DISPARITIES IN HEALTH

Inside

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Affordable Care Act 2015

By Richard J. Gimpelson, MD

I did a search on the Internet before Net Neutrality becomes the controller of the Internet to see how the Affordable Care Act (ACA) will affect our medical care and pocketbooks in 2015. I reviewed articles by a number of columnists and will list each by name and the issues they describe.

The Bad News

Scott Gottlieb, MD (Twitter @ScottGottliebMD):
Insurers will be forced to be all in or all out of a particular state exchange. The result is Aetna is offering health plans in just eight states. Cigna only entered five states. Humana only went into 14 states. Only one or two insurance carriers are serving exchanges in more than half of this country’s 2,500 counties. This all or none will discourage many of the plans that sat out of the market in 2014 from entering in 2015, and some with plans in the market may drop out of some states.

Exchange plans are not subject to federal anti-kickback rules. Thus, third parties such as drug companies and hospitals can assist patients in paying the cost of health plan premiums and offset drug co-pays. This sounds good and can help the young and poor purchase entry level coverage. The unintended consequence is that many unhealthy people enter the plan with this assistance, but not healthy people who do not utilize a large portion of the medical dollar. In addition, the subsidizing drug companies may encourage the use of their expensive medicines. All of this puts a large financial burden on the insurance companies who may actually drop out because of deficit spending. (They do not have the luxury of the federal government to just raise taxes and print money to cover the deficit).

The ACA will become a risk pool for the sick and poor. The young and healthy will gravitate to the cheaper bronze plans, thus reducing income to the insurance companies.

It is hard to feel sorry for the big insurance companies since they have been able to pass most of their new costs to consumers and in their greed made a Faustian bargain in supporting the ACA, thinking it would boost their income. (All this—thanks to Medicine’s “Man of the Year,” Jonathan Gruber.)

Sally Pipes (President, CEO and Taub Fellow in Health Care at the Pacific Research Institute):
Because of an accounting glitch, the ACA overpaid up to 3.4 million Americans to help them buy subsidized health insurance. Now they will have to pay back the IRS when they file their taxes.

continued on page 8

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 SPRING

Whoever wants to know the heart and mind of America had better learn baseball . . .

- Jacques Barzun

Spring is the season for baseball in St. Louis. Those who live in and around this city are not so much citizens as they are fans. One cannot talk to someone here without mentioning the Cardinals, no matter what the reason for their meeting. Baseball is almost a religion. People dress up in team paraphernalia to go to work or out to dinner. So I won’t talk medicine or life lessons or even how beautiful the spring flowers are at this season. No, I’ll just dust off my cotton cap and trade it for my wool cap that I wore during the cold weather. I’ll make note of the home games and begin the vigil for the pennant chase. Go Cards! –

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.
Cover Feature: Health Disparities

Health Disparities in St. Louis
Studies show African-Americans continue to have worse health outcomes

Regional Cooperation Needed to Resolve Health Disparities
Candid discussion and accountability called for to reduce fragmentation, address health access and social factors that influence health
By Will Ross, MD, MPH, Washington University School of Medicine

When Treatment Doesn’t Lead to Healing
How trauma and toxic stress impact health
By Fred W. Rottnek, MD, MAHCM, Saint Louis University School of Medicine

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MGMA of Greater St. Louis ➞ By Diane S. Robben, JD, with Denise Bloch, JD
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An Important Day as Physicians Advocate for Tort Reform

Michael J. Stadnyk, MD, Medical Society President

Our mission as the St. Louis Metropolitan Medical Society is to “support and inspire member physicians to achieve quality medicine through advocacy, communication and education.” In the last issue of St. Louis Metropolitan Medicine, I discussed the importance of communication—one of the pillars of our mission—to the physician-patient relationship. Advocacy is also part of our mission and is just as important to the physician-patient relationship. Advocacy is defined as public support for or recommendation of a particular cause or policy. As it applies to SLMMS and medicine, it pertains to a political process by a person or group which aims to influence certain decisions within political, social and economic systems and institutions.

On Tuesday, February 24, we had the opportunity to become advocates for the medical profession and lobby at the Capitol in Jefferson City for tort reform. The issue of tort reform has become a hot topic in medicine since the cap on non-economic damages in medical malpractice cases was overturned by the state Supreme Court in 2012. Over 100 physicians from around the state gathered in the Capitol for a busy day of lobbying and advocating.

I personally spoke with Representatives Keith Frederick, DO, of Rolla; Diane Franklin of Camdenton; Don Gosen of Ballwin; and Eric Burlison of Springfield. All four of these representatives are pro-tort reform and are working hard to replace the cap on non-economic damages with new legislation. I admire these individuals who have respect for us and our patients. I heard from these four and other representatives about how much of an impact we made by being there. Hearing that legislators took notice that we were there was a far cry from the comments I heard two years ago when one representative said to me, “If tort reform is so important to you all, where are all of the doctors?”

After arriving in the rotunda, we gathered in the House Lounge (also known as the Thomas Hart Benton room) and heard comments from House Speaker Rep. John Diehl. We also heard from the sponsor of the bill, Rep. Eric Burlison. At the end of Rep. Burlison’s statement I asked to make a statement of my own. I asked the representatives to remind their cohorts that just as they are representatives of their constituents back home, we are representatives for our fellow physicians at home. It is not the number of White Coats that should make a difference, but the fact that over a hundred of us gave up a day of work—and a day to care for our patients—to show our representatives that tort reform matters. Lastly, Rep. Keith Frederick, DO, offered his encouragement and advised us about how to talk to our representatives. We then took to the halls to visit our respective legislators. The lunch break allowed us time to visit with our fellow White Coats from around the state.

After lunch, we attended the Senate Small Business, Insurance, and Industry Committee.
meeting to hear testimony on SB 239, the Senate version of our tort reform bill. The Senate bill was sponsored by Sen. Dan Brown of Rolla. The chamber room was standing-room-only due to the presence of the White Coats. Four physicians, including our own Ravi Johar, MD, gave excellent testimony in support of the bill. Of course, the only opposition to the bill came from two trial attorneys.

I find some of the statistics about tort reform that were presented worth mentioning. You can see these and more at www.showmetortreform.com.

- Between 2002 and 2005 when Missouri had ineffective caps on non-economic damages, the number of insurance companies writing policies in the state dropped from 32 to 8.
- 27% of physicians stopped performing high risk procedures or seeing high risk patients.
- 49% of physicians admitted that insurance costs caused them to cut staff positions.
- 28% of physicians were compelled to forego updating or acquiring new technology.
- Among neurosurgeons, 53% refused to accept Medicaid patients, 23% refused to see Medicare patients, and 66% reduced the services they could otherwise provide to their communities.
- By 2004, 1 in 10 ob-gyns quit practicing obstetrics due to insurance costs. One ob-gyn I talked with said he was paying at the time, $110,000 a year for a malpractice premium, forcing him out of the obstetrical business.

Between 2005 and 2012 when the state had effective caps in place, Missouri gained approximately 1,000 physicians. There had been a $44 million decrease in written liability insurance claims. The number of claims had dropped 47%. The average indemnity on paid claims fell 20%.

The state of Missouri boasts several excellent training hospitals, not limited to but including: Saint Louis University Hospital, the Barnes-Jewish Hospital system, Mercy Hospital and St. Luke’s Hospital in St. Louis; the University of Missouri-Kansas City, the Kansas City University of Medicine and Biosciences and Saint Luke’s Health System in Kansas City; and the University of Missouri-Columbia and the Kirksville College of Osteopathic Medicine. Unfortunately, the state also is one of the nation’s leaders in export of physicians.

The disparity in malpractice premiums is certainly a contributor to the problem. I know our detractors really don’t care how much we collectively pay in malpractice premiums. They should however care about the effect of exporting our physicians. The real problem becomes what one button on White Coat rally day described as “CRITICAL CONDITION—Patient access to care.” I would hope that all senators and representatives in Jefferson City care enough about their constituents at home to do the right thing.

On February 24, I believe we made a difference. I was told our presence was noticed. I was honored to be in the company of so many fellow physicians fighting for the same cause. I am humbled to be your advocate. I would like to thank all of the people involved in making the 2015 White Coat Rally day successful.

On another note, the “Vesalius and the Invention of the Modern Body” conference was held in St. Louis Feb. 26-28. SLMMS, through the St. Louis Society for Medical and Scientific Education, was a sponsor for the session titled, “Mapping the Interior: 3D Anatomy Demonstration.” The presentation was held in the former Medical Society building on Lindell which is now owned by Saint Louis University.

I was able to make some remarks prior to the presentation, then settled in for a lecture and 3-D presentation subtitled, “A Fabrica-Guided Neo-Vesalian Public Dissection of the Brain Ventricular System 500 Years Later at Saint Louis University.” SLU faculty member Solomon Segal, MD, entertained the audience for the next hour performing the dissection as Vesalius himself would have 500 years previously. The whole event was sponsored by Washington University and Saint Louis University, and they both should be proud. I only wish I could have been able to attend the entire conference.

I welcome your comments and questions. Reach out to me at docstads2@yahoo.com. Thanks for reading.
Reaffirmations and Renewal

David M. Nowak

The first quarter of the year is a busy time in the Medical Society office, but even more this year. The annual cycle kicks off with the January installation banquet and moves quickly to a new Council being seated, committee appointments, and the yearly process of preparing resolutions for the April MSMA convention. This year, your Medical Society also is bustling with a variety of other member educational activities and services that keep our plates full, but deliver more to you.

For starters, we have completed the successful launch of the Physician Leadership Institute running from February through May. Early in the process, when we were just initiating the planning of this program with our partner, Anders Health Care Services, if you would have told me we would have 26 physicians who would commit to giving up five Saturdays in their busy schedules for this brand new course, I would not have believed it. But that’s exactly what has occurred—a fully-enrolled program the first time out of the box.

We have been fortunate to attract a diverse group of physicians representing a number of different specialties, including five doctors from outstate Missouri. As I write this column, we have completed the first two sessions, and the level of engagement and the spirited discussions that are taking place have been inspiring. For many, this is new information, coursework not covered in their medical school education. For others, it’s a refresher course, or a new spin on a previously-explored topic. For all, it’s a reaffirmation of their commitment to the business side of practicing medicine, and to addressing the always changing landscape of rules, regulations, and policy that can be challenging.

This program is yet another benefit of your Medical Society membership, and a fulfillment of one of the objectives of the SLMMS strategic plan. I am thrilled it’s been a huge success, and plans are underway to offer it again in the not-too-distant future.

Another reaffirmation was witnessed in late February when a spirited group of physicians from across Missouri descended upon Jefferson City for the annual White Coat Rally for tort reform. Though the crowd was smaller than in past years, the experience was nonetheless worthwhile, with doctors getting face time with legislators to influence the debate on why tort reform is necessary to protect the practice of medicine in Missouri. The visit was well-timed, as we were able to attend a Senate hearing on one of the bills. The outlook is more optimistic than in past legislative sessions, but it’s still important for your elected officials to hear your voice. Visit ShowMeTortReform.com to connect with your legislator and for talking points to keep this battle brewing in the State Capitol.

Let me take a moment to remind you of the many extra benefits your SLMMS membership affords you. One of these, the discounted scribe services benefit offered by Medi Globe America, is discussed more fully elsewhere in this issue on page 11. This benefit has been both updated and enhanced, with new pricing packages, but more importantly, the addition of coding services, which can be purchased independent of the virtual scribe. If your practice is feeling the crunch of the impending ICD-10 implementation, or you want usage of your EHR to be more productive, I encourage you to look more closely at this benefit. Just an hour or more spent with their team in a no-obligation demonstration could help you discover enhanced patient and physician satisfaction while improving efficiency.

Finally, as I write these words the temperature outside has topped 60 degrees for several days in a row. The snow has melted away,
and spring—the season of renewal—is definitely in the air. We also can see the reaffirmation and renewal around the Medical Society.

To continue our good work, another type of renewal also is important—membership renewal. Membership is the lifeblood of the Medical Society. After March 1, unpaid dues are considered delinquent and we begin the process of contacting members urging them to renew their commitment to organized medicine. If you have not yet made that commitment, you could help the process tremendously by contacting us to renew as soon as possible.

If you’ve already renewed your membership for 2015, we thank you. But I ask you to think about a colleague who might want to join us in our reaffirmations of all things important in organized medicine—advocacy, education and communication—and encourage them to join SLMMS today. Remember, together we are stronger.

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**SLMMS Members: Save Big on Muny Season Tickets**

Again this year, SLMMS members can save big and enjoy great outdoor musical theater under the stars when you purchase season tickets through The Muny Corporate Advantage Program. With a discount of more than 10% on season tickets, combined with the savings compared to purchasing single tickets, SLMMS members can receive the equivalent of three shows free. It’s the lowest price you’ll find on Muny season tickets to seven great musicals, including “My Fair Lady,” “Hairspray,” “Into the Woods,” and more.

The discount is easy to obtain. Use the special promo code **SLMMS15CA** when ordering your tickets by phone, online or in person at The Muny box office. The code is good on new season ticket subscriptions only when purchased between April 6 and May 4, and is not retroactive to prior season ticket purchases or renewals, and may not be used for individual ticket purchases. Corporate Advantage season tickets are limited to Terrace A and Terrace B seats only.

Visit www.muny.org to see the complete 2015 lineup of shows, dates and ticket prices. If you have questions about the discount program, contact Bill Borger at The Muny at 314-595-5762 or bborger@muny.org.
The employer mandate took effect on January 1, 2015, and now all companies with 100 or more full-time employees must offer health insurance to at least 70% of their workers. Next year the mandate must cover 95% of employees of companies with 50 or more workers. Time will tell if employers cut employee working hours to part-time. In addition, employers have increased the amount of outsourced work done. If the insurance offered is considered unaffordable or not generous enough according to the ACA, the company pays $3,000 per employee who gets exchange subsidies or $2,000 per employee, whichever is less.

The Congressional Budget Office predicts fines of $139 billion in the next decade. This is a lot of money that could have been used to hire more employees or raise wages. The individual mandate for people who didn’t buy health insurance will have a penalty of $325 per adult and $162 per child or 2% of taxable household income, whichever is greater.

Forty-one percent of primary care physicians either refuse to see Medicaid patients or limit the number they treat because of the ACA low payment rates.

Edward Morrissey (The Fiscal Times) is a senior editor at the blog Hot Air, part of a group of conservative publications:

The healthcare.gov website continues to have problems. Consumers who get married, divorced, or have children between the end of enrollment and the next enrollment period will find making changes a convoluted multi-step process.

Estimated enrollment is somewhere between 9.5 million and 11.4 million people. Compare this to 30-48 million uninsured for which the ACA was made into law. It does not demonstrate a great help for the many uninsured. According to research done by the Kaiser Foundation, no more than 5.4 million uninsured are actually included in the 9.5-11.4 million new enrollees. Thus, nearly half of the new ACA enrollees already had insurance prior to the ACA.

People who have insurance outside of the ACA may have to file Form 1095-A to certify that they have suitable health insurance that meets the ACA mandate. If one doesn’t have insurance, they have to file Form 8965. (Lucky for me, my employer, Mercy Hospital, satisfies the ACA and there is a good possibility my W-2 will satisfy the IRS).

The Good News

Will the Fox Poll results of the ACA be good or bad for the United States? The results showed a 47-47 tie for good versus bad. This is an improvement from 2014 when the vote was 51-42 bad versus good. (I guess this is good news considering what the administration thinks of Fox News).

Over 1.1 million people switched to a different ACA plan (I guess this is good news). Unfortunately, good news is hard to find since most of the good news articles are predictions and not facts (not very valid information).

In addition, much of the information listed when I searched “Good News for Obama Care in 2015” was actually bad news. Don’t worry! As President Obama said many times, “If you like your doctor, you can keep your doctor, period! If you like your health insurance, you can keep your health insurance, period!”

Do not forget: Jonathan “Honest John” Gruber for Medicine’s “Man of the Year.”

CALENDAR

APRIL

SLMMS Council, 7 p.m. 14
MSMA Annual Convention, Kansas City 17-19

MAY

SLMMS Council, 7 p.m. 12
Memorial Day, SLMMS office closed 25

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A large group of physicians from across Missouri spent Feb. 24 at the Missouri Capitol contacting legislators during the annual White Coat Rally organized by MSMA and the Missouri Tort Reform Coalition. Physicians seek to restore reasonable limits on non-economic damages in malpractice cases. As of March 17, this legislation (SB 239) has passed the Senate and been sent to the House where it still must go through a committee process and two floor votes. Other major physician-related legislation would prohibit the state from requiring maintenance of certification as a condition of medical licensing (SB 400 and HB 683); this has been heard in committee so far. If you were not able to attend the rally, you can still support both of these important pieces of legislation by contacting your state representative and state senator.
Physician Leadership Institute Fills First Class

The inaugural Physician Leadership Institute (PLI) launched in February with a full class of 26 physicians. A partnership between SLMMS and Anders Health Care Services, the five-session educational program focuses on the business side of medical practice, with the objective of helping doctors build their leadership and management skills.

The first two sessions have included highly-interactive programs on the future of health care, physicians as board members, successful IT strategies, legal issues and compliance, effective revenue cycles and much more.

Several of the class participants offered their perspectives on why they enrolled in the PLI and what they hope to gain from the sessions. Ari Levy, MD, (SLMMS), neurosurgeon, is one of the inaugural enrollees. “I believe the future success of medicine will rely upon collaboration among engaged physicians, hospitals, and payers,” he said. “This class was conceived at this ideal juncture, covering topics that comprise some of the foundations of common-ground cohesion among these parties.”

Steven Shields, MD, (SLMMS) ophthalmologist, agrees. “I enrolled in the PLI because I thought I could learn more about the economic, legal and political factors influencing medical practice,” he said. “The speakers have been excellent; the discussions with other participants invaluable. I don’t know where else I could access these resources.”

Sri Kolli, MD, (SLMMS) internal medicine, adds “leadership is needed to strengthen and focus people to gather talent at various levels, and look at strategy with a vision toward future goals. I have learned from the program that a good leader does this and in the process can make change happen within an organization.”

“I enrolled in order to expand my understanding of the issues surrounding the delivery of health care,” said radiologist and SLMMS Past President David Pohl, MD. “Looking at issues from multiple perspectives hopefully will allow me to negotiate and adjust to today’s reality. I also want a better understanding of how other entities analyze what I do.”

The program continues through early May with sessions on operational excellence, risk management, ethics, and moving our industry forward with physician leadership. Plans to offer the program again later in 2015 or early 2016 have already begun.

Physician Wellness Conference Scheduled for April 25

SLMMS is reviving a popular member program from recent years, the Physician Wellness Conference, scheduled for Saturday, April 25, from 8:30 a.m. to 12:30 p.m. The event will be held in the Emerson Auditorium at St. Luke’s Hospital in Chesterfield.

Specifically designed to help physicians “renew their love of medicine,” presentations will cover resilience, stress management and physician counseling services, along with financial wellness topics including asset protection and the qualified spousal trust. The program, coordinated by SLMMS Councilor Robert A. Brennan, Jr., MD, is offered free of charge to SLMMS members and their spouse/guest. The fee is $25 for all others. Continuing Medical Education credit will be available.

Registration and continental breakfast will begin at 8:30 a.m. followed by three presentations:

- James G. Blase, JD, CPA, LLM, Blase and Associates, LLC
  “Asset Protection Planning for Missouri Residents and the New Missouri Qualified Spousal Trust”

- Jeremy Duke, MA, LPC, Missouri Physicians Health Program
  “MPHP: We Know More Than Substance Abuse”

- Stuart Slavin, MD, M.Ed., Saint Louis University School of Medicine
  “Building Resilience and Coping with Stress in Medical Practice”

Advance registration is requested by Monday, April 20. To RSVP, contact Liz Webb at 314-989-1014, ext. 108, or email lizw@slmms.org.
Medi Globe America, a partner with SLMMS in providing discounted scribe and consulting services to our membership, has recently announced enhancements to the benefits available to SLMMS physicians and their practices.

According to Prahaan Cumarasamy, founder and CEO of Medi Globe, the firm is now providing ICD-10 ready coding and coding review services to its physician clients. They are available at no additional cost to users of their scribe services, or they may be purchased independent of the virtual scribe service at a discounted rate. “This enhances our ability to offer skill, scale and speed using a cost-effective model to help physicians meet the challenges of reimbursement, compliance, ICD-10 and regulatory changes,” he explained.

The virtual scribe services benefit, introduced to SLMMS members last year, enhances physician satisfaction by minimizing data entry time, increases patient revenue by improving productivity, and positively impacts patient satisfaction. New, flexible payment plans for the scribe services benefit are also available and can be tailored to meet the specific needs of a practice, added Cumarasamy.

Medi Globe offers free trial demonstrations of their services to all SLMMS members. In as little as one to two hours, Medi Globe can show your office how a “virtual assistant,” added to your existing EHR, will enhance productivity, bolster revenue, and increase face-to-face time with patients. The addition of coding audit services makes documentation complete, and provides recommendations on the correct level of service.

SLMMS members are encouraged to contact Medi Globe America to learn more and begin a pilot program for your practice. Contact Prahaan Cumarasamy at 314-971-6111 or email prahaan@mediglobeamerica.com or Mike Meyer at 314-401-9746 or email mymreyem@gmail.com.
The crisis in Ferguson has called attention to the disparities in opportunity between the African-American and white populations in the St. Louis region. Recent studies have illustrated the disparities in health outcomes that adversely affect African-Americans. They also point out that the problem is far deeper than simple access to health services, involving socioeconomic status, education, neighborhood safety, health care access and other factors.

As SLMMS Past President Nathaniel Murdock, MD, notes, “If you are poor you may never be exposed to adequate educational opportunities. If you do not have the exposure, you will never know what your potential could have been. Our society must try to encourage all of its citizens to be productive. Being productive means having goals and aspirations to make one’s life better. Also it means trying to teach and stimulate the next generation to reach higher goals and improve the lives of all citizens.” Dr. Murdock spent his career serving in African-American neighborhoods.

Much data and study recommendations are available on the issue of disparities. The St. Louis Regional Health Commission, formed in 2001 following the closure of the region’s last public hospital, studied the area population’s health status in 2003 and updated the study in 2010. An overview of the issue from a physician leader of the RHC begins on page 16. On page 14 is a commentary from Will Ross, MD, of Washington University, who has been involved in nearly every initiative on disparities in the past decade-plus.

In 2014, a major study, For the Sake of All, was completed by researchers at Washington University and Saint Louis University, supported by a panel of community partners. The study recommends a multi-faceted approach to health disparities, ranging from investing in early childhood education, to improving mental health awareness, screening and treatment, along with expanding school-based health promotion, and coordinating chronic and infectious disease prevention and management.

African-Americans, Poverty and Health Disparities

<table>
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<th>Percent African American population by ZIP code</th>
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<td>1% - 5% (LOWEST)</td>
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<tr>
<td>6% - 44% (MIDDLE)</td>
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<td>45% - 97% (HIGHEST)</td>
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<th>Percent of all residents living in poverty</th>
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<tr>
<td>1% - 8% (LOWEST)</td>
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<tr>
<td>9% - 18% (MIDDLE)</td>
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<tr>
<td>19% - 54% (HIGHEST)</td>
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Source: For the Sake of All
Lead researcher Jason Purnell, PhD, of the Washington University Brown School of Social Work, shares his thoughts on the For the Sake of All study with St. Louis Metropolitan Medicine:

SLMM: **What is the major takeaway message of For the Sake of All?**
PURNELL: There are many messages in For the Sake of All, but one of the most important is that social and economic factors like poverty, education, segregation and the quality of neighborhoods have to be considered alongside health if we’re going to be a vibrant region. Resources for living a long and healthy life are not distributed equally in the St. Louis area, and it has both health and economic consequences for everyone. And there are things we can do to change the situation.

SLMM: **Why is it important to consider the social determinants of health, such as education?**
PURNELL: Education is one of the strongest, most consistent predictors of health outcomes. One analysis by Dr. Steve Woolf and colleagues at Virginia Commonwealth University showed that we’d save more lives by giving everyone the education of those with college degrees than all of the medical advances of the past several decades combined. Social determinants of health like education have a powerful effect on population health.

SLMM: **Has the crisis in Ferguson increased interest in the report and the impetus for action on the problem of health disparities?**
PURNELL: The crisis in Ferguson has certainly highlighted the need to attend to inequality in our region that has existed for a long time. While no one could have planned for the events of August, many have turned to the report and recommendations in the months since for an explanation of causes and some potential solutions.

SLMM: **Do you have any suggestions for what physicians could do?**
PURNELL: Physicians need to be out front talking about the social determinants of health. They see these issues all the time in clinical settings, but part of what the report says is that health care cannot fix these problems alone. We need rigorous, standardized assessment of social and economic needs in the clinical setting paired with mechanisms for referral to available community resources.

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For more information: [http://forthesakeofall.org](http://forthesakeofall.org)

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<th>Heart disease death rates per 100,000 residents</th>
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<tr>
<td>103 - 196 (LOWEST)</td>
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<tr>
<td>197 - 270 (MIDDLE)</td>
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<td>271 - 354 (HIGHEST)</td>
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<th>Cancer death rates per 100,000 residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>129 - 170 (LOWEST)</td>
</tr>
<tr>
<td>171 - 212 (MIDDLE)</td>
</tr>
<tr>
<td>213 - 359 (HIGHEST)</td>
</tr>
<tr>
<td>NO DATA</td>
</tr>
</tbody>
</table>
Regional Cooperation Needed to Resolve Health Disparities

Candid discussion and accountability called for to reduce fragmentation, address health access and social factors that influence health

By Will Ross, MD, MPH, Washington University School of Medicine

All too often in our region, the story of health and health care is a story of disparity. While we have witnessed overall improvement in health status throughout the St. Louis region over the past 10 years, race- and gender-based disparities persist. Despite sharing geographic boundaries, many municipalities in the St. Louis metropolitan area, particularly north St. Louis, suffer from health disparities and go without adequate health services. In these places, issues like diabetes, heart disease, and infant mortality hit far harder than in neighboring communities. ZIP codes separated by only a few miles experience a difference in life expectancy of up to 18 years, as documented in the Regional Health Commission’s Decade Review of Health Status,1 the St. Louis City Health Department’s Understanding Our Needs report,2 and the recent For the Sake of All study.3

While it is striking to see these disparities persist over time, what is remarkable is that these disparities can improve with collective community engagement. That’s not news to the community; they get it. In 1997, I co-authored a report on Public Health in St. Louis;4 in the interim period I have spent countless hours in late-night meetings, focus groups, and impromptu conversations on how to reduce health disparities. In all of those sessions I have heard a consistent community response: “The system is broken and our community is unhealthy, fix it!” I recall one night when I sat in on a community focus group being conducted for the 2008 North St. Louis Health Care Access Study.5 One resident passionately spoke on the need to coordinate access to primary health care across the region: “There’s got to be collaboration, partnership, you can’t just draw the line between, you know, one part of the city and the other part of the city. Everybody’s got to work together. There’s got to be accessibility to resources and there’s also got to be accountability.”

Fragmentation plays a major role in these inequities. These problems cannot be neatly defined as “City issues” or “County issues.”

As a physician, educator and researcher involved in public health issues in the St. Louis region for almost 25 years, I’ve long advocated such regional approaches, which involve systemic change and accountability, as the best way to improve leading health indicators. As the chair of the Better Together Public Health Committee, I have reviewed prodigious amounts of data that quantify the inequity of health care in our region. The recently-released Better Together Public Health Study6 highlights some of the health disparities among African-American residents and white residents of St. Louis City and County. We all agree this is one of the greatest injustices facing our region.

Fragmentation plays a major role in these inequities. These problems cannot be neatly defined as “City issues” or “County issues.” If we are ever going to adequately address our region’s health needs, particularly among those families who live below the poverty line, we must find effective, economically-sound ways to tackle these issues as one region. Fortunately, I have

Will Ross, MD, MPH, is professor of medicine and associate dean for diversity at Washington University School of Medicine. He has been active for many years in community efforts to reduce health-care disparities. He is a charter and founding member of the St. Louis Regional Health Commission, and is past board chairman for the Missouri Foundation for Health. Currently he is chair of the Better Together public health committee and a leadership council member of Flourish St. Louis. He serves on the Centers for Disease Control Health Disparities Subcommittee and is a member of the St. Louis City Board of Health. He can be reached at rossw@wusm.wustl.edu.
had the opportunity of working closely with the directors of health for the City of St. Louis and St. Louis County over many years. The two offices are staffed by compassionate, capable professionals who perform their work with great care. But no matter how smoothly the individual offices are run, we will never be able to address our region’s serious health issues—and serious health disparities—if we view our departments, our work, and ourselves as separate.

Infectious diseases, asthma, obesity and cancer do not care where the City ends and the County begins. We need a regional approach that reflects this reality. Our current departments try to work together on many initiatives, but while this collaboration is important and appreciated, it is not enough. Currently, agencies must dedicate already-tight resources to navigating two public health systems. These resources could be used to actually provide services to citizens. Additionally, sometimes agencies—including those that serve individuals with mental-health needs and those that assist survivors of domestic violence—must turn away people in need because of political boundaries applied to funding services.

Time and again, the citizens most negatively impacted by health care disparities are those who live in communities with fewer resources, many of which are predominantly African-American. These communities are in critical need of health professionals who can provide caring, compassionate health care. It would certainly help to have access to more physicians of color; however the pipeline producing such physicians dries out in communities at risk. According to the Department of Health and Human Services and the Association of American Medical Colleges’ 2010 Center for Workforce Studies, by 2020 there will be an estimated shortage of 20,000 primary care physicians, many whom would provide care to underserved communities. The Association of Schools and Programs in Public Health also estimated that 250,000 more public health workers will be needed by 2020. Many of these workers are also essential to providing services to communities of color. The root problem is that the pipeline of African-American students in our public schools who are interested in medicine and public health has slowed to a trickle. Only a few states have demonstrated the need to enhance the quality of science and math education that undergird health, more cognizant of the interface of social determinants with macro-economic policies; and more embracing of allies who can help spell out the hard truths about living in depressed, traumatized communities. We need to come together as a region to address the crisis of poverty, youth violence and low infant mortality rates and to ensure that, as the new initiative Flourish St. Louis asserts, every child born in St. Louis gets to live a happy and productive life. We need to support comprehensive community development that leads to sustainable, livable, and affordable communities for all. We need to invest in high-quality public education that encompasses early childhood education and career counseling for high school students. And, we need to emphatically embrace quality, affordable health care for all, which can be exercised through Medicaid expansion and support of a diverse health care and public health workforce. To address these and other issues would be to right an injustice that has existed for too long. The community has spoken; it’s better if we work together as a region to make St. Louis a healthier place.

References

St. Louis Metropolitan Medicine 15
Empathy has its limits.

As physicians, we are trained to care for our patients. Sometimes that caring is relatively straightforward. We listen, we evaluate, we diagnose and we treat. Goals are clear and attainable.

But we always have patients who are difficult to treat. We may try our best to care, to place ourselves in their situation, and to imagine what they need to be healthy. We may go out of our way in providing referrals, staff support, and resources for them to be successful. But ultimately they do not get better. Many times, they make choices that lead them down the path toward illness, and we are left scratching our heads. Seemingly, no amount of time, no amount of empathy makes a difference in our outcomes.

Persistently poor outcomes are frustrating to the patient and to the physician. They lead to poor individual health, poor outcomes for family and communities, and ultimately strained systems of care.

In this article, we look at research that resulted from one physician’s struggle with persistently poor outcomes that led him to discover a root cause of illness and self-defeating behavior. In 1985, Dr. Vincent Felitti, chief of Kaiser Permanente’s department of preventive medicine, could not understand why patients continued to drop out of his obesity clinic even after experiencing success in losing weight. Through his persistent quest to find an answer, he discovered an alarming number of his patients had experienced sexual assault and experienced significant weight gain only after the assault. He learned why overeating was a preferred solution for patients.¹

His acknowledgment of this root cause and his modification of his practice to address it with his patients not only brought him greater clinical success, it sparked a collaboration with his health system and the Centers for Disease Control and Prevention. This work ultimately led to the Adverse Childhood Experiences (ACE) Study, which some have called, “the most important public health study you never heard of.” In short, the study demonstrated a staggering correlation between adverse events as a child and poor health outcomes as an adult.

Today, the ACE study is shaping how we think about improving the health of our community. As leaders of the St. Louis Regional Health Commission, we are particularly interested in how we can apply the findings from this research to reduce health disparities in our region, leading to better health outcomes for all citizens, regardless of age, race, sex or insurance status. Many attempts have been made to reduce these disparities. Solutions often have been focused on the delivery of health care to uninsured and underinsured individuals.

Historically, St. Louis—like most communities—has served uninsured and under-insured patients through public hospitals and clinics. Some of the names of the public hospitals may sound familiar, but all of their doors closed during the

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Fred W. Rottnek, MD, MAHCM, is chair of the Provider Services Advisory Board of the St. Louis Regional Health Commission. He is associate professor and director of community medicine for the Department of Family and Community Medicine at Saint Louis University School of Medicine. He also is a practicing physician at the St. Louis County Justice Center. He can be reached at rottnekf@slu.edu. For more information about Alive and Well STL, visit www.aliveandwellstl.com.
last century. Homer G. Phillips, St. Louis Regional Hospital, City One, and others are now part of the archives of St. Louis history. The closure of the last public hospital—St. Louis Regional Hospital—marked a turning point in the delivery of health care to the uninsured and underinsured.

Regional leaders determined that the community did not need more hospital beds to provide health care to the uninsured and under-insured but instead needed viable physician services located in the communities of highest need. In 2001, the St. Louis Regional Health Commission (RHC) was formed to restructure the safety net system and ensure its financial stability.

Today, the St. Louis health care safety net includes a network of five community health centers and area hospitals and medical schools. The RHC in partnership with the State of Missouri operates a Medicaid 1115 Waiver—Gateway to Better Health. This is an outpatient coverage model, serving as a temporary funding source for the region’s health care safety net, currently scheduled to expire at the end of 2015, or when Missouri expands Medicaid.

More than 21,000 otherwise uninsured adults in St. Louis City and County are currently enrolled to receive basic medical services through Gateway to Better Health. These individuals represent about 50 percent of uninsured adults living in poverty in St. Louis City and County. Of those enrolled, about 50 percent are living with a chronic condition, most commonly diabetes or hypertension, or both.

The physicians at our community health centers know simply providing access to medical care isn’t enough to improve the health of our region.

The physicians at the community health centers are on the frontlines treating these patients and their chronic diseases along with the thousands of other patients they treat each year, most of whom are uninsured or insured through Medicaid. The physicians at our community health centers know simply providing access to medical care isn’t enough to improve the health of our region.

<table>
<thead>
<tr>
<th>Age-adj. rates per 100,000 COMBINED CITY AND COUNTY</th>
<th>WHITE</th>
<th>BLACK</th>
<th>HIGHER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEART DISEASE</td>
<td>194.0</td>
<td>294.0</td>
<td>↑52%</td>
</tr>
<tr>
<td>Chronic Ischemic</td>
<td>81.6</td>
<td>97.5</td>
<td>↑20%</td>
</tr>
<tr>
<td>Acute myocardial Infarction</td>
<td>58.2</td>
<td>79.9</td>
<td>↑37%</td>
</tr>
<tr>
<td>Hypertensive</td>
<td>7.2</td>
<td>32.0</td>
<td>↑344%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>12.3</td>
<td>16.1</td>
<td>↑31%</td>
</tr>
<tr>
<td>CANCER (all types)</td>
<td>173.0</td>
<td>240.0</td>
<td>↑39%</td>
</tr>
<tr>
<td>CEREBROVASCULAR (stroke)</td>
<td>38.1</td>
<td>64.0</td>
<td>↑68%</td>
</tr>
<tr>
<td>DIABETES</td>
<td>14.5</td>
<td>40.7</td>
<td>↑180%</td>
</tr>
<tr>
<td>KIDNEY DISEASE</td>
<td>12.3</td>
<td>31.4</td>
<td>↑155%</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>19.0</td>
<td>34.0</td>
<td>↑80%</td>
</tr>
<tr>
<td>CHRONIC LIVER DISEASE/CIRRHOSIS</td>
<td>6.6</td>
<td>7.4</td>
<td>↑12%</td>
</tr>
</tbody>
</table>

 Indicates chronic conditions in which age-adjusted risk for death among African-Americans is over 100% greater than the risk among Caucasians.

This discussion about our regional health outcomes began in earnest in 2010 when the RHC released a Decade Review of Health Status,2 focusing on the changes observed in our region’s health since the formation of the RHC. Over the observed ten-year period, St. Louis City and County saw a substantial drop in mortality attributable to leading chronic health conditions, including heart disease, stroke, diabetes and cancer. Between 2000 and 2010, the rate of heart disease mortality fell 29%; diabetes mortality rates declined 24%; and mortality for breast, lung, colorectal and prostate cancer fell (11-24%).

Despite an improvement in health status in the St. Louis region over the past 14 years, race- and gender-based disparities persist. In 2010, three-fold differences or greater were observed between African-Americans and Caucasians in diabetes and AIDS mortality, low birth weight, and emergency continued on page 18
room visits attributable to childhood asthma. Two-fold or greater differences were observed between males and females in heart disease, stroke and diabetes mortality.

The ACE study led by Dr. Felitti, demonstrates that persistent, toxic stress creates poor health outcomes. The study also highlights the prevalence of trauma and toxic stress in our society.

After the RHC published the Decade of Health Status Report, the Missouri Foundation for Health and area universities undertook an effort to dive deeper into the underlying cause of the highlighted disparities. This work—For the Sake of All—details the factors that lead to poorer health outcomes, particularly among African Americans. The result of this work and national research demonstrate that while the health care delivery system can impact health outcomes once someone is sick, the system may have little impact on preventing poor health—especially in communities that experience significant stress. While access to physicians, medications and other health services is necessary, and just, it is not enough.

The ACE study led by Dr. Felitti, demonstrates that persistent, toxic stress creates poor health outcomes. The study also highlights the prevalence of trauma and toxic stress in our society. Conducted in 1995, patients enrolled in the Kaiser Permanente HMO in San Diego, received questionnaires asking about adverse childhood experiences. The topics included physical and sexual abuse, emotional and physical neglect, the marital status of parents, and having family members who were incarcerated or had a mental illness. The physicians conducting the study assigned each patient an ACE score by assigning points for each adverse experience the participant reported.

The results revealed the prevalence and impact of traumatic experiences. One in eight of the surveyed population had an ACE score of four or higher. In addition, researchers identified a staggering correlation between negative childhood experiences and adult health outcomes. For nearly every chronic disease and addictive behavior, the correlation between a high ACE score and poor health outcomes was nearly linear. Based on the study, patients who reported an ACE score of four or higher were four times as likely to have emphysema or chronic bronchitis, twice as likely to be diagnosed with cancer, twice as likely to have heart disease, seven times as likely to experience alcohol abuse and twice as likely to smoke. When controlling for lifestyle by looking at patients who did not smoke, drink to excess, and were not obese, patients with an ACE score of 7 or more were 360 percent more likely to have heart disease than those with an ACE score of zero.

The correlation between traumatic and stressful childhood events and negative adult health outcomes results not only from behavioral factors but also from biological changes to the body. For example, the increase in stress hormones can cause increases in glucose levels and blood pressure. When these hormones overload the body for a long-period of time, particularly in youth, individuals experience negative effects that impact physical, psychological and neurological development.

The prevalence of toxic stress and trauma in the region is inhibiting people’s abilities to be healthy and well. To continue supporting a healthy population, the RHC is working with regional partners and community members to build a resilient and trauma-informed community under the name Alive and Well STL. The RHC encourages service providers both in health care and other sectors to become trauma informed, and create understanding and acceptance in the general community of the fact that good health is a result of both physical and emotional well-being. This also will highlight the region’s best practices for trauma-informed services to ensure that mental wellness is a funding priority for the State of Missouri, foundations and other funders.

St. Louis is the latest region to build upon the ACE study to reimagine a healthy community for all. Communities across the country are engaged in efforts to become “trauma informed.” We are hopeful that our trauma-informed community will prevent illness before it occurs, giving people the skills, tools and resources they need to overcome the stress in their lives in order to lead a healthy life. As physicians, when we encounter patients whose health is not improving despite our every effort, perhaps we should ask about the stress in their lives. Connecting patients to resources to help them heal from
stress and trauma may improve their health more than any other intervention we can recommend.

To learn more and to become involved in Alive and Well STL, visit www.aliveandwellstl.com.

(Right) During the September 30, 2014 Alive and Well STL Community Conversation, an artist illustrated the discussion. This design is based on the group’s conversation on how we can become Alive and Well in St. Louis.

On September 30, 2014 more than 150 community members and health care professionals gathered to begin planning the Alive and Well STL initiative sponsored by the St. Louis Regional Health Commission (RHC). Participants in this conversation engaged in small group conversation about:

1. The impact of trauma and toxic stress on our health
2. The barriers to becoming “Alive and Well” and
3. Actions we can take to advance the emotional and physical wellness of our community using the research around the impact of trauma.

References
Recent Alliance Fundraising and Legislative Activities

By Gill Waltman, SLMMS Alliance

Valentine’s Day Dinner and Doctor of the Year Award

The Alliance Doctor of the Year Award was presented to SLMMS Past President Ravi Johar, MD, at the annual Valentine’s Day Dinner on Feb. 13 at the Hilton St. Louis Frontenac Hotel. See accompanying story about Dr. Johar.

Also attending the event was MSMA President Jeffrey Copeland, MD, and his wife Cindy, along with second-year medical students Scott Maughan (Saint Louis University) and Kavon Javaherian (Washington University). Prior to the award presentation, psychiatrist and SLMMS and Alliance member Jo-Ellyn Ryall, MD, gave an entertaining and informative talk on handling stress.

Annual Movie Fundraiser at the Hi-Pointe

The fifth annual movie fundraiser was held Jan. 31. Angela Zylka and Hi-Pointe Manager Brian Ross selected another perfect classic, Hitchcock’s Rear Window, starring Jimmy Stewart and Grace Kelly. Proceeds from ticket sales and a raffle supporting medical student scholarships and Alliance health programs at Loyola Academy of St. Louis.

White Coat Rally and Alliance Advocates for Health Care

On Tuesday, Feb. 24, Alliance members joined Missouri physicians at the Capitol for the White Coat Rally. After registration in the Rotunda, physicians and Alliance members visited legislators encouraging them to support tort reform and to oppose the involvement of managed care in the proposed Medicaid expansion.


Benefit Fashion Show and Luncheon

The Patio Room at Neiman Marcus was the venue for the fashion show and luncheon held Saturday, Mar. 7. Kelly O’Leary and Sandra Murdock organized this popular event which attracted a sellout crowd. Proceeds from ticket sales will help support SLMMS Alliance community programs and medical scholarships.

Two medical students attended the event. From left, Millie Bever of the Alliance, honoree Ravi Johar MD, Nikki Maughan, student Kavon Javaherian, Kavon’s guest Lauren Eisdorfer, student Scott Maughan, the Alliance’s Angela Zylka and MSMA President Jeffrey Copeland, MD.

UPCOMING EVENTS

FRIDAY, APRIL 17  Foundation Dinner and Casino Night and MSMA Alliance Annual Meeting

Join members for the MSMA Alliance annual two-day meeting at the Westin Crown Center in Kansas City, April 17-18. This year celebrates the 90th anniversary of the state Alliance, one of the oldest in the nation. A Casino Night fundraiser with a silent auction will benefit the AMA and Missouri State Medical Foundations. Tickets for the fundraiser are $130 per person, a portion to be donated to the foundation of your choice. Tickets must be purchased in advance. (No tickets available at the door.) For details, contact Sue Ann Greco at sueanngreco@sbcglobal.net.

FRIDAY, MAY 1  SLMMS Alliance Installation Luncheon

Alliance members, friends and supporters are invited to the installation of the 2015-2016 officers. The luncheon will be held Friday, May 1, at Pan D’Olive, 1603 McCausland Ave., at 11:30 a.m. A short ceremony will follow a leisurely lunch. For reservations and information, contact Kelly O’Leary at kellyoleary20@gmail.com.
Ravi Johar, MD, Named 2015 Alliance Doctor of the Year

By Gill Waltman, SLMMS Alliance

Ravi Johar, MD, is an obstetrician and gynecologist who has served as a leader in many organizations, including SLMMS as president in 2006. He is well known to the Alliance for his warm acceptance of its members at SLMMS events and ongoing encouragement of Alliance programs.

The Alliance Doctor of the Year Award was presented to Dr. Johar at the annual Valentine’s Day dinner which honors physicians in recognition of Doctors’ Day. Joining Dr. Johar at the event were his wife Kay, along with two of their three children, Alex and Megan, and his parents, Joginder and Marjit Johar.

The recipient of this award must be an active member of SLMMS, an advocate for the profession of medicine and for quality health care, a role model for future physicians, and a supporter of the Alliance. Previous recipients include Drs. Erol Amon, Edmund Cabbabe, Jeffery Thomasson and Sam Hawatmeh.

Born and raised in Nebraska, Dr. Johar graduated from the University of Nebraska College of Medicine in Omaha, and completed his internship and residency in obstetrics and gynecology at the Medical College of Georgia in Augusta.

Dr. Johar has continued to practice, teach and become an active participant in organized medicine, lobbying on behalf of the profession at the local, state and national levels. He is employed by Gateway Ob-Gyn, part of the SSM DePaul Medical Group, and has served in various leadership capacities at DePaul Health Center, as well as in professional organizations including the American College of Obstetricians and Gynecologists, the American College of Gynecologic Laparoscopists, and the St. Louis Gynecologic Society. Dr. Johar is also currently chair of the MSMA Council, and the state legislative chair to the Missouri section of the American Congress on Ob-Gyn.

In the community, he has served as scoutmaster for Troop 809 of the Boy Scouts of America, on the St. Louis Post Partum Depression Advisory Board, and the board of Primaris, a Missouri State Quality Improvement Organization. He is a frequent guest on KMOV Channel 4’s Health team segments.

The Alliance congratulates Dr. Johar on all his accomplishments.

Ravi Johar, MD, receives the SLMMS Alliance Doctor of the Year Award. From left, Sue Ann Greco, Dr. Johar, Sandra Murdock, Kay Johar and Millie Bever.

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Physicians Beware of Referrals for Home Care and Potential Fraud Charges

By Diane S. Robben, JD, with Denise Bloch, JD

The provision of home health care in the United States is on the rise and accounts for a significant cost to Medicare. Low-income beneficiaries have seen an increase in the provision of such services for chronic disease management. While it may be less expensive to care for post-acute illness patients in the home to reduce costs in the long-run, providing such services for the chronically ill and those with deteriorating health conditions not expected to improve has come under scrutiny in the past several years. The Affordable Care Act required the secretary of Health & Human Services to conduct a study on the costs of home health care. With this increased scrutiny on cost containment, the government is also looking to crack down on inappropriate referral patterns, to offset the financial burden.

The five most important federal fraud and abuse laws that apply to physicians are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities and the Civil Monetary Penalties Law (CMPL). Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. As physicians continue to navigate the complexities of regulations affecting their practice, it is crucial to understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from federal health care programs, or loss of your medical license from the state medical board.

In the arena of home health care referrals, we have a recent example of a physician arguably unwittingly getting into trouble. On Feb. 10, 2015, the Seventh Circuit U.S. Court of Appeals decided the matter of U.S. v. Kamal Patel, No. 14-2607, upholding the conviction of a physician for violating the Anti-Kickback Statute. By way of background, the Anti-Kickback Statute prohibits the payment of remuneration to a health care provider in exchange for referrals. Dr. Patel is a Chicago-area internal medicine physician who commonly prescribes home health care services for his patients. The physician’s patients selected the home care services provider after being given brochures for an array of various providers by the physician’s medical assistant. Dr. Patel argued that neither he nor his assistants directed which home health care provider the patient chose, and therefore, he claims he did not personally “refer” patients to a particular home health care provider.

However, one home care provider paid the physician each time he signed the Form 485 certifying a new admission and for each signed recertification for that provider. The government viewed this as an impermissible kickback to the physician for referring new patients. The physician was sentenced to eight months imprisonment and ordered to forfeit $31,900 of kickback payments. The court held the doctor was the gatekeeper and even though it seemed the home care was medically necessary, the purpose of the Anti-Kickback Statute is to prevent Medicare and Medicaid fraud. Because the physician received payment each time he signed a Form 485, the danger of fraud at the certification and recertification stages was apparent with the potential both for increasing cost of care and undermining patient choice. The Court held this was the type of conduct Congress intended to criminalize by enacting the Anti-Kickback Statute.

Diane S. Robben, JD, is a shareholder at the law firm of Sandberg, Phoenix & von Gontard, P.C., where she regularly advises health-care clients on regulatory and risk issues, including HIPAA, fraud and abuse, compliance and credentialing matters. She also defends health-care providers in medical malpractice actions. Denise Bloch, JD, is counsel with Sandberg, Phoenix & von Gontard, P.C. She can be reached at drobben@sandbergphoenix.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.
The Seventh Circuit decision has vastly expanded the definition of “referrals” that are illegal under the Anti-Kickback Statute. It is too early to predict if other courts will follow this expanded definition, but in the meantime, health-care professionals should take steps to protect themselves in business arrangements with health-care providers, including home health, to whom they refer or certify the need for services. If any money or other form of benefits/remuneration is changing hands, be careful. The financial arrangements need to be structured to ensure any payments are for a bona fide and documented reason, are fair market value, and fit within the safe harbors under the AKS.

References
1. Anti-Kickback Statute ("AKS") [42 U.S.C. § 1320a-7b(b)]. The AKS is a criminal law that prohibits the knowing and willful payment of “remuneration” to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals and excessive compensation for medical directorships or consultancies. The statute covers the payers of kickbacks—those who offer or pay remuneration—as well as the recipients of kickbacks—those who solicit or receive remuneration. Each party’s intent is a key element of their liability under the AKS.

2. To be eligible for Medicare benefits for home care services, the provider must complete a Form 485 certifying that the care is medically necessary, and outlines the patient’s diagnosis, medication and treatment plans and goals. The form must be signed by the physician and recertified every 60 days.

**OBITUARY**

Seth E. Wissner, MD
Seth E. Wissner, a board-certified obstetrician-gynecologist, died Dec. 14, 2014, at the age of 92.
A St. Louis native, Dr. Wissner received his undergraduate and medical degrees from Washington University, graduating from the School of Medicine in 1945. He completed his internship at the former Deaconess Hospital, and served in the U.S. military from 1946 through 1948.
Dr. Wissner spent his entire career in St. Louis specializing in obstetrics and gynecology, and was on staff at the former Deaconess Hospital.
He joined SLMMS in 1946.
He was preceded in death by his wife of 52 years, Ruth Ricky Wissner. SLMMS extends its condolences to Dr. Wissner’s children, Seth Paul Wissner, Mark David Wissner and Sarah Ann Whitehead, and his two grandchildren.

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Advice on Issues You May Encounter in Your Practice

By Susan Martin, PHR, Member Answer Center Coordinator, AAIM Employers’ Association

Q If we are giving away prizes or gifts to employees, is the employer required to tax the employees for the value of the item?

Answer
The general rule is that employee gifts and prizes are counted as income. However, as with most laws, there are exceptions.

“De minimis” fringe benefits are excluded from income. De minimis benefits are those that are “so small as to make accounting for [them] unreasonable or impractical.” Examples are occasional tickets for entertainment events, certain holiday gifts, flowers, fruit, books, etc.

The IRS has ruled that items with a value exceeding $100 cannot be considered de minimis. Additionally, cash and cash equivalent gifts/prizes (such as gift certificates/cards) cannot be considered de minimis and must always be included (and taxed) as income.

So whether the prizes would be taxable as income depends on the type and value of the prize. Something minor such as a t-shirt, water bottle, or coffee mug would be de minimis and would not need to be included in employee income. However, larger prizes such as mobile devices, electronic equipment, vehicles, vacations, etc. as well as gift certificates in any amount would need to be taxed as income and included in wages on the employee’s W-2.

Q We have an employee who is going through a divorce, which is not yet finalized. The employee wants to drop his spouse from health insurance coverage before the divorce is finalized. Does this situation trigger COBRA coverage for the spouse?

Answer
A loss of insurance coverage and a qualifying event (i.e. a finalized divorce) must occur before COBRA applies. Generally, if the loss of coverage occurs in anticipation of the event, the employer’s plan is usually responsible for offering COBRA coverage to the ex-spouse effective on the date of the divorce (but not for any period before the date of that event). Since the specific facts of the situation may determine a different course of action, employers should seek legal advice.

Q Can you provide guidance for a policy covering non-exempt (hourly) employees who check and respond to email outside work hours?

Answer
Under the Fair Labor Standards Act (FLSA) de minimis rule, employers may disregard insignificant periods of time beyond the scheduled working hours. For example, if employees are checking emails for only 2 or 3 minutes, employers will likely not have to pay for this time. However, if employees are spending 10 to 15 minutes or more after work hours, employers will have to pay employees for this work time. It is recommended that employers have a policy prohibiting after-hours reading and writing of business emails and discipline employees that violate the policy. However, even if employees violate the policy, you may discipline the employees but you still have to pay them for the time.

Q We terminated an employee last week and now he wants a copy of his personnel file. Are we required to provide a copy to him?

Answer
In Missouri, personnel files are considered company property and the discharged employee is not entitled to inspect nor make a copy of the file. However, a copy must be provided if requested under a subpoena.
<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Date of Birth</th>
<th>Date Licensed</th>
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<td>Frank J. Bender, MD</td>
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<td>1950</td>
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<td>Anjali M. Bhorade, MD</td>
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<td>Saad Z. Khan, MD</td>
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<td>Gary D. Koenig, MD</td>
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<td>Timothy F. Kurt, MD</td>
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<td>David M. Sheinbein, MD</td>
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<td>Carla Jean Siegfried, MD</td>
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<td>James L. Smith, MD</td>
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<td>Renee M. Stein, MD</td>
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<td>Andre S. Strzemboz, MD</td>
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<td>Richard R. Sun, MD</td>
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<td>Krishna R. Chunduri, MD</td>
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<td>Paul M. Gannon, MD</td>
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<td>John J. Glass, MD</td>
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<td>Martin E. Gordon, MD</td>
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<td>Christina M. Hugge, MD</td>
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<td>2009</td>
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