Electronic Health Records Update

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     Dissatisfaction with EHRs
Already in 2015 your St. Louis Metropolitan Medical Society has delivered these benefits and more for physicians:

• Joining with Missouri physicians to pass tort reform legislation and restore limits on non-economic damage awards

• Working with physicians nationally to achieve repeal of the Medicare Sustainable Growth Rate formula

• Introducing eight resolutions at the meeting of our state organization to improve the practice of medicine

• Presenting educational programs including the Physician Leadership Institute and the Physician Wellness Conference

• Supporting community and scientific health education including the Greater St. Louis Science Fair, IDEA Labs Demo Day, and the Vesalius Conference

To continue similar achievements, we need you!

Please invite other physicians you know to join SLMMS

If you haven’t yet renewed your membership, please do. Every member is important!

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www.slmms.org
The Emergency Room Will Test the Patient’s Patience

By Richard J. Gimpelson, MD

Major hospital emergency rooms are fantastic for those in obvious danger of losing life or limb. However, if the danger is not obvious or even a real emergency, how does the patient really know if there is a true emergency, even if the patient is a physician or the relative of a physician?

Two real personal examples:

1. One week after having a total knee replacement, I woke up with dizziness so bad that I was unable to move my head more than two inches without extreme vertigo. My wife took me to the emergency room of a major hospital. I entered by wheelchair and told the triage nurse that I was unable to move without dizziness, was one week post total knee replacement, was a diabetic and that I had an MI around 10 years earlier. (I actually thought I was having a stroke.) After taking my blood pressure, I was put on a gurney in the hall unattended for three-and-a-half hours. In addition, I was less than ten feet from a woman walking in the hall with her 3- to 5-year-old son who had a chronic cough. I thought for sure that staph or strep was going to attack my knee. After 11 hours, I was finally discharged.

2. My son was in an auto accident in which his car was rear-ended while he was stopped at a traffic light. The estimated speed of the car that hit him was 20-30 miles per hour with no obvious noise of screeching breaks. He had no obvious lacerations, fractures or loss of consciousness. He was experiencing severe neck and back pain with movement. I took him to the nearest major hospital where his wait was only two-and-a-half hours before being put in an exam room. I called the emergency room of another major hospital. This ER had an empty waiting room and informed me that unless they had a large influx of injuries, my son would probably be seen in minutes after entering that ER. Unfortunately, my son did not want to leave the ER where we were waiting.

These two incidents gave me some ideas to make the non-emergency but patient-imagined emergency more quickly evaluated. I made several inquiries of hospitals in the St. Louis metropolitan area and surrounding counties. Many hospitals do not divert emergencies brought by ambulance, but some hospitals do (bad). If there is a major disaster, usually a director at the scene of the disaster arranges the transportation to the major trauma centers (good).

I found an article on the Internet that listed the average time by state that patients spent in an emergency room before being seen by a doctor. The shortest wait was 15 minutes (Wyoming), continued on page 15

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.

HARRY’S HOMILIES®

Harry L.S. Knopf, MD

ON COMMUNICATION

Talking and eloquence are not the same: To speak, and speak well, are two things. A fool may talk, but a wise man speaks.

- Ben Jonson

It has been a number of years since I opined about our communication (or lack thereof). Back then, email was replacing “snail” mail, and face-to-face communication was less and less common. Now we have “Face”book, Twitter, Instagram, Tumbler, etc., etc., etc. Communication is so fast, that the companies who sponsor these “social” networks are figuring out what you need BEFORE YOU KNOW YOU NEED IT! We can “GOTOMEETING” without getting out of bed. We have beaten time and space to achieve instant “communication.” But we have forgotten how to “speak,” and we are overwhelmed with “talk.” Those in the “know” are tweeting LOL (laugh out loud) as they text friends about this curmudgeon writing an article about communication. I think I will write my next article with a quill and deliver it by hand.

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.
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Evaluating the security of electronic health records in cloud computing
  ➞ By Montez Fitzpatrick, Keystone IT

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On the Cover: Surgeon and SLMMS member Kenneth G. Smith, MD, FACS, of Smith Surgical Services, a division of Signature Medical Group, uses the Signature Medical Group electronic health records system. Signature utilized physician input in designing its system.

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CORRECTION

In our April issue, the profile of Ravi Johar, MD, as Alliance Doctor of the Year incorrectly stated his practice. He practices with Mercy Clinic Women’s Health, a division of Mercy Clinic, and is on staff at Mercy Hospital St. Louis. He formerly practiced with Gateway Ob-Gyn, part of SSM DePaul Medical Group. There were two other errors. The correct spelling of his mother’s name is Manjit; Dr. Johar is state secretary-treasurer of the Missouri Section of the American Congress of Ob-Gyn. We apologize for the errors.
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EHRs and Attempts to Script Doctor-Patient Conversations

Michael J. Stadnyk, MD, Medical Society President

I know this edition of St. Louis Metropolitan Medicine is about the subject of electronic health records, but I really don’t care. I don’t care for a lot of reasons. But mainly, I don’t care because I don’t use them, and I think they detract from the physician-patient relationship. I don’t know enough about the subject to even comment on the intricacies of the topic.

However, I do know what my peers have said to me. Electronic health records remove from the medical relationship what is the most important part of it. The bond between the doctor and patient is empiric, and the use of electronic health records eliminates the practical experience of a patient-doctor interaction.

The communication between a patient and doctor is of utmost importance and the electronic health record eliminates any non-scripted conversation between the two. A patient may present to a doctor for a scheduled follow-up for hypertension, but may have just lost a spouse in a car accident. If the patient starts talking about the spouse, the conversation may be shifted to questions regarding the hypertension. The EHR directs the conversation, not the doctor.

During three years of general surgery residency and many years moonlighting as an ER attending, I saw many patients. I remember when “T-sheets” were introduced to the emergency room to help “guide” emergency room attending physicians to streamline patient assessment and focus their questioning about the stated complaint. For those who don’t know, a T-sheet was a piece of paper that was chosen from literally a tower of papers based on a chief complaint. The topic of the chief complaint—be it chest pain, abdominal pain, shortness of breath, etc.—was broken down into questions with items to check off depending on the patient’s answers. In theory, it was meant to shorten the time a physician was spending with the patient.

The less time a physician spent with a patient meant that more patients could be seen in a given shift. Of course, the added advantage was that the physician would have a lesser chance of forgetting to ask a pertinent question. None of the stated benefits of the T-sheet came to be proven, and the T-sheet went the way of the dinosaur. As much as we all may hope, I don’t think the same fate is going to come for electronic health records.

I could go on about the issues with the EHRs, but I will not. Good luck to those of you who are required to utilize these in their daily work. I am thankful to not be in the specialty that is required to utilize these frequently.

Any comments are welcome and can be sent to me at docstads2@yahoo.com.

On a Better Note

The long battle about tort reform is over for the immediate future. Passing the General Assembly by a vote of 127-25, the bill for the new tort reform legislation was signed into law by Gov. Jay Nixon on May 7. Gov. Nixon did what was deemed to be the prudent move by signing the bill into law as opposed to a veto. Had he chosen to veto, surely the bill would have been made law by the override of the General Assembly. The new law places caps on non-economic damages for a “regular” malpractice case at $400,000. A “catastrophic” case (strictly defined in the law) would have a cap of $700,000. Some may say that the caps are too high, but I think these caps are better than no caps at all.

I would like to thank all of the people who made the trip to Jefferson City in February for the White Coat Rally Day. I really do believe it made a difference to be there. This
time I actually heard some of our representatives make comments about the physician attendance being intimidating. As I said before, a representative two years ago said to me that if tort reform was so important to physicians, why aren’t there more attending? We were well represented this year from both sides of the state, and we should be proud. But for some reason, I feel a bit insecure. I don’t think the issue of tort reform is over forever.

Missouri Gov. Jay Nixon signs the tort reform bill into law on May 7 restoring caps on non-economic damages in medical malpractice cases. Looking on are MSMA member physicians including SLMMS Past President Ravi Johar, MD, second from left.

Fourteen SLMMS members were among the 36 physicians honored by the Missouri State Medical Association for achieving 50 years of practicing medicine. At the MSMA Annual Meeting and Convention on April 18, MSMA 2014-15 President Jeffrey Copeland, MD, presented recognition pins to SLMMS members Jorge M. Alegre, MD; George M. Bohigian, MD; Harry O. Cole, MD; Juan C. Corvalan, MD; Stephen R. Crespin, MD; Carl F. Ehrlich, MD; Andrew E. Galakatos, MD; Gary Kulak, MD; Wayne W. Meyer, MD; Thomas M. Moran, MD; J. Gail Neely, MD; S. Michael Orgel, MD; Thomas F. Reardon, MD; and H. Bryan Rogers, MD. Congratulations from SLMMS for achieving this distinction.

Final Dues Notice
SLMMS members who have not renewed their memberships for 2015 received final dues notices mailed to their home addresses in mid-May. Dues statements for 2015 must be paid by June 30, or membership will be revoked. For your convenience, you may call the SLMMS office at 314-989-1014 to pay by phone using your credit card. Also, you can now pay anytime online using our secure credit payment link at www.slmms.org.

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The annual meeting of the Missouri State Medical Association always provides an interesting amount of discussion and debate of issues relevant to organized medicine. The April 2015 meeting in Kansas City was no exception. Again this year, your St. Louis Metropolitan Medical Society delegation was well-represented in this process, sponsoring eight of the sixteen resolutions that proceeded through reference committee review, caucus discussions and the House of Delegates. We can be proud that all eight resolutions were either recommended for adoption or referred to MSMA Council for additional analysis or study.

Most importantly, this work illustrates how your local Medical Society can influence policy, one of the most valuable attributes of your SLMMS membership. Following is a brief synopsis of each SLMMS-sponsored resolution along with an acknowledgement of its physician sponsor.

Creation of “Medical Student” Category in Federal Direct Student Loan Program, sponsored by Mr. Ramin Lalezari of the SLMMS Medical Student Section, asked that the MSMA propose that the AMA study the true rate of default in federal student loans among medical student borrowers, and further propose that the AMA advocate for the creation of a separate “Medical Student” category, such that interest rates on loans to medical students can be properly risk-adjusted. Following the Reference Committee’s recommendation of a slight wording adjustment, the amended resolution was adopted.

Patient-Physician Continuity upon Health Plan Termination, authored by Joseph Craft III, MD, sought a revision to the existing Missouri statute 354.612.1 (Continuation of care after provider termination) to support extension of the continuity of care window to nine months or the end of the next enrollment period, whichever comes later, after patient and physician notification of the health plan’s termination of the physician contract. With the addition of terms extending to the end of the next enrollment period, the resolution was adopted.

Opposing the Interstate Medical Licensure Compact, authored by Helen Gelhot, MD, concerns the goal of the Federation of State Medical Boards (FSMB) to entice states to join the Interstate Medical Licensure Compact, increasing regulatory authority over physicians and the practice of medicine. Dr. Gelhot’s resolution asked the MSMA to strongly oppose the compact, and further requested the AMA to likewise voice opposition. Recognizing the intricacies involved with this national issue, the resolution was referred to the MSMA Council for further study.

Truth in Advertising, one of four resolutions presented by Samer Cabbabe, MD, petitioned the MSMA to work to have Missouri adopt truth in advertising legislation for all practitioners who provide health care across the state, including advertising claims related to licensure, board certification or additional post-graduate training. Given its similarity to another resolution introduced by Herluf Lund, MD, concerning the use of the term “board certified” in physician marketing, it was recommended both resolutions be referred to the MSMA Council for further study and action.
Dr. Samer Cabbabe’s next resolution, **Flexibility in Scheduling Pre-Authorized Events**, asked the MSMA to seek, through appropriate channels, to adopt a policy whereby the pre-authorization of a point of care event, at a particular facility, is good for a minimum span of 28 days in order to provide flexibility in scheduling which physicians need to accommodate their patients’ schedules and needs. The Reference Committee was supportive of the concept of the resolution but believed further study was needed prior to the adoption of a specific policy, therefore recommended it be referred to the MSMA Council.

**Reduced Payments for Subsequent Services within the Global Period**, also authored by Samer Cabbabe, MD, called for MSMA to oppose the medical insurance company practice of reduced procedural fees for indicated, necessary, and appropriate medical services performed by physicians during the global period. Believing the issue includes CMS Medicare policy and recognizing that reimbursement problems exist, it was felt this issue would benefit from additional study, thus it was referred to MSMA Council.

The fourth and final resolution presented by Dr. Samer Cabbabe, **Accurate and Updated Listing(s) of Participating Physicians in Networks**, resolved that the MSMA work with regulating agencies to have Missouri insurance companies maintain accurate and up-to-date listings each month of participating physicians by specialty within their network(s), was adopted.

**Reclassification of Medications**, introduced by Ravi Johar, MD, addressed recent changes by the Food and Drug Administration to the classification of many medications to Schedule II to decrease prescription drug abuse. A substitute resolution recommended by the Reference Committee, then further amended by the House of Delegates, was adopted, stating that MSMA educate physicians and study compliance of pharmacies regarding the federal and state regulations for emergency telephone prescriptions for Schedule II controlled substances.

SLMMS extends a message of gratitude to those who authored and sponsored resolutions, presented testimony to the Reference Committees, and/or represented our district as a delegate. We will continue to keep the membership apprised of further developments with regard to all of the 2015 resolutions.

In other business at the MSMA annual convention, long-time District 3 Councilor Ravi Johar, MD, practicing ob-gyn and SLMMS past president, was nominated as MSMA president-elect. He will be installed as the next state association president from our district at the 2016 meeting in St. Louis. Robert Brennan Jr., MD, and Michael Stadnyk, MD, were elected to two-year terms as MSMA District 3 councilors, and Steven Slocum, MD, was named to complete a one-year term as vice councilor. William Huffaker, MD, was re-elected to another term as an AMA delegate from Missouri. Best wishes to these physicians as they begin or continue these leadership roles.
SLMMS Physician Wellness Conference

A small but spirited group of area physicians and medical students attended the SLMMS Physician Wellness Conference, held April 25 at the Emerson Auditorium at St. Luke’s Hospital in Chesterfield. They were treated to an outstanding keynote presentation, “Building Resilience and Coping with Stress in Medical Practice,” by Stuart Slavin, MD, M.Ed., of Saint Louis University School of Medicine.

The half-day program included two additional presentations: “Asset Protection Planning for Missouri Residents and the New Qualified Spousal Trust,” by Jim Blase, JD, CPA, LLM, of Blase & Associates; and “MPHP: We Know More Than Substance Abuse,” by Jeremy Duke, MA, LPC, with the Missouri Physicians Health Program, and Sherry McNamara, LPC, CRC, of the De Novo program.

Designed to help physicians explore topics related to both physical and financial well-being, the program was chaired by SLMMS Councilor Robert A. Brennan, Jr., MD. The program was moderated by Jay Meyer, MD, and the welcome was given by SLMMS President Michael Stadnyk, MD. Participants received up to three CME credits, and also enjoyed a preview of the May 1 IDEA Labs Demo Day when medical students were to present medical bioengineering design concepts. Slides from Dr. Slavin’s and Mr. Blase’s presentations are available at www.slmms.org.

IDEA Labs Demo Day Focuses on Innovation

Through an educational grant from the St. Louis Society for Medical and Scientific Education (SLSMSE), SLMMS served as a sponsor for the IDEA Labs Demo Day on Friday, May 1, at 4240 Duncan Ave. in the Cortex District. Multidisciplinary teams from Washington University, including many medical students, participated in prototype demonstrations, poster exhibits, and a pitch competition at the event.

IDEA (Innovation, Design and Engineering in Action) Labs is a medical bioengineering, design and entrepreneurship incubator founded in 2013 by students at Washington University. It is a collaboration of medical, engineering and business students, plus faculty, staff and St. Louis entrepreneurs with the common goal of tackling unmet needs in health-care delivery and clinical medicine.

A number of SLMMS members attended the event, including Past President Joseph A. Craft, III, MD. “I was very impressed with the level of innovation these students are reaching through this extracurricular work,” said Dr. Craft. “This project fits perfectly with the mission of SLSMSE in support of medical and scientific education. I hope the Medical Society can continue to support this activity, with the physician community getting more involved as mentors.”

For more information about the IDEA Labs program, visit idealabsincubator.org.
SLMMS Call for Nominations
An opportunity to provide leadership and positively influence the future of medical practice

The St. Louis Metropolitan Medical Society serves as the collective voice for area physicians at the local, state and national levels. Strong 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 later this summer to consider candidates for leadership roles beginning in 2016. 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 committee appointments.

Time is everyone’s primary concern when serving in a volunteer capacity. Please know that SLMMS leadership roles can be as much or as little as you want them to be. The SLMMS Council has nine scheduled evening meetings per year. SLMMS Committees meet only as needed, usually no more than two or three times per year, and many meetings are virtual via email when appropriate. Ask any current or former council or committee member and they will be quick to tell you that it’s not a huge time commitment.

As physicians are challenged and threatened from all directions, there’s never been a more important time for organized medicine than the present. Yet securing volunteer leaders continues to be a challenge for us. Practicing 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. That makes it definitely worth your time.

SLMMS Councilors serve a three-year term; MSMA delegates are elected to a two-year term. SLMMS Committee terms are one-, two- or three years, depending upon the committee.

SLMMS Committees seeking appointees include: Continuing Medical Education; Membership; Peer Review; Physician Grievance; Political Advocacy; and Publications.

To be considered as a potential nominee or 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.

The Nominating Committee will present its slate of officers and councilors at a General Society meeting on Tuesday, Sept. 8, 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.

CALENDAR

JUNE
SLMMS Executive Committee, 6 p.m. 16

Community Event: The St. Louis Regional Health Commission will present its 2015 Health Disparities Symposium, “Toxic Stress and Trauma in Our Region,” on Friday, June 19, from 7:30 to 9:30 a.m. at the BJC Learning Institute lower auditorium, 8300 Eager Rd. No cost to attend. Information: nahseSTL@gmail.com.

JULY
Independence Day, SLMMS office closed 3
MSMA Quarterly Meeting, Jefferson City 11-12
SLMMS Executive Committee, 6 p.m. 14

AUGUST
SLMMS Executive Committee, 6 p.m. 11
Floating in the Cloud
Evaluating the security of electronic health records in cloud computing

By Montez Fitzpatrick, Keystone IT

M any organizations today view cloud computing as the direction of information technology and a stable platform on which to build their businesses. Medical practices considering a move to cloud-based electronic health records systems should also be aware of the increased security risk and plan accordingly.

What is Cloud Computing?

In cloud computing, data from your practice is stored on a remote server you access through the Internet, instead of you storing the data on your hardware in the confines of your brick-and-mortar facility. All of the infrastructure is managed for you offsite—system software, servers, storage, etc. As the end user, you simply access the system from the computers in your office. The major benefit is that your office is relieved of the responsibility of maintaining storage and keeping the system up to date. Instead of making a major up-front investment for software and hardware, you pay a monthly fee for the service.

An additional form of cloud computing is becoming more widely available—software-as-a-service (SaaS). In SaaS, the vendor hosts a software application but allows the customer the flexibility of customizing the software.

Cloud computing enables the user to take advantage of the vast storage capability available through these systems. Google and Amazon have advanced so-called “big data” where massive amounts of data are stored across networks of computers. In the past, the ultimate was “high-performance computing” producing the maximum number of calculations that could be performed per second by one massive supercomputer. Today, the focus is on “high-throughput computing” where the goal is the highest number of sustained operations over a longer period of time, typically months or a year. In “big data,” a wide network of computers talk to each other as one computer. If one computer goes down, the network continues to operate.

Security: Access vs. Accessibility

For a medical practice considering a move to the cloud, the question of security should be asked. Moving to the cloud is less secure than the same system hosted in an internal data center. Once you go through the cloud, you have made your data more accessible.

Quite simply, there is a basic tradeoff between security and accessibility (Fig. 1). The more accessible your data is, the less secure it is, and vice versa. The graphic shows a slider bar that depending on what measures you take, moves toward security or toward accessibility. The cloud makes your data more accessible moving the slider bar toward accessibility, so you need to counter this with increased security to return the slider bar to a balanced halfway point.

Evaluating the security of a system involves three factors as shown on this triangle: confidentiality, availability and integrity (Fig. 2). Confidentiality protects the privacy of data. Integrity ensures that data is not corrupted. Availability makes sure that access is available only in the right places. Since moving to the cloud will afford greater availability, more will have to be done to ensure confidentiality and integrity.

A possible solution for confidentiality would be to upgrade the authentication and authorization mechanism of the EHR system to include a more robust identity and access management solution. Password access to systems can be strengthened by adding additional layers of access or by checking access with directory software. Practices should carefully consider the perimeter around where the data resides.

To increase data integrity, the practice might install an out-of-band warden to watch the file level changes of important files on the system.

In availability, one security step is to limit the locations from which the system can be accessed. If physicians want to be able to access the system from out of the office or while traveling, a restriction at least can be placed on the countries from which the system can be accessed.

To protect their information, practices should consider:

- Know where information resides. What protections are in place?
- Designate someone as the security officer with specific responsibility to know and understand all security procedures and processes.

- Have clear procedures in office about who has access to what.

With a move to cloud computing, the security profile of the organization looks different than before; the risks are different and a decision must be made. Pursuant to the risk management framework adopted by the organization, the security officer has to make a decision on accepting the risk or mitigating the vulnerabilities to regain some balance on the confidentiality-integrity-availability triad.

The classic health-care enterprise environment is modeled as a multi-tier system that consists of multiple data access or management parties, including data service providers, business users, data custodians and other end users. The EHR has to provide role-based access control for the various stewards of the service provider. Protected health information is constantly created, altered and used. Misconfiguration can lead to data leakage and loss; thankfully, this issue is not compounded by moving to a cloud computing platform.

Concerns about data loss will be the same regardless of the underlying platform. On the other hand, moving to cloud computing will fundamentally change the approach to security risk assessments. The scope for incident response, contingency operations and disaster response planning is widened considerably, each becoming areas of critical focus. The needs of the service provider must be carefully assessed and weighed against the potential offerings of the cloud computing provider to be sure that the approach to information security is consistent with the objectives of the risk management framework.

The cloud is a fantastic opportunity to add infrastructure and availability to your practice, but it doesn’t come free. You should consider a strong risk management framework to make it secure. Cloud technology has many benefits and is the direction of the future. As you use the cloud, take steps to ensure the security and integrity of patient data.

Montez Fitzpatrick is Director of Information Security and Compliance with Keystone IT. He can be reached at mfitzpatrick@keystone-it.com. The firm’s website is http://keystone-it.com.

References
Physicians embrace many forms of technology—smartphones, tablets, Twitter and the latest medical devices. But there’s one form of technology they remain at best lukewarm over—electronic health records.

With federal Meaningful Use guidelines in place and greater outcome-based reimbursement on the way, EHR is a way of life in medical practice. A recent online poll of SLMMS members finds that physicians continue to be dissatisfied with EHR systems.

Physicians and experts also are exploring why this dissatisfaction exists and what can be done to improve EHR systems.

**Difficult to Use, Interfere with Patient Interaction**

Among the 34 SLMMS members responding to the poll conducted at the end of April, 51% were dissatisfied or very dissatisfied with their systems. Only 24% were satisfied and none were very satisfied. In addition, 90% of respondents agreed or strongly agreed with the statement that “the EHR has many features that are not user-friendly.”

These results mirror those of national surveys. In a July 2014 Medscape survey, 38% of physicians reported that EHRs worsen patient service and 35% said they worsen clinical operations. A 2013 AMA-RAND Corporation physician satisfaction survey identified EHRs as a major source of physician dissatisfaction and sparked an AMA initiative resulting in a September 2014 set of recommendations for improving EHR systems.

While computerization has made work more efficient in most occupations, that is not the case with EHR. When asked if the EHR allows them to manage and complete tasks more efficiently, 60% of SLMMS members disagreed or strongly disagreed. A total of 67% said their productivity has decreased since installing the EHR, and 23.5% said their productivity has decreased by more than 20%.

A frequent complaint of physicians is the extra time required to enter notes. Nearly two-thirds of poll respondents (65%) said they spend additional time after hours completing charting due to the EHR. The average amount of time spent is one to two hours.

Another issue with EHRs is how they interfere with face-to-face interaction with the patient, with a total of 86% of SLMMS physician respondents agreeing or strongly agreeing that EHRs interfere. A small percentage (18%) attempt to alleviate this at least sometimes by using a scribe to assist with information entry during appointments. Said one general practitioner, “I can’t afford the EHR, how can I afford a scribe?” Another cautioned that the scribe should be knowledgeable and accurate with coding in the specialty.

Those responding to the survey were divided equally among various practice settings—24% independent solo practice, 26% independent group practice, 38% in hospital-employed practice, and the remainder in universities and other settings. Most (35%) have been using an EHR for four to six years. Another 20% have been using systems one to three years, and 20% seven to ten years. Fifteen percent do not use an EHR and generally do not intend to.

Nearly 65% of SLMMS respondents say their practices are complying with Meaningful Use requirements, at least Stage I. Only 24% report they use the EHR to measure quality metrics and monitor care trends across the practice—one of the intended benefits of EHR and something that will become more important as the nation moves toward outcome-based care. One respondent said of the monitoring feature, “This is a necessary piece to have with the reporting/reimbursement methods forthcoming.”

Despite the dissatisfaction, few (15%) are considering changing systems. Respondents cite the time and expense. Those who are employed in hospital systems will use the system provided by the hospital.

**Searching for Solutions**

So why can’t we have an EHR system that’s as easy to use and as intuitive as the iPhone?

“EHRs are designed by computer people to meet government regulations and mandates. They are not designed by the people that actually use them, physicians,” said dermatologist George Hruza, MD, a SLMMS past president. “Most EHRs do not follow the natural workflow of a physician’s practice. This problem becomes compounded in hospital-based EHRs that have to accommodate many providers and physician specialties.”
Added radiologist David Pohl, MD, also a SLMMS past president, “The major problem is that EHRs seem to be designed to optimize data acquisition for statistical purposes. As such, they are NOT designed to reflect how a physician works or thinks. The expectation is that the physician will have to adjust to how the EHRs work, with no concern given as to how the EHRs could be altered to work better for the physician.”

In his new book, *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age*, Robert Wachter, MD, of the University of California, San Francisco discusses a session with the engineers who designed the Boeing 777 cockpit computer. “They would not dream of designing a cockpit and sending it out to be used without having pilots first spend thousands of hours testing with the engineers sitting right behind the pilots, observing,” he said in an interview on the UCSF website.

The AMA issued a September 2014 report calling for improvements in EHR systems. Challenges for EHR systems noted in the report include interference with the patient visit, lack of product modularity to support unique practice needs, increased cognitive workload for physicians, insufficient support for incorporating end-user input into product design, and more.

Said the report, “The ways that EHRs structure information, process data and generate clinical reminders (e.g., "pop-ups") too often detract from physician time with a patient. Inflexible software with cumbersome menus or poor graphical user interface configurations leads to excessive clicking and scrolling which increases the administrative time spent during patient visits.”

Dr. Wachter in his book tells the story of how a teenager at UCSF Medical Center in 2013 nearly died after being given a 39-fold overdose of a common antibiotic as prompted by the EHR system. The nurse had assumed that the EHR’s bar-coding system would prevent improper dosing of medications.

Among the AMA’s recommendations regarding workflow:

- “EHRs should be designed and developed to meet the cognitive and workflow needs of physicians. This involves adhering to proper user-centered design techniques and conducting research to understand how physicians perform their daily work.”

What Some Practices Are Doing

Several practices are incorporating physician input into EHR implementation.

Signature Medical Group, a physician-owned multi-speciality group encompassing more than 130 physicians in 29 practices at 46 locations, standardized most of its practices on a NextGen EHR platform three years ago.

“We sought to minimize the amount of work the physician does in the system,” said Scott Paneitz, chief information officer for Signature. “Physicians are used to being able to dictate and have someone else transcribe. Anything you do with a computer is going to be inherently slower since you have to navigate screens and go through menus. However, we make it possible for the physician to still dictate some of the notes for transcription. At the same time, we are in compliance with Meaningful Use guidelines.”

Metro Imaging, also physician-owned, installed new EHR and radiology picture archiving and communication (PACS) systems in 2013, said Christine Keefe, chief financial officer and director of strategic initiatives.

“The interfaces and flexibility of our two systems have allowed us to create a user-friendly workflow for our staff, and especially our radiologists,” she said. “Our radiologists have everything they need on one screen and no longer have to shuffle papers. We capture patient history electronically using a data pen which stores both as a scanned document and as structured data.”

BJC HealthCare and Washington University Physicians are converting to a new Epic EHR system over the next few years, integrating several systems into a single database, according to a report in the publication *BJC Today*. Physicians have played an active role in the selection process and will continue to work in the conversion process, including documenting clinical workflows.

Interoperability a Concern

Many cite the importance of increasing interoperability between systems, i.e., the ability to share information seamlessly. Among SLMMS members, 58% say interoperability would affect the efficiency and quality of care a great deal.

“The main problem with EHRs is the lack of interconnectivity,” said plastic surgeon Samer Cabbabe, SLMMS president-elect. “I still have to get referring physicians to fax their office notes, then I still have to write new H&P for surgical patients and my orders have to be redone, etc.”

continued on page 14
Signature’s CIO Paneitz suggests that a major issue is arriving at common standards. “It’s a long, hard road to get everyone to use the same terminology. Without standards, doctors are going to be reluctant to use information from sources they are unfamiliar with.”

Mark Gaynor, Ph.D., professor in the Department of Health Management and Policy in the Saint Louis University College of Public Health and Social Justice, said some health-care providers and software vendors are reluctant to exchange data. “From a technical point of view, interoperability is not that difficult. People have to agree on standards. Although I hate to see the government get more involved, it may need to step in and require providers and vendors to share data. Lots of other industries share data. It’s not easy, but solvable.”

He noted an April 2015 “Report on Health Information Blocking” to Congress by the Office of the National Coordinator for Health Information Technology. The report said the ONC has received many reports of health systems vendors charging fees to exchange data, or developing health IT in nonstandard ways that restrict data exchange.

An additional dimension of interoperability is patients being able to have greater access to their health information. Dr. Hruza said, “In the future, EHRs will improve physician efficiency and enhance patient care by more effective and timely communications through a patient portal. This will allow patients to be more involved in their care and as a result improve their clinical outcomes.”

Last year, the ONC released “A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure.” The vision covers interoperability between systems as well as patient access.

A Human Solution or a Technology Solution?

In The Digital Doctor, Dr. Wachter quotes Harvard psychiatrist Ronald Heifetz as describing two types of problems: technical and adaptive. Technical problems can be solved with new tools and practices. Adaptive problems are those that require people themselves to change. Medicine will require both, Dr. Wachter says.

Dr. Gaynor said, “EHRs today do not fit the workflow that is best for the hospital or physician. But physicians also will have to make changes to the workflow to incorporate the system. Like anything, we will go through new iterations. The systems will get better.”

Montez Fitzpatrick of Keystone IT said, “The frustration today is that the systems are not as agile as pad and paper. Technology has not yet reached that point. This problem crosses all domains of computing. Minds beyond the medical community are looking at this.”

Dr. Wachter sees medicine at the start of a digital revolution. “Health care is being utterly transformed into a digital industry and it is now happening at breakneck speed. … But to get there, we are going to have to make some different choices. Those choices are less about the state of the technology and the computer code and more about us: how we organize our work, how we interact with each other and our values. This is our moment where we have the opportunity to hit the reboot button and get it right,” he said in the UCSF website interview.

Who would have known that in 2015 we would carry in our hands a device with as much computing power as a room full of 1970 computers? Or that the bagphone of the 1980s would evolve into a smartphone that provides a limitless encyclopedia to the world, instant communication and the capability to handle wide-ranging transactions?

Anything is possible. Stay tuned.

References


1) The “Stanford” system.

My suggestion:

is definitely a real time saver.

of staffing and may be prohibitive for many hospitals; but it

significantly increase the cost of operating an ER because

also provide this service. However, this arrangement may

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to handle the imagined emergencies so that no one waits

adequately handle the real emergencies and a separate staff

evaluates patients on admission to the ER. They have staff to

and Clinic. Stanford has a “Fast Track and Team Triage” that

One of the best solutions I came across was at Stanford Hospital

with a funeral parlor.

threatening emergency, the final call may be for an appointment

imagined emergencies. If the patient has an unrecognized life-

until the scheduled time. These patients most likely have the

schedule their emergency room visit so they can wait at home

perceived emergencies.

I have serious doubts that these times pertain to the patient-

and the longest wait was 53 minutes (District of Columbia).

There is one hospital in the region that allows patients to

schedule their emergency room visit so they can wait at home

until the scheduled time. These patients most likely have the

imagined emergencies. If the patient has an unrecognized life-

threatening emergency, the final call may be for an appointment

with a funeral parlor.

One of the best solutions I came across was at Stanford Hospital

and Clinic. Stanford has a “Fast Track and Team Triage” that

evaluates patients on admission to the ER. They have staff to

adequately handle the real emergencies and a separate staff to

handle the imagined emergencies so that no one waits long in the ER. There are several hospitals in our region that also provide this service. However, this arrangement may significantly increase the cost of operating an ER because of staffing and may be prohibitive for many hospitals; but it is definitely a real time saver.

My suggestion:

1) The “Stanford” system.

2) Connect all ERs by a computer scoreboard that shows patient volume and estimated wait times. This way, if someone comes to an extremely busy ER, they can be directed to an ER with a much shorter wait time. Unfortunately, there are three factors at the present time that make my solution impossible to achieve:

a) Money: Hospitals are not eager to lose the revenue they make from ER patients and the potential admissions.

b) The “Stanford” system may be cost-prohibitive for some hospitals.

c) Litigation: The Emergency Medical Treatment and Active Labor Act (EMTALA) governs when and how a patient may be refused treatment or transferred from one hospital to another when in an unstable condition. EMTALA is the main disincentive for my solution.

EMTALA requires the ER to provide an appropriate screening exam to determine if the person is suffering from an emergency medical condition when any patient presents for care. If it is deemed an emergency, the hospital is obligated to provide treatment until stable or transfer to another hospital that conforms to the statute's directives. If there is no emergency condition, then the hospital has no further obligation.

I will not cover the pregnant woman in this column. Violation of EMTALA can result in fines up to $50,000 and civil action for damages with no maximum on the liability.

At this time there is not a solution to the long ER wait times. I leave you with the question: Do three-and-a-half hours unattended on a gurney in a hallway 10 feet from a kid with consumption or even two-and-a-half hours in an ER waiting room with a neck injury after a car accident satisfy as being properly evaluated prior to care?

Next time you go to an ER for what you feel is an emergency, be sure to bring a book or movie.
Ob-Gyn Resident/Fellow Research Papers Recognized

On April 21, the St. Louis Ob-Gyn Society held its annual scientific meeting showcasing resident and fellow research papers from the area’s three ob-gyn training programs, Mercy, Saint Louis University and Washington University.

From these peer-reviewed papers, eight were chosen for presentation and the top three papers received awards. Following are excerpts from the abstracts.

For more information, contact Ob-Gyn Society members Andrew Galakatos, MD, (SLMMS), galakatos@wudosis.wustl.edu, or Gilad Gross, MD, ggross@slu.edu.

First Place

Baseline Uterine Tone in Labor: Does it Matter?

Kristina A. Epplin, MD; Molly J. Stout, MD, MSCI; Methodius G. Tuuli, MD, MPH; George A. Macones, MD, MSCE; and Alison G. Cahill, MD, MSCI; Obstetrics & Gynecology, Washington University.

Heather A. Frey, MD, MSCI, Obstetrics & Gynecology, Ohio State University College of Medicine

Objectives

There is limited data regarding uterine tone and labor outcomes. We aimed to estimate the effect of baseline uterine resting tone during labor on adverse neonatal outcomes.

Results

Of 4,890 eligible laboring women, 2,640 women had intrapartum pressure catheters (IUPCs). Of these, 2,640 women, 1,450 (55%) had an elevated resting tone >20 mmHg, and 760 (29%) had a resting tone >25 mmHg. Women with a resting tone >20 mmHg were more than twice as likely to have a 5 minute APGAR <7 (aOR 2.58, CI 1.44-4.61); but, the overall rate was low occurring in 58 (4%) infants. There was no difference in 1-minute APGAR <7, NICU or higher order nursery admission, acidemia, or rate of cesarean. The resting tone group >25 mmHg had higher rates of 1- and 5-minute APGARs <7 (aOR 1.48, CI 1.13-1.94; aOR 3.20, CI 1.95-5.27), but otherwise resting tone >25 mmHg did not impact outcomes.

An analysis comparing all women with either external or internal monitors revealed similar results.

Conclusions

Elevated uterine tone above 20 mmHg and 25 mmHg is associated with abnormal APGAR scores, but not with more clinically meaningful outcomes such as NICU or higher order nursery admission, neonatal acidemia or cesarean delivery. Resting tone alone should not impact a clinician’s judgment on labor management.

Second Place

The Effect of Pyrroloquinoline Quinone on Meiotic Progression in Aged Mouse Oocytes Fed a Control and High-Fat Diet

Violet Klenov, MD; Kasey Reynolds, MD; Emily Jungheim, MD; and Kelle Moley, MD; Ob-Gyn, Washington University

Introduction

It is accepted that the primary cause of decreased fecundability in aging women is an increased prevalence of aneuploidy in oocytes resulting from disordered regulatory mechanisms involving meiotic spindle formation and function. It is possible that reactive oxygen species (ROS) are responsible for these abnormalities. Previous work suggests that supplementing mouse diet with pyrroloquinoline quinone (PQQ) improves reproductive outcomes. Ongoing work suggests that the pathophysiology of the aging oocyte may be similar to the oocyte from an obese model. This study evaluates whether adding PQQ to in vitro maturation (IVM) culture media can increase normal meiotic progression in mice exposed to age alone or to age as well as a high fat diet (HFD). Given the suboptimal rates of normal embryos and clinical pregnancy using in vitro matured oocytes in humans, and the continued epidemic of obesity, this study is particularly relevant.

Results

Chi-square analysis was used to compare proportions of normal versus abnormal oocytes obtained from culture in MII media versus cysteine and MII versus PQQ. No differences were noted. The same comparisons were made for oocytes obtained from mice on the HFD. No differences were noted in oocytes cultured in MII media versus cysteine. There were however significantly fewer abnormal oocytes noted after culture in PQQ supplemented media versus the MII media (p=0.04; OR 0.07, 95% CI 0.007-0.75).

Conclusions

PQQ increases normal meiotic progression in mice exposed to age and HFD. Adding PQQ to IVM media may improve the rate of normal oocytes and therefore improve clinical pregnancy rates in this growing patient population. Further research is warranted.
Third Place

Effect of Salpingectomy on Ovarian Reserve: A Systematic Review and Meta-Analysis

Christina E. Boots, MD; Emily A. Seidler, MD; Angela Hardi, MLIS; Emily S. Jungheim, MD, MSCI, Department of Obstetrics & Gynecology, Division of Reproductive Endocrinology & Infertility; Washington University. Ali Ainsworth, MD, Department of Obstetrics & Gynecology, Mayo Clinic, Rochester, Minn.

Objective

As a treatment for ectopic pregnancy or for excision of hydrosalpinx, salpingectomy is a relatively common procedure performed on patients undergoing assisted reproductive technology (ART). However, shared vasculature in the mesosalpinx raises the question of ovarian devitalization at time of surgery. The effect of salpingectomy on ovarian reserve is not well understood and presents a unique concern in women with already diminished reserve. The objective of this study is to ascertain the impact of salpingectomy on the future fertility of women undergoing ART by evaluating ovarian reserve and ovarian responsiveness in the ART cycle following unilateral or bilateral salpingectomy for the treatment of ectopic pregnancy or hydrosalpinx.

Results

Eight studies and our center's primary data were included, totaling 274 women. No differences were noted comparing pre-salpingectomy in vitro fertilization (IVF) cycles to post-salpingectomy cycles in regards to ovarian reserve parameters or ovarian response as assessed by stimulation duration, total dose of gonadotropins or peak estradiol levels. In addition, there were no differences in oocytes retrieved. A post-hoc power analysis determined that a study of this size would be able to detect an 8.3% difference in oocytes retrieved (1 oocyte) with 80% power.

Conclusions

Our findings support the continued use of salpingectomy in the management of ectopic pregnancy and hydrosalpinges. Primary data is needed to stratify the analysis to determine if women of advanced age or diminished ovarian reserve are at a higher risk of effects from salpingectomy.

Additional Presented Papers

Text Messages and Compliance in Diabetic Pregnant Patients

Dorothea Mostello, MD; Shannon Grabosch, MD; Scott Ballmann, MD; Jeffrey Gavard, PhD; Saint Louis University Department of Obstetrics, Gynecology, and Women’s Health

Objective: The purpose of this study is to determine if the use of text message reminders improves patient compliance and clinical outcomes in pregnancies complicated by diabetes mellitus and gestational diabetes mellitus.

Symptoms and Timing Associated with Mesh Revision After Sacrocolpopexy

Simon P. Patton, MD; Sara C. Wood, MD; Dionysios K. Veronikis, MD; Division of Female Pelvic Medicine and Reconstructive Surgery, Department of Obstetrics and Gynecology, Mercy Hospital St. Louis

Objective: Studies on sacrocolpopexy mesh revision specifically reporting data regarding symptoms and the timing of presentation are limited possibly due to the infrequent incidence. The objective of this study was to describe the chief complaint and the time elapsed since implantation surgery in patients presenting for revision of sacrocolpopexy mesh.

The Maternal Glucose Response to Steroids for Fetal Lung Maturity: The Effect of Gestational Age, Body Mass Index, Maternal Age and Race

Genie Pierson, MD; Jennifer Goldkamp, MD; Jeffrey Gavard, MD; Dorothea Mostello, MD; Saint Louis University

Objective: To determine if the glycemic response in pregnant women who received steroids for fetal lung maturity differed by gestational age, BMI, race, or maternal age.

Like Mother, Like Daughter? A Comparison of Anti-Müllerian Hormone Levels in Sample Pairs of Maternal Serum and Female Neonatal Cord Blood

Emily A. Seidler, MD; Julie S. Rhee, MD; and Amber R. Cooper, MD, MSCI; Department of Obstetrics & Gynecology, Washington University, Barnes-Jewish Hospital. Elizabeth Eklund, BS; Geralyn Lambert-Messerlian, PhD; Brown University, Women and Infants Hospital Providence, R.I.

Objective: Anti-müllerian hormone (AMH) is gaining popularity as an ovarian reserve screen. Nomograms for AMH have been created for healthy populations across the age spectrum. However, the mother/daughter correlation of AMH at the time of birth is unknown. Our goal was to examine this critical time just after fetal oocyte endowment.

Pharmacy Claims Data Versus Patient Self-Report to Measure Contraceptive Method Continuation

Jourdan E. Triebwasser, MD, MA; Stephanie Higgins, BA; Gina M. Secura, PhD, MPH; Qiuqiong Zhao, MS; Jeffrey F. Peipert, MD, PhD; Department of Obstetrics & Gynecology, Division of Clinical Research, Washington University School of Medicine

Objective: To compare self-reported 12-month continuation of oral contraceptive pills (OCPs), patch and ring versus continuation by pharmacy claims data.
Your Goal: Formulating an Investment Plan

Identify your goal and the resources you have available

By Bill Bender, CPA, PFS, MS

Previously I have discussed market timing, active trading, listening to or reading noise, and how to find a proper advisor. The last mistake investors make is to try to put all of the pieces together.

There are certain rules you must follow in order to be a successful investor. Yogi Berra said, “If you don’t know where you are going, you’ll end up someplace else.” You must have a clearly defined investment plan. Most investors invest without any endgame laid out for them. You are at the starting line today. You need to identify an endgame. For example, if you would like to retire at age 62 with a post-tax income of $100,000 per year adjusted for inflation—assuming Social Security will be (in)solvent at the time—and if you save money regularly, it will be easy to project how much money you will have by age 62. You will then be able to determine whether or not you need to adjust your goal. You may find that you are going to need to work longer, or you may find that you will reach your goal ahead of time. In any case, you must have the discipline to keep doing what you are doing consistently.

Cash and Gold Underperform

Cash has historically been the worst performing asset in history. Over long periods of time, cash has always underperformed all other major asset classes. Sure, holding cash as opposed to investing in a stock market that loses value or purchasing gold that loses value is a better investment, but holding cash for long periods of time guarantees that you will not keep up with inflation. Late in 2014, Americans were sitting on more than $3 trillion in cash, the most in history. The cash peak started when the stock market bottomed in 2009, at precisely the worst time. Instead of buying low, which I have preached for years, investors let their emotions get the best of them and were scared out of the market. Since they have yet to see the green light that it is safe to buy, many individuals are still sitting on their cash. Having a short-term reserve is a good idea. The amount of cash reserve you need depends on the amount of money you have, the amount of money you spend, and the security of your job; or if you are retired, your sources of your income. Generally, it is a good idea to have a three- to six-month stash of cash to weather any emergency.

Many of my clients own a certain amount of gold. Gold produces no income and is not a critical resource. Historically, gold has underperformed stocks, real estate and bonds, and has barely kept up with inflation (Fig. 1). During times when it has outperformed other investments substantially, it subsequently collapsed. If you own gold in your portfolio, you face several disadvantages: First, you will not get paid any income as you hold it. Second, if you ever sell it at a profit, you will pay higher taxes (28%) than on a typical capital gain. Finally, you will actually have a more volatile ride than the stock market; and if history repeats itself, receive a lower long-term return than with bonds.

Bonds Are Good Insurance

Bonds can be boring. To me, bonds are sort of like insurance. You give up potential return in exchange for increasing the likelihood that your needs will be met in the short and long term. As you get closer to retirement or are retired, it is a good idea to have cash and bonds that could cover up to five years of living expenses to avoid the scenario of having to draw down on your stock portfolio during a bear market, especially if that were to occur during the first year of retirement.

Determining Asset Allocation

Some investors have too aggressive or too conservative of a portfolio for their actual needs. Someone who can easily retire with $4,000,000—and may already have $3,500,000 by age 55—certainly can afford to be conservative with their investments and hit their goal. If the same individual has $2,000,000 but needs $4,000,000 in order to retire and is age 55, depending on how much he saves per year, he will probably need to have a more aggressive portfolio. As Fig. 2 shows, from 1926 to 2012 the portfolio with 60% stocks and 40% bonds returned 8.68%. This is the prudent-man portfolio held by the vast majority of our retirement clients.
A more conservative portfolio, consisting of 40% stocks and 60% bonds, returned 7.79% during that same time period. Having 20% more stock exposure created an additional return of 0.89% over 86 years. On $1,000,000 that would be an additional $8,900 per year. If you had $2,500,000 and your goal was to get to $3,500,000, if history repeats itself, investing an additional $1,000,000 in stocks could earn you an additional $8,900 per year. If you know you could easily work an additional year before retiring and assuming you make $150,000 per year, $110,000 per year after taxes, you could reduce your stock exposure from 60% to 40% and, if history repeats itself, end up working one more year to amass the same amount of money but perhaps with a lot less worry.

Make sure your assets are in the proper account. Taxable bonds and real estate investments, usually real estate investment trusts referred to as REITs, belong in a retirement account. Investments that can create capital gains like stocks, belong in your taxable account. By simply putting assets in the most tax-efficient location, you can improve your after-tax return. If you are going to buy bonds and taxable bonds pay more than municipal bonds, you could simply put the taxable bonds in your retirement account and purchase mutual funds in your own name. As I write this, a 15-year corporate bond yields 3.19% and a 15-year AA municipal bond yields 2.56%. You could earn an additional 0.63 more, often referred to as 63 basis points, by owning corporate bonds in your retirement plan than with municipal bonds in your own name. On $1,000,000 this would amount to $6,300 per year. Corporate bonds may have more risk than a general obligation municipal bond. You would have to make sure that the credit ratings are the same.

You would only want to buy an investment-grade corporate bond(s). I cannot tell you how many portfolios I see with a huge personal municipal bond portfolio and a tremendous number of mutual funds and/or stocks in the retirement plan. The thought is that stocks and mutual funds will grow faster and that growth will not be taxed until you are forced to make withdrawals from the plan. You will not be forced to pay taxes on equities held in your own name unless you choose to sell those equities. If you sell stocks or funds with a gain inside your retirement plan, you have potentially converted a long-term favorable tax capital gain to ordinary income, most likely paying a higher tax (capital gain tax is lower than ordinary income tax).

**In conclusion:**

- Ignore written and audible noise.
- Do not panic when the market has its sudden burst of volatility.
- Do not change your plans in the middle of what appears to be a crisis because it sure appears that every week we have a new crisis.
- Stay focused on your goals.

Try to measure the return you need against the volatility you can stomach, and realize that reducing your exposure to the stock market may not affect your overall returns to such an extent that if you need to work an additional year you couldn’t end up in the same place.

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**Bill Bender, CPA, PFS, MS, is a partner of Mason Road Wealth Advisors (MRWA) representing the well-respected Dimensional Funds. SLMMS has a special partnership with MRWA, which offers SLMMS members a discounted advisory fee and access to these highly sought funds with a lower minimum investment than commonly offered. For more information, call MRWA at 314-576-1350 or visit www.mrwallc.com.**

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Fig. 2. Source: Data from The Vanguard Group, Inc. 2013b, 10.
Alliance Activities for Spring 2015
By Gill Waltman, SLMMS Alliance

SLMMS Alliance Installation
Millie Bever and Gill Waltman were installed on May 1 as SLMMS Alliance co-presidents for 2015-16. Millie returns after completing two years as co-president with Sandra Murdock. Further information about the officer installation will appear in this section in the August issue of St. Louis Metropolitan Medicine.

Alliance Awarded
The SLMMS Alliance received several awards at the MSMA Alliance annual meeting April 17-19 in Kansas City. These include first place for most donations made to the AMA and Missouri State Medical Foundations, second place in Health for the Smoking is Not for Me contest, and first place for the most miles completed in the Move Across Missouri health competition. Gill Waltman earned a MAM second-place individual award.

Sue Ann Greco to Serve as 2015-16 MSMA Alliance President
Sue Ann Greco was installed as MSMA Alliance president for 2015-16. A past SLMMS Alliance president and active volunteer at the local and state levels, she holds a master’s degree in nursing and manages the medical practice of her husband, Thomas J. Greco, MD.

The MSMA and SLMMS alliances are among the oldest in the nation, both celebrating their 90th anniversaries this year. Sue Ann gave an informed and inspiring speech, talking about the next 10 years when both alliances will be 100 years old. She wants to build the membership over the next decade so there will be strong alliances ready to celebrate a century of serving their respective medical societies.

Incoming MSMA Alliance President Sue Ann Greco, whose theme is Eye on the Future, flanked by members of her newly-installed board of officers, five of whom are from St. Louis. In sunglasses, from left: Shirley Collison, Sandra Murdock, Diana Corzine, Jana Wolfe, Sue Ann Greco, Gill Waltman, Marsha Conant, Millie Bever and Angela Zylka.

Alliance Antiviolence Programs Stay Strong
Alliance activities for the national SAVE (Stop America’s Violence Everywhere) program continued this spring. Programs include Hands are Not for Hitting, and Smoking is Not for Me. Sixth graders at Loyola Academy participated in the antismoking contest organized by Angela Zylka. Sandra Murdock conducted a timely AMA-sponsored program for second-graders called I Can Be Safe at Cool Valley Elementary School in the Ferguson-Florissant district, along with the goal-oriented program I Can Be... at a St. Louis charter school.

Further information on the above Alliance events is available at www.slmms.org in the Alliance section.
MD News

- Pediatric surgeon Martin Bell, MD, (SLMMS), has been appointed chairman of the Mercy Kids board of trustees. Mercy Kids comprises more than 700 pediatricians and family doctors in partnership with 125 pediatric specialists serving children in Missouri, Arkansas, Oklahoma and Kansas. Dr. Bell is one of the founding pediatric specialists at Mercy Children's Hospital St. Louis.

- Scott W. Fosko, MD, has been named interim director of Saint Louis University Cancer Center. Dr. Fosko joined the faculty of SLU School of Medicine in 1993 when he created the first Mohs Surgery and Cutaneous Oncology program.

- James Bleicher, MD, has been appointed president of the SSM Health Physicians’ Organization in St. Louis. He most recently was president and CEO of the employed physician group at Pinnacle Health System in Harrisburg, Pa.


Hospitals

- Just 46 months after the May 22, 2011, F-5 tornado devastated Joplin, Mercy in March opened its new Mercy Hospital Joplin. The structure incorporates a variety of tornado safety features including a window and frame system that can protect its most vulnerable patients from winds up to 250 miles per hour, as well as a concrete roof, fortified “safe zones” on every floor and half-buried generators away from the main building. The $465 million, 900,000-square-foot facility includes a nine-story hospital patient tower and five-story clinic office.

- The former Mineral Area Regional Medical Center in Farmington is now operating as part of BJC HealthCare's Parkland Health Center after its acquisition by BJC. Mineral Area has 127 beds; Parkland has 100. The 25-bed Lincoln County Medical Center in Troy became part of Mercy effective March 1.

Research

- New research at Washington University School of Medicine highlights how nerves—whether harmed by disease or continued on page 23

Are your financial investments looking a little thin?

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Angelo A. Speno, Sr., MD

Angelo A. Speno, Sr., MD, specialist in internal medicine and occupational medicine, died Dec. 12, 2014, at the age of 89.

Born in St. Louis, Dr. Speno received his undergraduate degree from University of Missouri. He earned his medical degree from the University of Louisville in 1955.

Dr. Speno served in the U.S. Army during World War II with the 12th Armored Division. After several years of private practice, he served as corporate physician for the Chrysler Corporation in St. Louis.

Dr. Speno joined the St. Louis Metropolitan Medical Society in 1959, and became a Life Member in 2008.

He was preceded in death by his wife, Mary Lea Speno. SLMMS extends its condolences to his son, Angelo Speno, Jr., and his daughter-in-law, Christine.

James C. Redington, MD

James C. Redington, MD, board-certified in internal medicine, died March 21, 2015, at the age of 86.

Born in Galesburg, Ill, Dr. Redington received his undergraduate degree from the University of Notre Dame, and graduated from Saint Louis University School of Medicine in 1950. He completed his training at the former Firmin Desloge Hospital, and served in the U.S. military from 1951 through 1953.

Dr. Redington served on staff at SSM St. Mary’s Health Center for more than 50 years, and on the faculty of Saint Louis University School of Medicine.

Dr. Redington joined the St. Louis Metropolitan Medical Society in 1956, and served on the SLMMS Council from 1985-1987. He was made a Life Member in 2013.

He was preceded in death by his wife, Estelle Marie Redington. SLMMS extends its condolences to Dr. Redington’s children, Kathleen Redington, MD; Ann Imgrund; Patricia Miriani; James C. Redington Jr., MD; Nancy Vigland; Barbara Redington and Colleen Scott; his 10 grandchildren and four great-grandchildren.

Robert E. Ryan, Sr., MD

Robert E. Ryan Sr., MD, board-certified in otolaryngology, died March 30, 2015, at the age of 97.

Born in St. Louis, Dr. Ryan received his undergraduate and medical degrees from Saint Louis University. He served his internship at Mercy Hospital St. Louis and residency at the Mayo Clinic.

Dr. Ryan was in private practice and served on the faculty of Saint Louis University School of Medicine. He co-founded the American Headache Society, and was the founding editor of its journal.

Originally a member of the Olmsted-Houston-Fillmore-Haddon-Carryer County Medical Society in Rochester, Minn., Dr. Ryan transferred his membership to the St. Louis Metropolitan Medical Society in 1947. He became a Life Member in 1985.

Dr. Ryan was preceded in death by his first wife, Eunice Mondelle Burtt Ryan, and his second wife, Madonna Kay Miles Ryan. SLMMS extends its condolences to his children, Robert E. Ryan Jr. MD, and Ronald Ryan; three grandchildren and five great-grandchildren.

Robert J. O’Connor, MD

Robert J. O’Connor, MD, board-certified in family practice, died April 18, 2015, at the age of 88.

Born in New Rockford, N.D., Dr. O’Connor received his undergraduate degree from the College of St. Thomas in St. Paul, Minn. He graduated from Saint Louis University School of Medicine in 1952. He practiced medicine in Windsor, Colo., from 1953-1955, then served in the Navy as an electronics technician instructor before returning to practice in St. Louis.

He was in private practice and served on staff at Christian Hospital. He was also a lifelong member of the Missouri Academy of Family Practice.

Dr. O’Connor joined the St. Louis Metropolitan Medical Society in 1955 and became a Life Member in 1994.

SLMMS extends its condolences to his wife Teresa O’Connor, and children, Susan Overkamp, Mary Openlander, Daniel O’Connor, Tim O’Connor, and Anne Rust, as well as his grandchildren and great-grandchildren.
Richard F. Huck, Jr., MD

Richard F. Huck, Jr., MD, board-certified in gastroenterology, died on April 26, 2015, at the age of 91.

Born in Quincy, Ill., Dr. Huck received his undergraduate degree from Notre Dame University. He earned his medical degree at Washington University School of Medicine, and served as an intern at St. Joseph’s Hospital, Milwaukee and St. Louis City Hospital. He completed his residency in gastroenterology at Ohio State University.

Dr. Huck served as a medical officer for the 101st Airborne Division of the U.S. Army during the Korean War. He served on staff at Mercy Hospital St. Louis, Missouri Baptist Hospital and St Luke’s Hospital, and was a faculty member of Washington University School of Medicine.

In 1952, Dr. Huck joined the St. Louis Metropolitan Medical Society. He became a Life Member in 1999.

Dr. Huck was preceded in death by his wife, Agnes (Dolly) Huck. SLMMS extends its condolences to his children, Richard F. Huck III, Margaret Picou and Paul D. Huck, and his four grandchildren.

Ralph V. Gieselman, MD

Ralph V. Gieselman, MD, board-certified in gastroenterology, died on April 26, 2015, at the age of 91.

Born in St. Louis, Dr. Gieselman received both his undergraduate and medical degrees from Washington University. His internship and residency were completed at Barnes Hospital and Washington University School of Medicine, where he also served on the faculty.

Dr. Gieselman served in the U.S. Army in World War II and the Korean War. Following his military service, Dr. Gieselman became chief of medicine at the Cochran Veterans Administration Hospital. A year later, he went into private practice until his retirement.

Dr. Gieselman joined the St. Louis Metropolitan Medical Society in 1954 and became a Life Member in 1990.

He was preceded in death by his wife, Betty Lou Gieselman. SLMMS extends its condolences to his children Linda, Andrew, Gwen and Gaye; his two grandchildren; three step-grandchildren and two great-grandchildren.

Frank J. Niesen, MD

Frank J. Niesen, MD, a surgeon, died May 6, 2015, at the age of 95.

Born in Cincinnati, Ohio, Dr. Niesen received his undergraduate degree from Xavier University, and graduated from the University of Cincinnati School of Medicine in 1945. He served his internship at Good Samaritan Hospital in Cincinnati, and his surgical residency at Missouri Baptist Hospital from 1948-1951.

Dr. Niesen served as a captain in the U.S. Army Medical Corps from 1946-1948. He served on staff at the former Incarnate Word Hospital including chief of staff.

Dr. Niesen joined St. Louis Metropolitan Medical Society in 1951, and became a Life Member in 2009.

He was preceded in death by his first wife, Norma Niesen. SLMMS extends its condolences to his wife, Loveda Niesen; children, Frank Niesen Jr.; Thomas Niesen, MD; Kathy Niesen; seven grandchildren, and three great-grandchildren.

Newsmakers  continued from page 21

traumatic injury—start to die, a discovery that unveils novel targets for developing drugs to slow or halt peripheral neuropathies and devastating neurodegenerative disorders such as Alzheimer’s disease, Parkinson’s disease and amyotrophic lateral sclerosis (ALS). The research, led by Jeffrey Milbrandt, MD, PhD, the James S. McDonnell Professor and head of the Department of Genetics, was reported online April 23 in the journal Science. As part of the study, the researchers showed they could prevent axons from dying, a finding that suggests therapies could be developed to counteract the withering away of nerve axons. Peripheral neuropathy damages nerves in the body’s extremities and can cause unrelenting pain, stinging, burning, itching and sensitivity to touch.

Researchers at Washington University School of Medicine have uncovered a unique connection between diabetes and Alzheimer’s disease, providing further evidence that a disease that robs people of their memories may be affected by elevated blood sugar. While many earlier studies have pointed to diabetes as a possible contributor to Alzheimer’s, the new study—in mice—shows that elevated glucose in the blood can rapidly increase levels of amyloid beta, a key component of brain plaques in Alzheimer’s patients. The buildup of plaques is thought to be an early driver of the complex set of changes that Alzheimer’s causes in the brain. The research was published May 4 in The Journal of Clinical Investigation.
Hooray! The SGR Formula is dead! The paralyzing, resource-draining threat of drastic Medicare payment cuts that has plagued physicians and legislators since 2002 was finally banished on April 16 when President Obama signed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) into law. Supported by every physician and hospital organization, the package extends funding for the Children’s Health Insurance Program (CHIP) for two years and provides a 0.5% pay increase for physicians each year until 2019, allowing transition to a new payment system.

Shift to Value-Based Reimbursement Models

While the Affordable Care Act and the various payment models it created set Health and Human Services’ intentions to move away from straight fee for service payment models into play, in a press conference on Jan. 26 of this year, HHS Secretary Sylvia M. Burwell announced clear goals and a timeline to move the Medicare program toward paying providers based on the quality, rather than the quantity of care they give patients.

Secretary Burwell’s plan was embodied in MACRA, which consolidates existing quality reporting programs and incentivizes Eligible Providers (EPs) to move into one of two new payment models: The Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM). Under MACRA, EPs will receive a 0.5% reimbursement increase each year until 2019.

In 2019, EPs that have tied at least 25% of their Medicare revenue to alternative payments would then be eligible for increased reimbursement.

Those providers who do not meet that threshold will see their payment rates freeze for six years, and for the purpose of brevity, payments after 2025 will not be addressed in this article.

While all existing Medicare quality reporting programs and any current penalties or bonuses will sunset at the end of 2018, they are currently in effect, so providers need to continue participating in them.

With their eyes on the viability prize, and with the help of their practice managers, Eligible Providers must take advantage of these next few years’ reimbursement stability and:

1. Evaluate their practices and improve operational efficiencies.
2. Implement patient-centric processes, which will in turn improve all medical practice Key Performance Indicators (KPIs).
3. Accept the value of, and comply with, Evidence Based Medicine guidelines in their practices.
4. Access their CMS QRUR Reports* to identify and work on areas needing improvement. The Medical Group Management Association (MGMA) offers many tools to assist this effort, which will pay off under both current and future payment models.
5. Educate themselves about the new value-based payment models (MIPS and APMs), choose which track they will participate in, and work to meet the thresholds.
6. Participate in advocacy efforts to shape the new payment models.
7. Adopt and embrace the technology that will assist them to accomplish all of the above.

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Kathleen McCarry is Vice President of Practice Advocacy for MGMA of Greater St. Louis. She is also a Senior Health Care Consultant with Anders CPAs & Advisors. Questions about the article can be directed to Kathleen at 314-518-0713 or kmccarry@anderscpa.com.

SLMMS-MGMA PARTNERSHIP

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

A QRUR is a CMS report that provides information to physicians and group practices about the resources used and quality of care provided to their Medicare Fee-For-Service patients as compared to performance among similar physicians or groups. Data included in this report is used in calculating the Value Modifier for physicians. Learn more: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html.

CMS Creates Health Care Payment Learning and Action Network: In an unprecedented effort to shift the payment paradigm of the health-care system at large, earlier this year HHS created the Health Care Payment Learning and Action Network, via which HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. For more information about HHS’ ‘Better, Smarter, Healthier’ initiative, including the Learning and Action Network, visit http://www.hhs.gov/news/press/2015pres/01/20150126a.html.

St. Luke’s Hospital Residency in Internal Medicine is looking for a part-time physician clinician-educator, specializing in Internal Medicine, to assist the clinic director in the operation of the resident continuity clinic and contribute to the innovative growth of our residency. The position is primarily outpatient ambulatory teaching and precepting in a St. Louis public health center for the medically underserved, staffed Monday through Friday afternoons from 12:30-5 p.m. Physicians are assigned by the week and share the position, working 10-20 weeks per year.

For further information, contact Fred Balis, MD, Program Director, at Fred.Balis@stlukes-stl.com or 314-205-6050.
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