. SLMMS extends its condolences to his children, Anne Pride, Lynn Shuter, Dale Shuter and Beth Herbster; and his six grandchildren.

Richard F. Jotte, MD

Richard F. Jotte, MD, a family practice physician, died April 23, 2017, at the age of 92.

Born in Highland, Ill., Dr. Jotte received his undergraduate and medical degrees from Saint Louis University.

He served in the U.S. Navy before medical school. He was in private practice for 40 years in St. Ann, and was on staff at SSM Health DePaul Hospital and SSM Health St. Joseph Hospital-St. Charles.

Dr. Jotte joined the St. Louis Metropolitan Medical Society in 1958, and became a Life Member in 1998.

Dr. Jotte is predeceased by his wife, Helen J. Jotte. SLMMS extends its condolences to his children, Richard P. Jotte, MD (SLMMS); Cindy Szewczyk; Randy Jotte, MD; Kathleen Judd; Christine Martin; Diane Lohmann; Robert Jotte, MD; and Carie Forrester; and his 25 grandchildren and four great-grandchildren.

PARTING SHOTS

Hippocrates, We Have a Problem

By Richard J. Gimpelson, MD

So, Hippocrates was talking with Asclepius and Asclepius' daughters: Hygieia, Iaso, Aceso, Panacea and Aglaea. Hippocrates was telling the others that the foundation of medicine was so solid that nothing could compromise the delivery of medicine for eternity.

Unfortunately, something has gone wrong and there are many factors in my humble opinion. I will go over what I consider to be the main culprits to this situation.

Attorneys and the Legal System

This has been covered so frequently and in such depth that I am not going to repeat the discussion in this column.

Hospitals

Fees are astronomical and make little sense because insurance companies have contracts with hospitals that reduce fees according to contracted rates. An example which I believe I have described in a prior column is as follows:

Ten years ago I had a one-and-one-half day hospitalization for which I was billed over $17,000. The insurance company reduced the charge to $1,800. One year ago I had a very similar one-and-a-half day hospitalization and the bill was over $43,000. Insurance reduced the charge to $23,000. There are two mysteries. One, if the hospital billed $17,000 or $43,000, why was $1,800 and $23,000 acceptable? Two, how can the charge go from $17,000 to $43,000 in less than 10 years? Cars, colleges, and even houses haven't shown that kind of inflation. Why shouldn't someone with no insurance also get the reduced fee?

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.

Insurance and Insurance Companies

As noted above, the insurance companies can save someone a lot of money; that is, if one can afford insurance. Often the deductibles are so high that the insurance is unaffordable. In addition, the insurance companies will often allow patients to see physicians only in the insurers' panels. So if one wants to see a physician who may be the best in town, but not part of the panel, the patient must pay cash to the doctor and the hospital.

In addition, most insurance companies use a pharmacy benefits company that may not approve a medication that a patient has been on for nearly half their lifetime with good results, only to make the patient try a new medication that may be less effective or have untoward side effects. Another plan used by the insurance company/pharmacy benefits team is requiring pre-authorization of a medication. The patient may be required to try several ineffective medications before they are allowed to use the medication that the physician in his or her experience feels is the best treatment. Insurance companies may also require that the patient go to a specific hospital that is inconvenient for the patient or may not deliver as high of quality care that another hospital can provide. In addition, insurers may limit the length of stay in the hospital even if the treating physician recommends a longer stay.

The Government and Its Lawmakers

I think most of you are aware that the Affordable Care Act (ACA) is getting more expensive and more difficult for patients to afford, and more difficult for physicians to follow the many rules that continue to be required. These rules may change from year to year. The Democrats want to make changes to the ACA while the Republicans want to repeal and replace the ACA. Neither party will go along with any recommendation by the other party; in fact, all they do is insult each other. Neither party offers any way to meet and work out a compromise. Thus, the ACA continues to increase in cost and decrease in care. The most glaring aspect of government and its lawmakers making medical care difficult to get (if not outright dangerous) seems to be the Veterans Administration hospitals. Patients may have to travel extremely long distances to get to a facility, and achieve this only after waiting an exorbitant amount of days, weeks, months, or even years to be seen.

continued on page 25

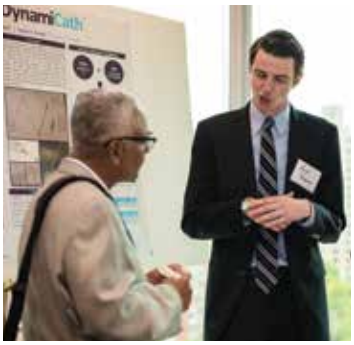
Medical Students Present Entrepreneurial Solutions Through Sling Health and MEDLaunch

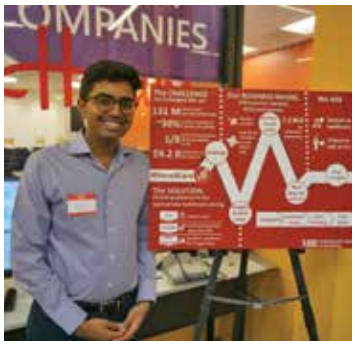
Will Dynamicath—an improved cardiac catheter tip—or Where4Care—an app that helps guide patients to the appropriate care setting—be major names in medical technology in the future? These were among dozens of entrepreneurial concepts presented by medical students at Washington University and Saint Louis University during their annual Demo Days in late April.

SLMMS is among the sponsors of these programs, **Sling Health** (formerly IDEA Labs) at Washington University, and **MEDLaunch** at Saint Louis University. Demo Days have become major celebrations, attended by hundreds and featuring national speakers. Sling Health's Demo Day, held at the Cortex Innovation Center, now involves students from eight other major universities across the nation. MEDLaunch's Demo Day is held at the Chase-Park Plaza Hotel. These programs align with St. Louis' robust activity as a hub for medical technology start-up companies.

Student projects are born in the fall when clinicians present various problems and needs to the students. Multi-disciplinary student teams develop solutions packaged into an entrepreneurial start-up model. Their presentations explain the proposed technology solution, create a name for the business, and present a budget for investors.

Congratulations to the students for this most impressive work!






Left to Right: Saint Louis University's Zach Provaznik discusses how Dynamicath changes the tip of the cardiac catheter to provide the user with more control. Washington University's Where4Care, third-prize winner, helps patients determine when to go to the emergency room versus urgent care or a physician office. Myah McCrary of Saint Louis University explains how her concept, Neura Synaptic Medical, delivers neurological exams assessing the consciousness level of patients. Washington University's William Johnston speaks to the Demo Day audience about his first-prize concept, InVizon, an endoscopic lens wiping tool.

Parting Shots

continued from page 24

Electronic Medical Records

Now I am not a Luddite, and I do value some of the aspects of Electronic Medical Records (EMR); however, as federal rules are constantly changing, they are having an effect on EMRs. The complexity and detailing of EMR seems to be more directed toward payment than care. Now we must go to multiple windows to record a patient history and physical to document complexity. One cannot just describe the patient's problem as we have done for many years in a written chart. (Note: The computer printout is much more legible than many physicians' handwriting, including my own). In addition, the cost of EMR is eliminating many physicians' thoughts of going into solo practice. Unfortunately, we are at the infancy of EMR and if the government continues to have the most influence, the EMR will become a monster rather than a helper.

Well, Hippocrates, we have a problem. We cannot give up hope, and as long as most physicians are dedicated to providing the best care for their patients, there may be a bright future ahead.

CALENDAR

JULY

3-4	Independence Day, SLMMS office closed
15-16	MSMA Council Meeting
20	MSMA Insurance Conference, 8:30 a.m. to 4:00 p.m.

AUGUST

8	SLMMS Executive Committee, 6 p.m.

SEPTEMBER

4	Labor Day, SLMMS office closed
16	2017 Physician Leadership Institute, First Session
19	SLMMS Council and General Society Meeting, 7 p.m.

Keeping the **game fair...**

...so you're not **fair game.**

Your Missouri medicine
is getting hit from all angles.

You need to stay focused and on point—
confident in your coverage.

Get help protecting your practice,
with resources that make important
decisions easier.

ProAssurance®
Treated Fairly

SINCE 2007 WARD'S 50

Healthcare Liability Insurance & Risk Resource Services
ProAssurance Group is rated **A+ (Superior)** by A.M. Best.

Want to reduce risk? ›› ProAssurance.com/Seminars

800.282.6242 • ProAssurance.com