Combating Skyrocketing Prescription Drug Abuse

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The Good Old Days—Part II: The Gatekeeper Lives

By Richard J. Gimpelson, MD

All of us who are old enough to remember the “Dawn of Managed Care” have always kept the Gatekeeper in a warm place in our memory bank. Specialists enjoyed the Gatekeeper questioning tests that we ordered. Sometimes the Gatekeeper would ask if only one of two or more tests could be done. Obviously, this questioning was just to make medical care very directed and to slice costs and maintain quality. (Wow, what a clever term, SCAM-Q!). On the other hand, the Gatekeepers surely remember how managed-care companies gradually whittled down the reimbursement for the Gatekeepers as they SCAM-Q’ed until they could hardly make a living.

Well, the Gatekeeper returns as millions of people enroll in Obamacare Rust Plans (ORP). A recent experience was with a patient who came to me for “well-woman care.” The only problem was that she also had a problem: prolonged and heavy periods. I saw the patient in mid-August and did all the allowable care that can be done at the well-woman visit. However, when I wanted to order some tests and schedule surgery, my office informed me that she needed a referral from her primary care physician (PCP) for me to evaluate and treat her. “Easy enough,” I thought. We will just contact her PCP and get the referral. Unfortunately, the patient told me that she did not have a PCP at that time, but had an appointment toward the end of September. When I asked her when she made the appointment, she informed me that it was sometime in March. Is six months really a reasonable amount of time for a patient to get an appointment to begin evaluation and treatment of a medical problem? Even if I agreed to treat her free of charge, she would still have very large laboratory, imaging and hospital bills. This is not the first victim (I mean Rust Plan enrollee) that I have seen.

The problem is not with the PCP since they must often clear the referral through the insurance company providing the ORP. What if the patient changes their PCP while under my care? There is a good chance the care will not be covered until a new referral is issued.

Between all the paperwork (electronic of course) and delay and refusal to cover care, this causes the PCP, specialist and the patient all to suffer.

By the way, costs are higher for many patients when premiums, co-pays, deductibles and non-covered care are taken into account compared to insurance prior to ORPs.

A warning to patients: Do not dare go out of network or it may literally cost you an arm or a leg.

A final promise:
If you like your doctor, you can keep your doctor unless the doctor is out of network or you cannot get a referral.

“The Gatekeeper lives.”

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 SELF WORTH

I dote on myself, there is a lot of me and all so luscious.
- Walt Whitman

Maybe Whitman goes too far; but then again, maybe not. There is a lot about you that is “luscious.” You are kind and honest; you care about your family and your patients; you help the needy; you are good-looking (had to throw that in). In other words, you are a good person and an upstanding citizen. That is most luscious and delicious. If you were any sweeter, you would melt in the rain! OK, I exaggerate. But don’t sell yourself short. There are plenty of “sour” people in this world, and if you count yourself in the opposite camp, good for you! Be proud of it! Pat yourself on the back, or, better yet, get someone else to do it, ’cause you deserve it! HIGH FIVE!!!

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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Polypharmacy, Parsimonious Prescribing and Personalized Medicine

Joseph A. Craft III, MD, FACC, Medical Society President

Medical therapies have come a long way in a short time. One hundred years ago, Bayer & Co. had just introduced aspirin for pain control. Barbiturates were new, and just starting to replace bromides for headaches and stress. Alexander Fleming had not yet discovered penicillin.

Since then, we have witnessed a medication revolution. Now we have meds for ailments of persons of all ages. Some are prescribed, some generic, some just deemed “supplements.” They come in all shapes and sizes. They are swallowed, inhaled, absorbed, injected and infused.

Americans have an ever-growing reliance on all types of medications. Nutraceuticals like amino acids, vitamins and probiotics enjoy a market expected to reach $75 billion annually in the U.S. by 2017. The vitamin category alone has grown at 7.4% per year from 2009 to 2014. The domestic over-the-counter (OTC) drug market continues to expand as well, from $1.9 billion in 1964 to $17.1 billion in 2011.

Prescription medication use has also surged in recent years. Patients expect prescriptions when they visit the doctor, and physicians are justified to write them. Why? Prescription meds can help people. Many of the successes of the last century of medical practice involve prescribed drugs. Antibiotics, vaccines, anti-hypertensives and chemotherapy can improve mortality and quality of life. As such, medical science publications and clinical guidelines emphasize prescribing one’s way to “best practice.” Indeed, to satisfy quality-reporting benchmarks, physicians now must prescribe certain meds for certain conditions pro forma, or they must justify why not.

In its 2013 annual update of health-related trends in the United States, the Centers for Disease Control (CDC) reports:

1. Prescription drug spending in 2011 was $263 billion in the U.S., representing 9.7% of all health-care expenditures—an increase from 5.6% in 1990.
2. Opioid analgesic consumption alone increased 300% between 1999 and 2010. Correspondingly, death rates for poisoning involving opioid analgesics more than tripled between 2000 and 2010.
3. According to the National Health and Nutrition Examination Survey (NHANES), the percentage of U. S. citizens reporting they take five or more drugs in the past month increased from 4.0% in 1988–1994 to 10.1% in 2007–2010 (age-adjusted). Forty percent of those 65 and older reported taking five-plus prescription medications in the last month.

Evaluating Polypharmacy

So how much better off are we living through pharmacy? No doubt, doctors add medications with honorable intentions, backed by strong science. But are we good enough at subtracting them also?

The word “polypharmacy” has no single universal meaning. Some experts simply use it to imply a specific number of concomitant drugs—five or more is a common range. The geriatric curriculum web page at the Landon Center on Aging at the Kansas University Medical Center defines it as “the use of several drugs or medicines together in the treatment of disease, suggesting indiscriminate, unscientific, or excessive prescription.” It may not be unjustified to suggest that multiple concurrent medications heighten patient risk.

In the elderly population, the number of medications directly correlates with fall risk, as well as emergency room visits and hospitalizations for adverse medication

continued on page 6
A bundle of thanks and warm wishes too. 
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events. Nursing home residents have a higher risk of hospitalization and death, if they take certain medications at higher doses or with greater risk of interaction.

Paula Span, long-time Washington Post correspondent and now educator at the Columbia University Graduate School of Journalism, writes “The New Old Age—Caring and Coping” series for the New York Times online. In recent posts, she laments the high incidence of nursing home patients taking dementia medications with questionable indications, and the prevalence of anxiolytic prescriptions for insomnia in the elderly. She cites the American Geriatrics Society guidelines, which explicitly caution doctors to minimize these practices. Although a non-clinician, she pens compelling prose, and her critiques remind us that sometimes less is more.

Burgeoning prescription med use among children reflects medical progress, yet has also triggered alarms. The NHANES study suggests 23% of children under the age of 18 reported taking 1-4 prescription drugs in the last month. Compared to similar survey tools from 1988-1994, antibiotics have declined for kids with cold-like symptoms. However, asthma medication use has doubled, and central nervous system stimulant use (for conditions like attention-deficit disorder) has risen sharply. Pediatric patients with autism spectrum disorder often take multiple different psychotropic drugs. Long medications lists are common among hospitalized children, raising concerns about unintended risks.

In a way, prescription drug benefit and risk sit on either end of a seesaw, while the individual patient adjusts the fulcrum. Most efficacy data on medical therapies are derived from trials with large treatment and control groups. We look for statistical significance among groups, and apply group results to our individual patient. In this imperfect system, physicians often must accept a “number needed to treat” (to achieve the desired outcome) in the high teens or 20s. We can only hope our patient is fortunate enough to avoid side effects and benefit well from the medication.

Greater Use of Personalized Data

Many health-care visionaries race to develop more “personalized medicine.” They aspire to employ an individual’s gene and protein data to tailor therapies. They strive to use cell- or receptor-specific imaging tools to guide highly focused treatment. Maybe then we could decrease medication numbers and potential side effects, while boosting therapeutic benefit. While some examples exist today, particularly in the hematology and oncology realm, these hopes remain a frontier in medicine.

Whole genome sequencing has helped physicians individually pinpoint leukemia therapy at the DNA and RNA level, and extend the life of Dr. Lukas Wartman, physician scientist at Washington University. Famed cardiologist and researcher Dr. Eric Topol has spent 40 years promoting applied genetic and technology solutions to improve the care of individual patients. He tweets daily about the promise of genomics and nanoparticles. His forthcoming book, The Patient Will See You Now, is expected to laud the digital revolution in medicine, predicting it will empower patients to guide doctors in personalizing their care.

Deborah Estrin is a professor of computer science at Cornell Tech in New York City and a professor of public health at Weill Cornell Medical College. In her 2013 TEDMED talk, she paints a future landscape of patient-centered health. She anticipates doctors will adjust and tweak care based on “small data” derived from patients’ personal and daily interactions with technology. Using the “digital bread crumbs” left behind from patients’ smart phones, web searches and Fitbit-like biofeedback tools, doctors will customize medication doses.

We must remember to apply new data to our patient, not the other way around. The doctor-patient relationship remains the cornerstone of customized patient care.

At St. Louis Children’s Hospital, when prescribing antiepileptics, residents and fellows-in-training demonstrate novel and time-honored approaches to personalized medical therapy. Trainees review seizure medication therapeutic benefits and side effects with attending physicians, pediatric pharmacists and patient families, according to F. Sessions Cole, MD, (SLMMS), chief medical officer and vice chairman of pediatrics. Children’s Hospital promotes a culture of “antibiotic stewardship,” in which trainees learn from infectious disease experts about antibiotic spectrum, drug metabolism in individual patients, and anticipated side effects.

Soon myriad technologies may enhance our prescribing successes and minimize our losses. So, should we hold our breath awaiting a better tomorrow? Clearly not. Every day doctors personalize patient care. In a world of guideline-directed medical therapy and large randomized controlled trials, one might easily forget the foundation of medicine is personal. The history of present illness and the social history seem less glamorous these days, but they are keys to a vast treasure chest of patient-specific data. We must remember to apply new data to our patient, not the other way around. The doctor-patient relationship remains the cornerstone of customized patient care.

Prescription medications help many patients, but may cause problems. Optimizing drug benefit and mitigating risks are complicated, dynamic tasks for physicians. To effectively add and subtract medications, we wield new and old tools. Scientific
data and technology continually hone our prescribing skills. Our relationship with our patients lends perspective and truly personalizes all health decisions.

Medical advancement is a meandering journey. Doctors and patients walk the road together. We endure many turns and switchbacks. Eventually the path straightens, and we progress.

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Cultivating Leaders—Today and Tomorrow

David M. Nowak

It’s hard to believe that it’s been nearly two years since I took the reins as your Executive Vice President. I’ve had the opportunity to meet many of our members individually at various programs and events, and I’m grateful for your continued support of organized medicine in St. Louis.

One of my initial objectives for this position was to work to get more younger physicians involved in SLMMS, and that starts by developing relationships with the students and residents here in St. Louis. Our community is fortunate to have two outstanding medical schools at Washington University and Saint Louis University, and no less than five graduate medical education programs in place at the two above schools and their affiliated hospitals, as well as Mercy Hospital St. Louis, St. Luke’s Hospital, and St. Mary’s Health Center. So there is an ample pool of talented young medical minds at work or study right here in our fair city.

Things began to fall into place a little more than one year ago when I was introduced to two students from Washington University School of Medicine—Avik Som and Ramin Lalezari—at a Missouri State Medical Association meeting. Interested in organized medicine, and already active with MSMA and the AMA, they were eager to start some type of program locally in St. Louis and sought to partner with SLMMS.

Recruiting others in the medical student community, they drafted a proposal to form a Medical Student Section within SLMMS. Their work was vetted by the SLMMS Membership Committee, then sent to our full Council, where it was enthusiastically accepted. The students sought to have a voice on the SLMMS Council, and were issued a challenge: recruit a minimum of 50 student members and SLMMS would explore changing its bylaws to allow for an appointed medical student liaison member.

Within a few weeks, the students had organized an informational gathering and easily met that objective. SLMMS President Joseph Craft III, MD; SLMMS Councilor Ramona Behshad, MD; and I had the pleasure of attending a medical student informational event at Washington University. We were reminded that while the students’ perspectives are different from practicing physicians, their objectives for organized medicine are the same: advocacy, education and communications/networking. You will see listed in this magazine’s New Member section on page 29 the names of the 50-plus medical students that were recruited as new SLMMS members.

As of this writing, the SLMMS bylaws are being amended to allow for an all-new Medical Student Section. While it’s true that most of these students will continue at residency programs in cities other than St. Louis, many will remain local, and the seeds are being planted to grow interest in organized medicine for many years to come.

This past summer I was contacted by two young physicians starting their residency programs here in St. Louis—Dr. Jamie Mull in dermatology at Washington University, and Dr. Blake Weis in radiology at Saint Louis University. They too sought to get more involved in SLMMS, and brought to the table fresh ideas and new energy. They have championed the formation of a SLMMS Resident/Fellow Section, writing a charter that was fully endorsed by our Council in September.

The Resident/Fellow Section was launched with a successful social hour in October. More than 20 residents from the various programs in St. Louis attended, and they were joined by seven of our SLMMS leaders. Since that event, they have already held their first organizational meeting and are off and running. They hope to partner with SLMMS.
to provide educational programming and mentoring opportunities.

These young physicians are the future leaders of our Medical Society. If you would like to get involved with either the Medical Student Section or the Resident/Fellow Section as a mentor or sponsor, please contact me at the SLMMS office. I have been impressed with their organizational abilities to get these two new endeavors off the ground so quickly. Organized medicine is something they do not learn in their respective programs, so it’s up to the local Medical Society to fill that gap. I turn to the SLMMS membership to help us fulfill our commitment to them to help prepare them for the practice of medicine.

The Resident/Fellow Section was launched with a successful social hour in October. More than 20 residents from the various programs in St. Louis attended.

Speaking of leadership, in this issue you will find information about an exciting new educational program—the Physician Leadership Institute. Last spring, Anders Health Care Services approached the Medical Society about partnering with them on this project, and for the past six months we have seen what was once an ambitious vision turn into reality. We are excited to bring together some of the top business and consulting minds in St. Louis to present a program targeted directly to physicians. We’re calling this the “inaugural class” as we hope it will become an annual offering. We realize the commitment of five Saturday mornings might be tough to fit into your busy schedules, but promise the reward to be well worth the investment. The tuition is significantly discounted for SLMMS members, so I do hope you will consider making the commitment to sharpen your business acumen through this program. Do not hesitate to contact me if you have questions.

Lastly, while I’m on the topic of leadership, I hope to see many of you at our Annual Meeting and Installation Dinner at Kemoll’s Top of the Met on Saturday, Jan. 10. At this event each year we recognize our outgoing leaders as well as welcome our new president, officers and councilors. This year we’ll also be giving a special salute to our members who have continuously supported SLMMS for 50 or more years.

SLMMS has been cultivating physician leaders for many years. I’m excited these new programs will help our Medical Society continue this valued tradition.
All Missouri Physicians Potentially Affected

Action required on MSMA resolutions opposing Maintenance of Certification and Maintenance of Licensure

By Helen Gelhot, MD

Lifelong learning, a longtime medical standard, has fostered a robust multi-billion dollar continuing medical education industry. Physicians determine individual educational needs; medical organizations historically oppose mandating specific CME content. Despite widespread protest, evident in all formal inquiries, a change in course looms for all physicians, including Missouri’s.

All Missouri physicians, including those previously “grandfathered in,” will be affected by Maintenance of Certification (MOC) and Maintenance of Licensure (MOL) if testing organizations continue advancing expansion into Missouri. The CME system would become obsolete as MOC requirements grow, entangling with the incubating MOL industry; they threaten to impose new burdens on physicians.

MSMA is considering resolutions opposing mandatory MOC and MOL in Missouri. These resolutions were introduced at MSMA’s April 2014 convention and are now being reviewed in committee. They will likely be brought for vote at their April 2015 convention. Your additional physician resolve in passing these two resolutions will make Missouri the 16th state medical association along with some state medical boards to openly reject MOC/MOL.

What is MOC?

MOC is now a continuous, unproven, allegedly voluntary, American Board of Medical Specialties (ABMS) program. With increasing corporate-like behavior, this organization and its 24 specialty member groups take CME considerably beyond traditional boundaries.

Recertification far surpasses basic medical licensure knowledge levels. Irrelevant requirements have physicians repeatedly spending hundreds of hours away from patients and thousands of dollars complying for one board; multi-boarded physicians are tasked accordingly.

Practicing physician MOC recertification failure rates are as high as 53%, while Ohio and West Virginia state medical board data show physician incompetence rates below 0.01%. Physician shortages notwithstanding, MOC could make it impossible to maintain hospital privileges, insurance reimbursement and malpractice coverage. The ABMS lobbies relevant industries, imposing these financial mandates through hospitals and insurance programs.

What is MOL?

MOL, a continuous Federation of State Medical Boards (FSMB) corporate product, aims to become obligatory for physician license renewal as they seek to institute and control a national medical license. They agree MOC would satisfy MOL. Many say MOC, connected to MOL, creates instant regulatory capture through medical practice monopoly. An antitrust suit by the national physician’s society, Association of American Physicians and Surgeons, against the ABMS claims restraint of physician’s trade violations and negligent misrepresentation.

Transparency and Conflicts of Interest

Working physicians complain of conflicts of interest and absent corporate transparency and oversight. The ABMS and FSMB, cooperating out-of-state, non-governmental nonprofits, with undisclosed financial MOC/MOL conflicts of interest, seek to regulate the medical industry.

Their six to seven figure-a-year salaried executives typically do not practice clinical medicine and classically have been MOC exempt/noncompliant. Like major corporations, medical board organizations’ assets total hundreds of millions of dollars.

Evidence Based?

The FSMB MOL product claims to improve health care with lifelong learning. However, there has been no outcome-based evidence regarding MOC/MOL, including in the ABMS’ own “evidence libraries.” MOC compliance does not assure improved patient outcomes. The ABMS itself states no certification guarantees “performance or positive outcomes.”

Take Action!

To help ensure MOC/MOL defeat in Missouri, call or email SLMMS or MSMA (Committee on Legislative Affairs); please copy the author: hgelhot1@gmail.com and call or text 314-322-0337 with inquiries. Join SLMMS, become an MSMA Delegate/Alternate. Notify your colleagues, etc. Visit www.changeboardrecert.com and similar physician MOC/MOL opposition websites/blogs.

Helen Gelhot, MD, is an internist in private practice and an SLMMS member. She introduced the Maintenance of Certification and Maintenance of Licensure resolutions at the 2014 MSMA convention.
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SLMMS has entered into a new partnership with Medi Globe America, an international health-care consulting and technology firm with offices in St. Louis, to provide scribe services at a discount to members.

“Partnering with Medi Globe America enables SLMMS to provide a new type of benefit to our members,” explained Joseph A. Craft III, MD, 2014 SLMMS president. “Their services help minimize EHR documentation time for physicians, enhance productivity, bolster practice revenue, and most importantly, increase face-to-face time between physician and patient.”

Medi Globe America’s scribe services combine cutting-edge technology with traditional medical dictation and are customized to meet the needs of each physician, enabling the doctor to streamline services. Essentially, each physician is provided a “virtual assistant,” who will enter each patient’s clinical visit notes directly into the practice’s existing EHR program within a few hours of the physician dictating relevant notes relating to the patient visit.

“Our scribe service is a revenue enhancer, and we are confident it will generate a 100% return on investment of the monthly service fee well within the trial period,” said Prahaan Cumarasamy, founder and CEO of Medi Globe America. “It requires no change in the client’s EHR or any other operational system. There are no software applications to be purchased or installed. Since most EHRs are web-based programs with remote access capability, our scribe services can be implemented with relative ease, utilizing usernames and passwords for scribe staff.”

The Scribe Services Process:

1. The physician dictates relevant patient clinical visit notes, using customized dictation guidelines.
2. The scribe staff retrieves the audio notes, reviews and transcribes the notes, and presents them for review by MGA’s Quality Assurance staff.
3. The Quality Assurance staff reviews and confirms the accuracy and completeness of information to be entered into the client EHR.
4. The scribe staff enters the quality verified patient visit notes directly into client’s EHR.
5. The dictated notes will be completed and will be available for physician review and electronic signature by 8 a.m. the next business day.

“After an initial learning period, MGA’s scribe staff will ensure that each patient’s clinical visit documentation is entered in the client EHR within four to six hours of the patient visit,” explained Cumarasamy. “Thus the clinical visit notes relating to morning patient visits will be entered and available for physician review and signature before end of the work day, and the clinical visit notes relating to afternoon patient visits by 8 a.m. the next morning.”

MGA’s partners are Health Information Portability and Accountability Act (HIPAA) and Information Security (IS) certified organizations. MGA also offers coding and a complete range of practice management services.

SLMMS members are encouraged to contact Medi Globe America to further discuss this new member opportunity and to 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 mjreyem@gmail.com to set an appointment or if you have any questions. Information also is available at www.mediglobeamerica.com and www.slmms.org.

MGA will offer SLMMS members a 10% discount from the monthly service fee during the initial six month trial program, and then be eligible for up to a 5% discount on service fees if the physician enters into a three-year agreement with Medi Globe America. The discount benefit is an exclusive offer available to SLMMS members only, resulting in savings of more than $1,800 per year.
Physician Leadership Institute Begins in February

The St. Louis Metropolitan Medical Society and Anders Health Care Services have partnered to create an all-new educational experience for doctors. The inaugural class of the Physician Leadership Institute will begin on Feb. 21. This five-part, high-intensity program will concentrate on the business side of medical practice, with the objective of developing leadership and management skills.

The curriculum is rooted in the six domains of the Medical Group Management Association, and was developed with input from the SLMMS CME Committee, local physicians and health-care executives, and the Anders team. The five sessions are as follows:

- Session 1 – Foundations of Health Care
- Session 2 – Finance and Revenue
- Session 3 – Practice Management
- Session 4 – Risk and Compliance
- Session 5 – Leadership Skills

The faculty will include many of the area’s most knowledgeable experts on topics relevant to all practitioners, whether they are independent, hospital-based, or part of a large group. Classes for the inaugural session will be interactive, and held on Saturday mornings in winter/spring of 2015 at Anders educational facilities in their offices at 800 Market Street, Suite 500, downtown St. Louis.

Up to 20 Continuing Medical Education hours will be awarded for completion of the entire curriculum. Tuition for the entire program, including lunch and all materials, is $500, discounted to $350 for all SLMMS members.

For more information or to register, visit http://anderscpa.com/physician-leadership-institute/ or use the link in the story on the SLMMS website. You must enroll in the entire program, and before the deadline of January 31.
Efforts Focus on Reducing Prescription Drug Abuse

Deaths from pharmaceutical opioid overdoses quadruple since 1999; measures advocated include state prescription drug monitoring

By Jim Braibish, St. Louis Metropolitan Medicine

The problem of prescription drug abuse and redirection has exploded over the past decade. Public health officials, medical leaders and others are calling for greater prevention and treatment measures to stem the growth. And Missouri is garnering national attention as the only state not to have a prescription drug monitoring program. Physicians are advised to exercise caution in prescribing painkillers.

All forms of drug overdose, including prescription and illicit drugs, became the leading cause of injury death in the U.S. in 2012, exceeding motor vehicle traffic crashes for people ages 25-64. The Centers for Disease Control report 41,502 drug overdose deaths in 2012, representing one overdose death every 13 minutes. Drug overdose rates increased 117% from 1999 to 2012 alone.

The fastest-growing area of drug overdose is prescription painkillers. Of those 41,502 drug-overdose deaths in the U.S. in 2012, 53% were related to pharmaceuticals. Poisoning deaths from one class of prescription drug, opioid-analgesics, quadrupled from 4,030 in 1999 to 16,007 in 2012. This class of prescription painkillers includes OxyContin, Xanax, Vicodin and others.

In 2012, health-care providers wrote 259 million prescriptions for painkillers, enough to medicate every American adult around the clock for a month, the CDC reports. At the same time, the CDC says about 12 million Americans age 12 and older—1 in 20—reported using prescription painkillers for nonmedical reasons in the past year.

While prescription drug abuse crosses all ages and socioeconomic groups, some are more likely to abuse or overdose, according to the CDC. Many more men than women are likely to die of overdoses. Middle-age adults have the highest prescription painkiller overdose rates. People in rural counties are twice as likely to overdose on prescription painkillers than people in big cities. And, whites and American Indians are more likely to overdose than blacks.

“The misuse and abuse of prescription drugs is a very serious problem in the Midwest and in the U.S. as a whole. It affects the young as well as the middle-aged and seniors,” said Anthony Scalzo, MD, director of the Division of Toxicology at Saint Louis University School of Medicine and SLUCare emergency physician at SSM Cardinal Glennon Children’s Medical Center.

Besides opioids, he notes that prescription drug abuse also involves the use of stimulants such as medications used for ADHD, along with relaxants such as benzodiazepines. “It is often combined with alcohol and/or other drugs of abuse,” he said, citing a recent study of high school seniors that found that an estimated 64.4% co-ingested prescription stimulants with other substances such as alcohol and marijuana.

Members of the Greene County Medical Society Alliance in Springfield, Mo., have created a video and educational module addressing the issue of prescription and over-the-counter medication abuse by young people. “Pills are NOT a Party!” targets children ages 10-12, a prime age identified by the CDC when drug abuse can begin. Since its release in 2012, the 15-minute animated video has been seen by 3,000 children in Springfield schools. Recently, the program was rolled out nationally with the help of a grant from the American Medical Association Foundation. For more information, contact Barbara Hover of the Greene County Alliance at arhover2@aol.com.
From Prescription Opioids to Heroin

“We are losing a lot of people, and a lot of lives are being ruined from prescription drug abuse,” said anesthesiologist Joseph Forand, MD, (SLMMS), president of the medical staff at St. Anthony’s Medical Center. Since the mid-2000s, Dr. Forand has been on the forefront of advocacy for a prescription drug monitoring program and other prevention and treatment measures, in his capacity with the Missouri Society of Anesthesiologists where he was 2007-08 president. He also served on the Missouri State Board of Health from 2005 to 2013.

Dr. Forand noted how opioids act on a primitive part of the brain, called the pleasure center or “I want more” center, first identified through research with rats by James Olds and Peter Milner in 1954. It is easy to become addicted to opioids because they leave the user craving for more of the substance. This craving consumes users and they will do almost anything to get more, he said.

The danger of opioids is that they are respiratory depressants. When anesthesiologists instill them in a patient during medical procedures, the effect is carefully monitored. However, an individual overdosing the drugs could cause their breathing to stop.

He also points to the problem of prescription drug abuse being a gateway to heroin addiction, particularly among youth. “Seventy-two percent of heroin addicts began with prescription pain medicine abuse. This is all too common,” he said, adding that today’s street heroin frequently is cut with fentanyl which has 50 times the potency.

These concerns motivated him to lead the production of a 20-minute video, “Anatomy of an Overdose,” just released in 2014 on the dangers of heroin and prescription drug abuse.

Theodore Cicero, Ph.D., professor of neuropharmacology in psychiatry at Washington University, has studied trends in drug abuse. His most recent study of 9,000 treatment center patients, released in May 2014, found that abusers were switching from prescription opioids to heroin because of the cost—$80 for an 80-milligram tablet of OxyContin, compared to $10 for a similar amount of heroin. A 2010 reformulation of OxyContin is another cause. His research shows today’s average heroin user started the drug at age 23, and got high with prescription drugs prior to moving to heroin. They also tend to live in suburban or rural areas and more than 90 percent are white. This is in contrast to the 1960s and 1970s, when more than 80 percent of heroin users were young male minorities who lived in inner cities.

Public Health Approach

Nationally, officials are increasing emphasis on a public health approach to the problem, and this was reflected at last April’s annual national drug-abuse summit of governmental and public health leaders. “The focus has now shifted from law-enforcement strategies to addressing the heart of the issue: prevention and treatment,” reported an AMA trustee who represented the association at the conference.

Current areas targeted by the CDC Center for Injury Prevention and Control include enhancing state prescription drug monitoring programs, evaluating policies to prevent “doctor shopping” and “pill mills,” ensuring health-care providers follow safe and effective prescribing of painkillers, and conducting public education.

Missouri is the only state without a prescription drug monitoring program. Legislation has been introduced and supported by a wide coalition ranging from MSMA and the Missouri Society of Anesthesiologists, to the Missouri Pharmacy Association and the Missouri Chamber of Commerce. The legislation has stalled in the Missouri Senate, where the opposition has been led by State Sen. Rob Schaaf, MD, (R-St Joseph), who cites privacy concerns. Missouri’s opposition to prescription drug monitoring was the subject of a July 20 article in The New York Times.

In 2013 testimony to the Missouri Legislature and a letter to the editor in the St. Louis Post-Dispatch, Dr. Forand wrote, “‘Doctor shoppers’—those who claim to have a condition amenable to treatment by prescription painkillers and who go from one doctor’s office to the next seeking these drugs—are numerous in Missouri. … At present, there is no way for a physician to know if his or her patient already has painkiller prescriptions. … Like it or not, the lack of any monitoring program has helped Missouri gain a national reputation as a place that makes painkiller prescriptions readily available to abusers.”

He also cited state data showing nearly 900 deaths in Missouri annually from prescription-drug overdose. “From a public health standpoint, a 50 percent reduction in these deaths would save 450 lives, nearly six times more than are estimated to be saved by primary enforcement of seat belt laws,” he wrote.

Lawrence Kuhn, MD, medical director of SSM Behavioral Health, concurred. “In Missouri, it’s easy to game the system. Physicians I talk to in other states are comfortable with a prescription drug monitoring program. It allows them to identify patients receiving medication from several prescribers.”

continued on page 16
Reducing Prescription Drug Abuse  continued from page 15

The problem of prescription drug abuse, and all drug abuse, is complex with no simple answers, Dr. Kuhn added. “People have been abusing opioids for centuries. You are not going to legislate it away. Restricting access to prescription opioids could also just direct more people toward heroin. It’s going to take a number of different approaches.”

One measure he suggests is greater prescribing of buprenorphine, a drug used to treat opioid addiction. While it can be prescribed by any physician, including primary-care physicians, current rules make it burdensome for the physician, he said. Drug courts are another effective measure.

Dr. Scalzo added, “More support for education about the dangers of prescription drug abuse would be welcomed as well as limitations on prescription volumes. It is not uncommon and supposedly more convenient for certain prescription warehouses to supply a patient with 90 days’ worth of medication. While this may be convenient for some, it increases the risk of misuse, abuse and diversion.”

Even if a prescription drug monitoring program is implemented in Missouri, it could be a while before such a system is widely used as providers learn the system, devote time to use it, and any system functionality issues are overcome, according to a recent study in Oregon.

Advice to Physicians and the Public

For the physician, Dr. Forand said, some warning signs that a patient might be a potential abuser include asking for a drug by name, or giving an excuse such as they lost their prescription.

Symptoms evidenced by an abuser noted by Dr. Scalzo can include pressure of speech, agitation, withdrawal signs such as unexplained tachycardia (fast heart beat), as well as sweating, nausea, vomiting, and shakes. Also noticed can be change in personality or loss of attention to hygiene.

The CDC offers the following suggestions to health-care providers:

- Screen and monitor patients for substance abuse and mental health problems.
- Prescribe painkillers only when other treatments have not been effective for pain.
- Prescribe only the quantity of painkillers needed based on the expected length of pain.
- Use patient-provider agreements combined with urine drug tests for people using prescription painkillers long term.

Dr. Kuhn suggested that physicians take the time to talk with patients about the dangers of drug abuse, when they are being prescribed controlled substances, or when possible abuse is suspected. “Patients prefer not to talk about it, and the physician has time constraints. The physician needs to be willing to have the conversation.”

He added, “We need to de-stigmatize those with drug problems and view it as a medical problem, not a lack of moral control or self-discipline. If we can see it that way, it is easier for the physician to address with the patient.”

Resources for Physicians

AMA Combating Prescription Drug Abuse and Diversion

- Includes continuing medical education to promote appropriate prescribing, along with federal and state legislative advocacy information.

MSMA Resource Guide to Prescribing, Administering and Dispensing Controlled Substances
http://www.msma.org/mx/hm.asp?id=GuidetoPrescribing#.VGfLzPnF8c0

Missouri Prescription Drug Monitoring Program
NOW Coalition
www.missourinow.org

U.S. Substance Abuse and Mental Health Services Administration
http://www.dpt.samhsa.gov/providers/prescribingcourses.aspx
- CME course on prescribing opioids for chronic pain.

“Anatomy of an Overdose” Video
www.stlheroinfilms.org

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“Missouri needs a robust program to monitor prescription drugs,” letter to the editor, Joseph Forand, MD, St. Louis Post-Dispatch, January 12, 2013.

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Protecting Assets and Reputation in the Midst of a Malpractice Claim

Affordable Care Act could influence rise in malpractice claims and how standard of care is viewed

By Paul Larson, CFP, CLU

Besides being healers and caretakers, doctors are also business owners, putting them at risk for additional lawsuits and claims. There are many assets at stake when a physician faces a medical malpractice lawsuit, and it’s not just the assets related to the medical practice that can be vulnerable. Even if there is a settlement out of court, a doctor’s reputation, medical record and credentials could all be tarnished in the process.

The implementation of the Affordable Care Act has led to speculation about the broader impact on medical malpractice claims. A 2014 study by the RAND Corporation theorizes a rise of up to 5 percent in malpractice claims. The theory is based on an assumed increase in procedures and patient interactions from a higher percentage of the population being insured. Consequently, higher liability premiums may be expected. Certain factors could have a broader impact on the risk profiles of physicians.

Standards Are Changing

A primary concern for physicians is that the quality and standard measures of the ACA could cause a shift in how “standard of care” is evaluated in the courtroom. The fear is that plaintiff attorneys could use these approved guidelines from specialty boards as “rules” for the standard of practice and patient safety. This would essentially allow operational guidelines to take precedence over proven clinical research.

Just as health care has undergone reform, some entities such as the Center for American Progress have suggested that a reform of medical malpractice law is necessary as well. One potential solution would be a safe harbor for physicians with legally-defined criteria for standard of care. Patients who bring malpractice claims must show evidence that their physician did not follow guidelines and meet the standard of care when diagnosing or treating their specific conditions. The ability to show documented proof that the physician did indeed adhere to established guidelines and upheld the standard of care is an effective means for defending such claims in the early stages of litigation.

Physicians can document their adherence to clinical guidelines by using a qualified health information technology system. Research published by the Archives of Internal Medicine suggests that adoption of electronic health records could lead to a reduction in malpractice claims. Electronic Health Records (EHRs) allow for more effective communication between health-care providers and cut down delays in receiving patient information. Also, the documentation provided by EHRs could improve the chances of a successful defense in the earliest stages of a malpractice lawsuit.

Preparing a Defense

Statistics indicate that the majority of physicians will be sued for medical malpractice at some point in their careers. In fact, a study published by the New England Journal of Medicine found that 99 percent of physicians in high-risk specialties will be sued by the age of 65. However, there are some proactive steps that can be taken when facing this ordeal.

Insurance carriers generally require to be notified at the first hint of trouble if there’s reason to suspect that a patient is considering a lawsuit. The insurer usually assigns a claims representative to investigate the claim, gather information and act as a guide through the litigation process. To maximize the defensibility of a malpractice claim, thorough records should be maintained and organized. Missing records and poor documentation in general could harm the chances of a successful defense.

Further, physicians should be cognizant of their rights when determining whether a settlement can be reached. In most cases, carriers won’t settle a claim without the doctor’s consent. However, some policies have a “hammer clause” that allows the carrier to assert pressure on their insured as to whether a case should be settled. Even if the medical facts are on the doctor’s side, a settled claim could show up in a physician’s professional history, affecting one’s professional reputation and potentially increasing their future risk of similar claims. Having a consent-to-settle clause in a
medical malpractice policy may allow a physician to retain a higher degree of authority in this critical decision. Maintaining confidentiality in the terms of any settlement can eliminate or limit the impact of a claim on potential future claims.

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Medical Malpractice Insurance is a complicated issue and cannot be fully covered within the context of this article. This article should not be construed as legal advice. Please contact a qualified attorney and/or insurance carrier with knowledge about your specific needs.

References

SLMMS Extends Agreement with Keystone Mutual

The Medical Society has renewed Keystone Mutual as an approved provider for medical professional liability insurance. This recent renewal extends the exclusive approved provider status for the next three years during which time all SLMMS member physicians will receive a 10 percent discount from Keystone.

“We appreciate the hard work and service Keystone Mutual has provided its physician policyholders,” says Joseph A. Craft III MD, SLMMS 2014 president. “Keystone continues to be a trusted insurer for our members. We look forward to more years working side by side.”

The partnership has benefitted many existing SLMMS members, as well as helped recruit new members into the Society. Keystone remains dedicated to its policyholders; with $36 billion in reinsurance backing from Lloyd’s and special retirement benefits like Keystone Capital®, they have been responsive to SLMMS members’ needs.

“The trust that SLMMS has placed in us allows our team to work even more diligently to strategically guide St. Louis physicians,” said Jim Bowlin, Keystone’s chief executive officer. “We are honored to once again receive this distinction and our commitment to SLMMS member physicians is solid.”

For more information or to obtain a quote, visit www.keystonemutual.com or call 1-866-212-2424.

Wanted – Your Ideas for Change

The process of resolution writing is one of the most powerful advocacy tools we have as a medical society. It’s time to begin thinking about submitting resolutions for consideration by the MSMA House of Delegates at the 2015 annual meeting April 17-19 at the Westin Crown Center in Kansas City. Resolutions passed by the delegation represent the voice of organized medicine in the state.

Support for member physicians through advocacy is a key theme of the SLMMS mission. In 2014, SLMMS was proud to sponsor more than half of the resolutions brought forward at the meeting. This process is one of the primary means to advocate for yourself and your fellow physicians, and your medical society is here to help support your position.

The deadline for submission to MSMA is March 2, 2015, for publication in convention materials. However, for a resolution to be put forward and sponsored by SLMMS, it must first come to the SLMMS Delegates’ Briefing Session scheduled for Tuesday, Jan. 27, 2015, at 7:00 p.m. in the dePazzi Bentley Room in the von Gontard Conference Center at Mercy Hospital.

Resolutions accepted by the SLMMS delegates at the Briefing Session go forward to a second meeting held in conjunction with the monthly SLMMS Council meeting on Feb. 10. All resolutions receiving final approval at the second meeting are then submitted as sponsored by the Society.

If you plan to submit a resolution for consideration, please notify the SLMMS office as soon as possible to have your issue added to the agenda. It is preferable for the author to be present at the Briefing Session and at the joint meeting with the Council to explain the rationale for the resolution(s).

Visit the SLMMS website for a link to MSMA’s Guidelines on Resolution Writing. Resolutions may be introduced individually at the convention, but different guidelines must be followed. For more information on this process, call the SLMMS office at (314) 989-1014.
Finding Good Employees

Tips on recruiting and selecting the people who are the face of your practice

By Christine M. Keefe, CPA, CMPE, MGMA of Greater St. Louis

Editor’s Note:

SLMMS has established a partnership with the Medical Group Management Association of Greater St. Louis (MGMA), which will include sharing information in publications, across websites, through organizational committees, and via joint educational programs. MGMA is committed to providing helpful management information to SLMMS members and their office staffs. The MGMA of Greater St. Louis has over 250 practice manager members representing over 140 local physician practices, as well as over 75 business partner members.

Payroll and benefits are often one of the most significant expense line items in a medical practice and one of the most difficult to manage. Employee turnover can be very costly, so it is important we do our best to hire and retain the best employees we can find. How do you find the perfect candidate? It can be an exhausting and time-consuming process. What are the steps involved?

Know What You Need

- Just because an employee quits, doesn't mean you should replace that exact position. It may be a good time to evaluate your workflow and consider changes. Is the position really necessary? Could the functions be distributed to other employees or minimized through automation? Is there a current employee who would want the position, possibly freeing up a position that is easier to replace?
- The more flexible you can be, the more options you will have.
- Can you use two part-time employees vs. one full-time? It's more training, but also gives the employer more flexibility. Many hourly workers prefer part-time employment.
- You may think you should hire someone young, but there are older adults available with considerable experience who are ready for a job with less responsibility. Be open to both younger and older workers. Sometimes older workers offer increased flexibility and can adjust their hours or schedules easily.
- You may think you need someone “right away,” but don’t focus only on candidates who are unemployed and available immediately. Sometimes you have to wait for the best person.
- Make a list of the job duties, or write a job description. This will help you stay organized as you evaluate candidates.

Decide Where to Look

- One option that will save you considerable time and trouble is to work with a staffing agency. They can perform the bulk of recruiting, screening, background and reference checks. You receive a supply of qualified candidates.
- If you are handling everything in-house, there are many options. Traditionally, the St. Louis Post Dispatch was the place to look for jobs. However, there are many less expensive options available now. We use Craig’s List, because the cost is minimal. One downside is, you will receive a lot of resumes to sort through, many of whom are not remotely qualified, but there are also some gems. We have also had good luck with Simply Hired, another on-line service. Of course there is Monster. You can also post an ad on the local Medical Group Management Association (MGMA) website or other professional websites related to your need.
- St. Louis is still a “small town” in the health-care community. Put the word out that you have an opening. Ask your current employees if they know of anyone. Ask your vendors. Ask your former employees. If they have moved onto another medical practice they know another pool of candidates. Or perhaps they would like to return to your practice? Sometimes an employee doesn’t value what they have until they have moved on.
- Consider offering your employees a small “referral fee” for qualified candidates if they are hired. If the new employee is still on board in six months, you can reward the referring employee with part two of the referral fee. This encourages your existing employees to help you recruit qualified candidates. The best candidates usually come from people you know.
- Don’t forget our local schools and colleges. If you recruit regularly, build relationships with the teachers or placement departments.
- Make your organization attractive. If you have good benefits, include that in the ad. For instance, when we surveyed our current employees, the most important benefit to them was health insurance. A strong benefit plan can help the recruiting process.
Optimize the Interview Process

The interview process can be very time-consuming but is critical to your success in choosing the right candidate. Here are just a few tips:

- Always do a phone interview first. This will allow you to screen out a number of candidates and takes less time than in-person meetings.
- Be prepared. Your first priority is whether the candidate is even qualified for the position. Start there and have your questions prepared in advance. Have your job description handy.
- Your next priority is to determine if they are a good fit for your practice and culture. This is where leading questions are invaluable.
- Interview questions: MGMA of Greater St. Louis recently asked nine different local medical practice managers “What is your favorite interview question?” They shared their favorites in a video which can be seen on the MGMA of Greater St. Louis website at www.mgmastl.org in the video section.

- Have more than one individual interview the final candidates. Your staff can provide valuable input, especially from the co-worker standpoint.
- Don’t be afraid to interview a candidate more than once. You can definitely learn different aspects about a prospective employee.

When you can find the best employees, you make everyone’s life (including yours) a little easier. Your employees are the face of your practice to your patients. The investment in recruiting the best pays off in the end.

Christine M. Keefe, CPA, CMPE is the CFO & Director of Strategic Initiatives for Metro Imaging, LLC, an independent group of outpatient imaging centers serving the greater St. Louis area. Chris can be reached at cfo@metroimaging.org or at 314-333-6725.

Physicians Help Feed the Hungry

SLMMS member physicians and their families joined with thousands of other volunteers from the community to help package meals for the hungry at St. Louis World Food Day on Oct. 10 at John Burroughs School. Of the 382,000 rice/soy protein meals and macaroni/cheese meals produced, 200,000 will be provided to children in Tanzania and the remainder will be distributed locally through the St. Louis Area Food Bank. World Food Day is a worldwide event observed each October; the St. Louis event began in 2010. Medical Society members participating included 2014 President Joseph Craft III, MD; Robert Brennan, MD; Amana Nasir, MD; Vikram Rao, MD; Paul Robiolio, MD; and Mauricio Sanchez, MD, along with Liz Webb from the SLMMS staff.

Above: Shedding their hair nets and aprons for a photo were, standing from left, Carol Craft; Joseph Craft III, MD; Robert Brennan, MD; Joan Brennan; Vikram Rao, MD; Hamza Khan; Mary and Dennis Rouche. Middle: Katie Corder, dietician. Squatting, Joey Craft, Kailyn Stann, Liz Craft, Sameera Rao, Zahra Khan, Amana Nasir, MD.

Bottom left: On the packaging line, from left, Joey Craft; Joseph Craft III, MD; and Liz Craft. Bottom right: Amana Nasir, MD, and her daughter Zahra.
**MD News**

**George Hruza, MD**, SLMMS past president and current MSMA treasurer, was inaugurated in San Diego on Nov. 7 as president of the American Society for Dermatologic Surgery, an organization of almost 6,000 dermatologists specializing in dermatologic surgery.

**David German, MD**, (SLMMS), plastic and hand surgeon, joined Mercy Hyperbaric and Wound Care. Mercy also named **H. Shawn Hu, MD**, chairman of oncology services across its east region.

**Hilel Frankenthal, MD**, a pediatric critical care physician, joined Mercy Clinic Children’s Critical Care where he will care for patients in the pediatric intensive care unit at Mercy Children’s Hospital. Urologist **Gregory McLennan, MD**, joined Mercy Clinic Urology. **Jason Shanker, DO**, an emergency medicine physician, joined Mercy Hospital St. Louis. **Srikanth Thalakoti, MD**, a child neurologist, joined Mercy Clinic Child Neurology.

**Joseph M. Arcidi Jr., MD, FACS, FACC**, joined St. Anthony’s Medical center as chief of cardiovascular and thoracic surgery and a member of St. Anthony’s Heart Specialty Associates. Cardiologist **Frank Gafford, MD, FACC, FCCP**, also joined St. Anthony’s Heart Specialty Associates. **Amanda Simmons, MD**, joined **Mario Salinas, MD**, at St. Anthony’s OB/GYN Specialists, formerly Seasons Healthcare for Women.

**Jeremy D. Leidenfrost, MD**, who specializes in adult cardiac and thoracic surgery, joined Cardiothoracic Surgery, LLC at St. Luke’s Hospital. He joins **Ronald D. Leidenfrost, MD, FACS, (SLMMS), Cordie C. Coordes, MD, FACS, (SLMMS), J. Gregory Lugo, MD, FACS, (SLMMS), and Stephen R. Broderick, MD, FACS** in the practice.

**Kelle H. Moley, MD**, has been elected to the Institute of Medicine of the National Academy of Sciences. She is the James P. Crane Professor of Obstetrics and Gynecology at Washington University School of Medicine. She also is a professor of cell biology and physiology and vice chair and chief of the Division of Basic Science Research in the Department of Obstetrics and Gynecology.

**Health Systems**

**SLUCare Physician Group** has become a member of the **St. Louis Physician Alliance**, a physician-led clinically integrated network of providers committed to delivering high-quality care in an efficient manner. SLPA now has 900 physicians and 73 health-care facilities.

**Robert Cannon**, BJC HealthCare group president, has been named president of Barnes-Jewish Hospital including responsibility for Barnes-Jewish West County Hospital. Prior to joining BJC in 2000, Cannon was assistant dean of the University of Chicago’s Division of Biological Sciences and Pritzker School of Medicine. He succeeds **Richard Liekweg**, who has been promoted to the new position of BJC executive vice president. Liekweg will focus on advancing operational and clinical integration across BJC’s hospitals, service organizations and shared services departments. Liekweg joined BJC in 2009 after serving as CEO at the University of California, San Diego Medical Center, and in various leadership roles at Duke University Health System.

**BJC HealthCare President and CEO Steven Lipstein** was elected to the Institute of Medicine of the National Academy of Sciences. Lipstein has served as BJC HealthCare president and CEO since 1999.

**Products**

**ApneaStrip**, a disposable sleep apnea screening device that adults can use at home, has been introduced in the St. Louis area. It is available by prescription at select Walgreens locations. Individuals use the device while they sleep to produce next-day results as to whether they have risk for sleep apnea and should seek out further testing.

**Research**

A vaccine that protects against an old strain of avian flu primes the immune system to mount a rapid response when a vaccine designed to protect against a related but different and new strain of avian flu is given a year later, according to **Saint Louis University** research findings reported Oct. 8 in *Journal of the American Medical Association*. In addition, when combined with an adjuvant, which is a chemical that stimulates the immune system to produce more antibodies, a lower dose of the new avian flu vaccine worked better in triggering an immune response than a stronger dose without adjuvant. “This is important because of the need to respond quickly to potential pandemics,” said Robert Belshe, MD, professor of infectious diseases, allergy and immunology.
Information technology offers great possibilities in the future of health care, despite the problems physicians experience with current electronic health record systems, American Medical Association President Robert Wah, MD, told over 100 Medical Society members and guests at the annual Hippocrates Lecture on Oct. 16.

“The problem today is not with technology, but how it is used,” Dr. Wah said. “Surveys continue to show EHRs are a major source of physician dissatisfaction. Clinical care improvement should be a prime focus of EHRs.” The AMA continues to advocate for more usable EHR systems that enhance physicians’ ability to provide quality care. He noted that on Oct. 14, the AMA submitted meaningful-use recommendations in a letter to the Centers for Medicare and Medicaid Services, and the Office of the National Coordinator for Health Information Technology (ONC). (A link to the letter is available at www.slmms.org in Medical News.)

Dr. Wah is an expert in technology, having served as the first chief operating officer of the ONC. He is now chief medical officer for Computer Sciences Corporation, and continues to practice and teach reproductive endocrinology at Walter Reed National Military Medical Center.

Systems today are missing out on many possible benefits, he said. “There is no connectivity with patient smartphones. There is not communication between hospital systems.” In the way it uses information technology and collects information, medicine today is far behind other industries, he added.

“Technology can deliver better information,” Dr. Wah suggested. “For example, using EHRs and a large pool of data, we can create algorithms to help us provide better care.” He added that replacing paper processes is just the first phase of EHRs, while their true potential lies in population analysis and care coordination. Another possibility he offered is online social networks through which patients share information, such as a MIT-sponsored website.

“My view of the future is a grand health-care platform with a virtual pool of information. We would be continuously contributing to the pool and extracting from it.”

AMA President Robert Wah, MD; Hippocrates Society President Arthur Gale, MD.

Harry Eggleston, MD; Nathanial Murdock, MD, and his wife, SLMMS Alliance co-President Sandra Murdock; Josiah Ekunno, MD.

MSMA President Jeffrey Copeland, MD, and Washington University medical students Steven Eckman and Jerry Fong.

AMA INITIATIVES

Dr. Wah provided an update on current AMA efforts. Besides advocacy for more user-friendly EHR systems and federal rules related to these systems, the AMA is:

- Launching programs to reduce the toll of diabetes and cardiovascular disease, including making innovation grants to local YMCAs
- Utilizing results of a recent RAND Corporation study to reduce physician dissatisfaction from EHRs, burdensome regulations and compliance requirements, and reduced autonomy
- Providing $11 million in grants to medical schools to foster innovation in medical education. Among the concepts is competency-based advancement that enables students to bypass some classroom training and thus save on education cost. The AMA also has set as a goal to achieve an additional 15,000 residency positions, and provide vehicles to help relieve debt.

He concluded, “Now, a lot of forces are aligned against physicians. We need to come together to help shape the changes and achieve better outcomes for physicians, medical students and patients.”
Membership Luncheon and Season Opener

By Gill Waltman, SLMMS Alliance

Alliance members met at the Missouri Athletic Club on Sept. 12 to welcome new members and honor past presidents. Co-presidents Millie Bever and Sandra Murdock introduced the newly elected and appointed board members.

Past presidents recognized were Millie Bever, Sue Ann Greco, Sandra Murdock, Marge Perkins, Gill Waltman and Angela Zylka. Also recognized was Thomas Applewhite, MD, SLMMS past president. Millie, Sandra and Marge all have been MSMA Alliance presidents, and Sue Ann is the current state president-elect.

Sandra discussed the upcoming year’s program and community health projects. These include Voices of Excellence™, Hands Are Not for Hitting, Smoking is NOT for Me, and Pills are NOT a Party!!! Millie talked about the continued success of annual Match Day events across the state. Sue Ann described the year’s MSMA Alliance program observing their 90th anniversary.

Guest speaker Erika Warner from Renaissance Rx described the pharmacogenetic testing her New Orleans-based company provides. The tests of patients’ DNA determine any specific genetic makeup that can help customize medications. Both Erika and her co-worker Susan Neely have joined the SLMMS Alliance as Friends and Family members.

Highlights from North Central Regional Meeting

By Sue Ann Greco, MSMA Alliance President-Elect

MSMA Alliance members Mary Shuman (Buchanan County) and Sue Ann Greco (SLMMS Alliance) attended the AMA Alliance Northwest Regional States meeting in Rapid City, S.D., Oct. 11-12. Attendees came from 10 different Midwestern states and featured national AMA Alliance President Sarah Sanders. The South Dakota and Ohio State Alliances hosted the meeting.

Attendees shared leadership, educational and service ideas from their representative states. AMA Alliance President Sarah Sanders spoke on how different leadership styles are needed at different times. Mary Beth Ellison, AMA district director, discussed membership retention and recruitment, highlighting the differences between the generations and their participation in organizations. Groups such as the Alliance will need to adapt to the patterns of the younger generations if they wish to survive.

To help Alliance members become more familiar with communication technology, an AMA Alliance video was shown demonstrating how to use Twitter to connect with Alliance members across the country. Anna Seiwert from Ohio described how to plan a webinar meeting using Fuze.com.

Missouri will host the 2015 North Central meeting.
State Alliance Fall Conference

MSMA Alliance President Kathy Weigand from Buchanan County hosted this year’s Alliance fall conference in St. Joseph Oct. 21-22.

Thomas Weigand, MD, Kathy’s husband and well-known oncologist, gave an update on breast cancer as October is National Breast Cancer Awareness month. Dr. Weigand spoke about the major risk factors that include age, genetic influences and hormonal exposure. He also described the staging of breast cancer determined by the tumor size, lymph node involvement and presence or absence of metastatic disease. He discussed the pathology, biopsy methods and surgical procedures and how the need for adjuvant therapy is determined.

After the lecture, energetic members met on the riverfront for a Move Across Missouri walk to record more healthy miles for our MAM contest.

During dinner at the historic Pony Express Museum, member Millie Bever spoke about the history and purpose of Doctors’ Day. This concept to honor all physicians originated in 1933 in Georgia when Eudora Brown Almond wanted to honor her own physician spouse. The Southern Medical Association later adopted the concept, and it has since become a nationwide tradition celebrated every year on March 30.

Health Vice President Shirley Collison discussed the MAM contest and urged members to keep track of their individual, family and alliance group physical activities. Results should be submitted in miles walked or run. Shirley announced the deadlines for this contest, and also for the statewide Smoking is NOT for Me competition in the schools. Submission forms for both of these programs are available at www.msma.org in the Alliance section.

Shirley also discussed Greene County’s Pills are NOT a Party!!! which is now being distributed nationally. With the help of an $8,000 AMA Alliance grant, the Greene County Alliance has sent 500 folders to state alliances around the country. The folder includes a free DVD, teaching materials and evaluation forms. The alliances are to distribute the materials to local schools and youth groups. Additional copies of the DVD are available for $35.

At the board meeting, members discussed plans for the upcoming Day at the Legislature in February to coincide with MSMA’s White Coat Rally.

In addition to the MAM walk in St Joseph, local SLMMS Alliance members met for an organized walk in Tilles Park. From left: Melody Burns, Millie Bever, JoEllyn Ryall MD, Angela Zyilka, Sue Ann Greco and Sandra Murdock.

Voices of Excellence™ Showcases Youth Speakers

Students from Loyola Academy of St. Louis recently developed their writing and speaking skills with the help of SLMMS Alliance members and the Voices of Excellence™ program. Students in grades 6-8 wrote five-paragraph essays and then practiced presenting their essays, with the guidance of their teachers and SLMMS Alliance members. Winners gave their speeches at a Sept. 30 luncheon with their families and Alliance members at the Missouri Athletic Club. Pictured with the winning students are Alliance members project coordinator Claire Applewhite, left, and Sandra Murdock, right.
Leonard N. Piccione, MD

Leonard N. Piccione, MD, board-certified in family practice, died June 21, 2014, at the age of 89.

A native of Rockford, Ill., Dr. Piccione completed his undergraduate studies at Miami University in Ohio, and then graduated from the University of Illinois College of Medicine in 1950. After completing his internship at St. Luke's Hospital in Chicago, he served in the U.S. Army from 1952–1954, during the Korean war.

Dr. Piccione had a private practice in Chicago for three years then moved to St. Louis in 1958. He was on staff at SSM DePaul Health Center and Christian Hospital.

Dr. Piccione joined the St. Louis Medical Society in 1958 and became a Life Member at his retirement.

The St. Louis Metropolitan Medical Society extends its condolences to Dr. Piccione's niece Anna Owens, nephew Anthony Giovingo, and three great-nieces and nephews.

A memorial service was held in Rockford, Ill.

Hubert A. Ritter, MD

Hubert A. Ritter, MD, a board-certified obstetrician-gynecologist and SLMMS past president, died Oct. 18, 2014, at the age of 90.

Dr. Ritter was active in organized medicine and many community organizations.

A St. Louis native, Dr. Ritter graduated from Westminster College in Fulton, Mo., in 1945, then obtained his medical degree from Saint Louis University in 1948. He completed his internship and residency at Saint Louis University, and served two tours of duty as a medical officer in the U.S. Navy.

In addition to his private practice, Dr. Ritter was a clinical professor at Washington University School of Medicine. After retiring from private practice, he served as head of the ob-gyn department at Myrtle Hilliard Davis Comprehensive Health Centers.

His hospital associations included Barnes-Jewish Hospital, SSM DePaul Health Center and the former Deaconess Hospital.

Dr. Ritter also was a member of the National Medical Association, Mound City Medical Association, the American College of Obstetricians and Gynecologists, as well as the NAACP, various fraternities and St. Louis-based organizations. In 2011, he received the St. Louis American Foundation's Lifetime Achievement Award.

Dr. Ritter joined the St. Louis Medical Society in 1952 and became a Life Member at his retirement.

The St. Louis Metropolitan Medical Society extends its condolences to Dr. Ritter's wife Margaret, daughter Lisa and granddaughter Jennifer. A memorial prayer service was held at SSM St. Mary’s Health Center.

Jonathan Reed, MD

Jonathan Reed, MD, a board-certified obstetrician-gynecologist, died Nov. 3, 2014, at the age of 80.

For almost 50 years, Dr. Reed served the St. Louis community in women’s health and delivering babies through private practice as well as public health.

After earning his undergraduate biology degree at Fisk University in Nashville, Tenn., Dr. Reed was drafted into the U.S. Army and served in Korea from 1956 until 1958. He graduated from Meharry Medical College in Nashville in 1965 and then completed his internship and residency at the former Homer G. Phillips Hospital in St. Louis.

In addition to his private practice, Dr. Reed also served as an assistant clinical professor at Washington University School of Medicine. After retiring from private practice, he served as head of the ob-gyn department at Myrtle Hilliard Davis Comprehensive Health Centers.

His hospital associations included Barnes-Jewish Hospital, SSM DePaul Health Center and the former Deaconess Hospital.

Dr. Reed also was a member of the National Medical Association, Mound City Medical Association, the American College of Obstetricians and Gynecologists, as well as the NAACP, various fraternities and St. Louis-based organizations. In 2011, he received the St. Louis American Foundation’s Lifetime Achievement Award.

Dr. Reed joined the St. Louis Medical Society in 1969 and became a Life Member at his retirement.

The St. Louis Metropolitan Medical Society extends its condolences to Dr. Reed’s wife Bettye, daughters Stacy Reed Mevs, MD; Michelle Reed Arnold, MD; Dana Reed; and four grandsons. A funeral service was held at Washington A.M.E. Zion Church in St. Louis with interment at Jefferson Barracks National Cemetery.
Advice on Issues You May Encounter in Your Practice

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

Q One of our employees is exhibiting strange behaviors and has confronted a co-worker. Can we require her to go to an Employee Assistance Program (EAP)?

Answer

Employers must proceed with caution when referring an employee to EAP based on the employee’s behavior because the referral may leave an employer vulnerable to a claim that it took adverse action against the employee because the employee was “regarded as” having a disability. To avoid such claims, it is important for an employer to focus on an employee’s performance problems instead of using terms that indicate the employer thinks the employee has a disabling condition.

It is important to approach a workplace performance problem as a disciplinary issue rather than a medical issue and to be very specific about the actions that violate your policies. You should also document the disciplinary process. If the employee refuses to use your EAP or uses it without success, your organization may use its disciplinary process to address any disruptive behavior that violates workplace policies.

The ADA does not require an employer to excuse behavior that violates an employer’s conduct standards, even if the behavior is caused by an employee’s disability. If the employee indicates that her behavior is related to a medical condition, your organization should engage with the employee to determine if there is a reasonable accommodation (e.g., leave for treatment) that would allow the employee to perform essential job functions.

Q What should we do if there are I-9 Forms missing for some of our current employees?

Answer

Every current employee hired after November 6, 1986, must have an Employment Eligibility Verification Form (I-9) on file at your business. If not, the employees should complete Section 1 of the I-9 Form immediately and submit documentation as required for Section 2. The new form should be dated when completed—never back-dated. A current copy of the form can be downloaded and printed from the USCIS website: www.uscis.gov/files/form/i-9.pdf.

Q Can we ask for an applicant’s Social Security number on our employment application?

Answer

It is not unlawful for an employer to ask for a Social Security number on an employment application. However, to protect an applicant’s personal identifying information, it is not recommended that employers ask for the applicant’s number on the job application.

Employers may request a Social Security number when it is necessary to conduct a background check, for benefits enrollment, etc.

Q Do we have to pay employees who voluntarily attend training that is related to their jobs?

Answer

Time employees spend in meetings, lectures, or training is considered hours worked and must be paid, UNLESS:

- Attendance is outside regular working hours;
- Attendance is voluntary;
- The course, lecture, or meeting is not job related; and
- The employee does not perform any productive work during attendance.

Training is directly related to the employee’s job if it is designed to make the employee handle his job more effectively as distinguished from training him for another job, or to a new or additional skill.

AAIM Employers’ Association has nearly 1,400 member organizations in the St. Louis and central Illinois areas. AAIM provides tools for its members to foster organizational growth and develop the potential of individual employees. For more information about AAIM, call 314-968-3600 or visit www.aaimea.org.
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Internal Medicine

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Pediatric Anesthesiology

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Pediatrics

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DO, Kansas City University of Med & Bioscience, 2014
Born 1987, Licensed 2014  ➔ Resident/Fellow
Radiology

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Cert: Urology

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Orthopedic Surgery

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Internal Medicine

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MD, Saint Louis University, 2013
Born 1986, Licensed 2013  ➔ Resident/Fellow
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Plastic Surgery

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Born 1975, Licensed 2005  ➔ Active
Dermatology

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Born 1970, Licensed 1997  ➔ Active
Cardiovascular Disease

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Born 1981, Licensed 2012  ➔ Active
Psychiatry

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MD, University of Texas Medical Branch, Galveston, 2008
Born 1979, Licensed 2013  ➔ Active
Surgery

Mohamed A. Zayed, MD
660 S. Euclid Ave., #8109, 63110-1010
MD, University of North Carolina, 2009
Born 1981, Licensed 2014  ➔ Active
Surgery

The Medical Society welcomes the following 58 student members from Washington University School of Medicine:

Chinwendu L. Amazu
Julia M. Berg
Cristopher Briscoe
Nora Burdis
Ami C. Chiu
Avril K. Coley
Kevin A. Cross
Elizabeth A. Daniels
Emily C. Davis
Kshitij A. Desai
Ian Ferguson
Seren Gedallovich
Jacob W. Groendyk
Chunder Guo
Norwin Haque
Seth G. Howdeshell
Lingling Huang
Abyie Ibiebele
Radhika Jain
Kavan Javaherian
Katerina Konstantinoff
Jodi Lapidus
Kevin Li
Marianne Ligon
Deepak Lingam
Andrew D. Linkugel
Sonya Liu
Shamaita Majumdar
Alexander M. Markov
Benjamin Masserano
Kunal M. Mathur
Manuela Mejia
Michelle Mendiola-Pla
Kelly S. Milman
Mahati Mokkarala
Gabriela Morris
Sindoora Murthy
Kenneth Newcomer
Elaine Otchere
Dylan Powell
Kristen K. Rosano
Derek Schloemann
Tony S. Shen
Sampad Sindhar
Andrea Soares
Rachel Springer
Robert L. Thomas
Ethan M. Tobias
Angus Toland
Rubabin Tooba
Sirish Veligati
Cynthia Wang
Caroline J. Wentworth
Jeannette Wong
Ian Wood
Zhuchen Xu
Naichien Yeat
Christopher J. Yoon

Protecting Your Reputation Is Paramount.

We Do What We Do Best, So You Can Do What You Do Best: Practice Medicine!

MPM spares no expense when it comes to protecting our physician’s medical reputation.

When a patient or family member publicly challenges a physician’s competency through filing a lawsuit we understand how personally devastating this is for a physician. MPM’s management policy has always been to retain only the “The Best of the Best” legal minds in the marketplace. Our stellar legal record speaks for itself.

Being the best, is in the details, from Missouri Professionals Mutual’s proprietary state of the art “real-time” legal-claims management reporting software; to our preparedness to obtain the necessary exhibits, and the number and type of expert witnesses to evaluate the merits of all allegations required to accurately defend a case. Our claims management team leaves no stone unturned in the defense of our members. These consistencies mark MPM as the best choice for professional medical liability insurance protection in Missouri and Kansas.

For more information on MPM Claims Management contact Jodi S. Sease, R.N., B.S.N., President, MPM Claims Management at 314-587-8087 or JSease@mpmins.com