ST. LOUIS METROPOLITAN
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Public Health Officials Take Aim

Harry's Homilies©

Harry L.S. Knopf, MD

ON MEMORY

The most reliable memories are those that someone else recalls.

My wife and I like to tell stories. They are mostly about our travels together, but when I tell them, I tend to embellish them … a little. So that particular event did not occur exactly on that day. So what? It helped the story to flow. My wife, however, is hard-wired to fact. She remembers verbatim whatever is said and factually what transpired. So I tell our friends: "If you want the story of our trip, let me tell you. If you want the facts, ask my wife." The next time, I'm going to bring a tape recorder!

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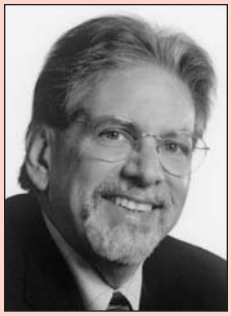
Dr. Knopf is editor of Harry's Homilies©. He is an ophthalmologist in private practice.

SCAM-Q*

** How insurance companies, hospitals, government, etc. Slice Costs And Maintain Quality*

Where Have All the Mowers Gone?

By Richard J. Gimpelson, MD



Richard J. Gimpelson, MD

Just down the street, in a home like a palace
Live H'mo and M'co, two twins full of malice.
They also have cousins as evil as they are
One's last name McAid and the other McAre.

When I and my friends mow lawns for ten dollars
H'mo and M'co both jump up and holler.
Although your efforts cost money and time
You shall only be paid four bucks and a dime.

My friends and I try to make up a plan
To organize together and take up a stand.
But McAid and McAre have friends in high places,
They are attorneys with ghost-like faces.

These attorneys from the firm of Justice and Fed
Say if we organize, they'll cut off our head.
We plead our case, we pay more for gas
But Justice and Fed rule this doesn't pass.

My friends and I struggle, and some lose their mowers
H'mo and M'co claim those losers are slower.
They say if you mow more lawns each day
You'll make up in volume what you lose in pay.

For some unknown reason, a real mystery to me
Justice and Fed have an epiphany
They find that H'mo and M'co are cheating
Justice and Fed order them to a meeting.

H'mo and M'co are accused of sleaze
They have been fixing both payments and fees
M'co and H'mo won't say yes or say no
But we'll pay billions if you just let us go.

So Justice and Fed take the twins cash
And put this new fortune in their own stash
M'co and H'mo leave after a while
And vow n'er again as they flash a slick smile.

Now McAid and McAre are really both cheap.
They don't want to part with the taxes they reap.
They constantly threaten double digit cuts
Our leaders continue to kiss their fat butts.

The lawn mowing business grows leaner and leaner
While lawns turn to weeds and the grass is less greener.
Soon there will be no mowers to mow
And those who need mowing can thank M'co and H'mo.

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Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.

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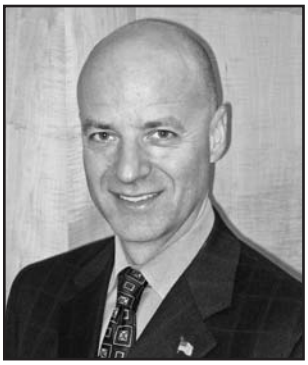
Never Pay for Never Events

CMS proposes to eliminate reimbursements for certain conditions



Medical Society President George J. Hruza, MD, MBA

After pay for performance (P4P) that supposedly rewards providers for good outcomes, now comes the inverse: no pay for poor performance. The National Quality Forum (NQF) has developed a list of 28 "never events" that are not present on admission, develop in the hospital setting and should not have occurred if proper established protocols are followed. Centers for Medicare and Medicaid Services (CMS) has determined that several of these never events should not be reimbursed including foreign object left in a patient after surgery, air embolism, transfusion with incompatible blood, development of stage 3 or 4 decubitus ulcers, physical injury in the hospital (e.g. burn, fall or electric shock) and severe hypoglycemia (proposed).

The basis for these actions is the 2005 Deficit Reduction Act, which instructed CMS to select at least two complications occurring during hospitalization that are either high cost or high volume and that could have reasonably been prevented through application of evidence-based medicine. The hospital would no longer be reimbursed for the costs associated with these complications. CMS took this directive to heart and is executing it with gusto. Rather than coming up with two conditions, they initially came up with eight and less than a year later propose to add nine more. The payment elimination will take place on October 1, 2008.

If CMS stuck to never events, most providers would support such an initiative. Most would agree that a hospital should not be reimbursed for fixing obvious errors such as leaving an instrument inside of a patient at the time of surgery. Refusing payment is a great motivator for hospitals to reduce medical errors that result in patient morbidity and mortality. Of course, eliminating payment for such rare events will achieve minimal savings for CMS and will have minimal financial impact on the hospital. Such events lead to far higher tort payments to the injured patient and loss of patients due to adverse publicity. These other costs provide a far greater incentive for hospitals to eliminate never events than CMS reimbursement reduction.

In search of more significant impact, CMS came up with other hospital-acquired conditions that they would not pay for including catheter-associated urinary tract infections (UTI), vascular catheter-associated infections, and certain surgical site infections (mediastinitis after coronary artery bypass graft surgery). Additionally proposed for inclusion are Legionnaire's disease, iatrogenic pneumothorax, delirium, ventilator-associated pneumonia, deep venous thrombosis/pulmonary emboli, *Staphylococcus aureus* septicemia and *Clostridum difficile* infection, methicillin-resistant S. *aureus* infection and surgical site infections (total knee replacement, laparoscopic gastric bypass and gastroenterostomy and varicose vein stripping).

> **"Unfortunately, their program as proposed is overreaching and will have significant unintended consequences which will dilute enhanced patient safety initiatives"**

Not paying for this second set of complications is far more controversial. The risk of these complications can be reduced with proper protocols, but not totally eliminated. Some are unavoidable in the course of treating the patient's underlying condition while others occur due to the patient's associated medical condition such as immunosuppression, debility, diabetes, etc. The cost of the care provided to these patients will have to be paid for somehow. It will probably be partly through cost-shifting to private insurers. Also, as diagnosis-related group (DRG) payment updates are based on hospital cost increases, the costs will be built into overall higher DRG payments. There will also be increased costs as hospitals increase screening

tests of patients at the time of admission to establish whether or not they have an occult infection or other abnormality that might become clinically apparent after admission and thus be non-reimbursable. There will potentially be a reluctance to admit high-risk patients or to do high-risk procedures on patients who need them.

Not to be outdone, private insurers have been jumping on the never event bandwagon. Wellpoint will no longer pay hospitals for any of the 28 never events on the NQF list. Cigna will not reimburse hospitals for some of the never events and is looking at not paying for the CMS-designated hospital-acquired conditions. The Blue Cross and Blue Shield Association and Aetna have also announced plans to stop paying hospitals for never events. Hospitals in 11 states (not in Missouri) have agreed to not bill insurers or patients for never events.

Impact on Physicians

Why should physicians care? How will this impact them? Hospitals can be expected to become far more vigilant in policing their medical staffs and tracking their performance. There will be new protocols introduced to reduce hospital-acquired conditions with physicians playing a key role in their development and implementation. These activities will benefit patient care and should be encouraged. Unfortunately, there will also be less desirable consequences such as increased bureaucratic documentation burden on physicians and medical care dictated by committee or fiat rather than individual patient and doctor considerations.

Since physicians bill under Medicare Part B, they would still get paid for taking care of these hospital-acquired conditions. However, CMS has mentioned in their various notices that ambulatory surgery centers and physician offices might also be included in future non-reimbursement for never events actions. Of course, most physicians already do not bill patients or insurers for correcting complications secondary to treatments or procedures that they themselves performed. For example, if a patient develops a postoperative infection, I do not bill the patient for taking care of it or if a patient develops a hematoma, I do not bill them for evacuating it. The point here is that the physician and not a government bureaucracy should determine if it is appropriate to bill for the treatment of an untoward outcome.

Another area of concern is the implied liability when a hospital-acquired condition is not reimbursed. Certainly plaintiff's attorneys will look for business among patients with hospital-acquired conditions. If surgery is done on the wrong limb, the liability of the hospital and surgeon is clear and the patient deserves to be compensated. But what about a patient who gets UTI after an indwelling urinary catheter placement, a patient who develops a DVT and pulmonary emboli or a patient who develops a bacterial infection in the hospital? To most physicians, many of these are unavoidable complications. To the patient and his attorney, all of these would be "avoidable" conditions, which in their mind means that someone was negligent and should be made to pay. The physician taking care of these patients will have a big bull's eye on them asking to be sued.

I applaud CMS's attempt to improve patient safety. Money is a strong incentive to reduce avoidable complications. Unfortunately, their program as proposed is overreaching and will have significant unintended consequences which will dilute enhanced patient safety initiatives with increased cost, increased bureaucracy, increased professional liability and interference in the patient-doctor relationship. If you have an opinion on the proposed regulations on the additional nine hospital-acquired conditions, consider sending comments to CMS by the June 13, 2008 deadline.

Resources

National quality forum list of 29 never events can be found at www.qualityforum.org. Final rule on non-reimbursement of hospital-acquired conditions: Federal Register 72(162):47200-47218, August 22, 2007.

Proposed rule on non-reimbursement of additional hospital-acquired conditions: Federal Register 73(84):23547-23562, April 30, 2008.

When sending comments on the proposed rule, refer to CMS-1390-P sending one original and two copies to Centers for Medicare and Medicaid Services, Department of Health and Human Services, Attention: CMS-1390-P, PO Box 8011, Baltimore, MD 21244-1850.

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From the Executive Vice President

Managing in a Time of Continuous Change

Trends affect both SLMMS and medical practices

Medical Society Executive Vice President Thomas A. Watters, CAE

Being in the association business is a lot different than being in medical practice, but the professions do have a few things in common. For one thing, it's a constant learning process, because things never stay the same. Like you, I have to continue to recognize that there are always new problems and new ways to attack those problems. And what I've learned in recent years is that associations and societies like SLMMS face an entirely different set of problems and issues than they did 10 or 15 years ago. I'm sure you see some of these same trends occurring in your practices.

First, the process of change itself is now different. Up until the early 1990s, if you plotted a curve of change over time, it followed a pretty normal curve – slow, steady and continuous. Today, the process is discontinuous. As you look at the curve, it gets steeper and steeper near the end, and in recent years has begun to take on the appearance of an EKG pattern.

> **"If you're not open to, and comfortable with, constant change, you'll quickly fall behind"**

What that means for SLMMS is that we can't plan as far ahead as in the past. That's why nobody does "long range planning" anymore. Today, it's called Strategic Planning, and your plan is likely to look no farther ahead than a couple of years. And it also means the leaders of societies need to understand that associations need to be structured in a way that they can react to change more quickly. The catch word today is nimble. If you're nimble, you can react quickly, and you may be able to ride one of those "spikes" upward on the curve. You may see a similar need in the business of running a practice.

A second change involves the nature of our members. Members of groups today – even very homogeneous groups like medical societies – are less similar to one another than they used to be … or, in other words, they're more dissimilar. In the past, societies spent more time working for all doctors in a general way. Today, with all the specialties, we find that members have more diverse and finely tuned needs and interests. One week we may be working on behalf of psychiatrists concerned with psychologists gaining prescribing privileges, and the next week working for OBGYNs dismayed with proposed new midwifery legislation. Within every group is a wider variety of people and personalities with a more diverse range of interests, activities and needs than in the past. What that means for associations is that they have to provide a wider range of programs than they have in the past. You have to be in more places. In technical terms, you have to provide more "stuff." Patients today may expect the same.

A third area of difference is accountability. Staffs that work for societies and other associations have always had to be accountable to the boards to which they report. If they weren't, there were quick and sure consequences. But today, boards and councils have to be more responsive to their members than ever before. The call for corporate accountability has crossed over into the nonprofit world like never before. Transparency isn't just a catch word in P4P programs, it's a necessity in the association business as well. We have new accounting standards ensuring that everything is laid open for the scrutiny of the membership. Finances, budgets, progress reports – they're all an open book – and the members will quickly let you know if they believe you're off track.

Another area is time availability. Members today have less time… or at least believe they have less time… than in the past. Societies used to be able to express their needs and ask the members to build their time around those needs. In spite of all the time savings brought about by technology, most of us find ourselves spending more time at our desks than in the past. Computers today may be fast, but they're also cruel taskmasters. They may allow us to do things more quickly, but they've given us more to do. And today, people are more protective of the little personal time they have than ever before, and associations have had to learn that they

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Managing in a Time of Continuous Change *(continued)*

need to build their programs around the members' time, not vice versa. In your businesses, you have had to establish your own time priorities, and have had to adjust to your patients' changing attitudes as well.

A fifth trend is technology itself. It's been around for many years, but not with the impact it has today. Back in the 1980s, people began to say the organization that had the biggest database would win out over its competition. Then in the 1990s, they said those who had the best software won. It was all about staying ahead of your competition by utilizing the best and the latest. Today, those who have the best Web sites and electronic communications have an edge.

The key thing is that if you're not open to, and comfortable with, constant change, you'll quickly fall behind. And it needs to be a constant and conscious effort to make sure you're always looking for opportunities to change, putting new opportunities to work for you, and not just reacting to change after it's inevitable. In your practices, you have to deal with the advent of EMRs. For us, it's the latest database management software and lightning-fast communication with members.

What I've found is that these trends make up a complex environment that makes the jobs of association leaders – and everyone else in business – more difficult than ever. Some things stay the same. Membership is a key issue for us, and always has been. But the way we deal with it has changed radically, and will continue to change rapidly.

There are a few other things that haven't changed. Members join societies, and more important, stay in societies, for a few very basic reasons. They want to belong to organizations that give them a good return on their investment. They want valuable benefits in exchange for the dues they pay. And they want to belong to an organization that they are proud to be part of – one they can brag about to their associates. And finally, they want to have an enjoyable experience. This is not why they join in the first place, but as time passes, if they don't feel good about their experience, many of them won't stay. That's why providing opportunities for participation is important. Your patients probably feel the same – they want a good return on investment, to be proud to be your patient, and to have an enjoyable experience whenever possible. Maybe our businesses aren't so different after all.

We all have our challenges, and perhaps they're not that different from business to business. But they're certainly different than in the past.

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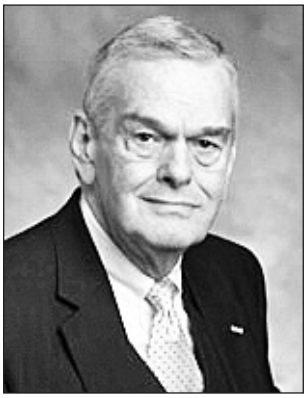
Investing in the Health of Missourians

The Missouri Foundation for Health awards $60 million in grants annually to projects that improve people's health

By James R. Kimmey, MD, MPH
President and CEO, Missouri Foundation for Health



James R. Kimmey, MD

When the Missouri Foundation for Health (MFH) was created in 2000, its vision was clear – improve the health of the people in the communities it serves. Today, having already made more than $280 million in grants, MFH stands as the largest non-governmental funder of health-related organizations in Missouri.

Created to receive the assets of Blue Cross Blue Shield of Missouri following its conversion from nonprofit to for-profit status, MFH is the third largest health conversion foundation in the country. With assets of approximately $1.3 billion, MFH awards about $60 million in grants annually to health-focused nonprofits in the MFH service area. That area includes three-fourths of the state – 84 counties and the City of St. Louis. (see accompanying map).

Through its grantmaking, MFH works to empower people in Missouri's communities to achieve equal access to quality health services that promote prevention and encourage healthy behaviors. Through its health policy work, which stands as one of the premier efforts among foundations in the country, MFH also strives to inform the public and community leaders about effective health policies that can result in long-term, positive health system change in Missouri. MFH regularly produces publications that evaluate and comment on key health issues and policy concerns.

Driving MFH's grantmaking decisions are three key charges:

- Identifying/filling gaps in the myriad public and private health care services already available to the uninsured and underinsured,
- Identifying/addressing unmet health care needs in the underserved populations, and
- Identifying/funding health care programs in order to maximize MFH's resources for the greatest possible effect.

As a foundation, MFH does not create or conduct programs, but rather supports existing community efforts that are helping hundreds of thousands of Missourians each day. A look at MFH's current 730+ active grantees displays a wide spectrum of program interest. A common thread is that each brings vital health services and information to their respective communities.

MFH's funding strategy is two-fold – to address significant health concerns in Missouri and to spur interest among communities and other funders to develop pro-active strategies for creating healthier environments and healthier Missourians. To achieve that, MFH both supports grant programs that target specific health issues and provides significant grants to drive statewide, health-related initiatives.

Those statewide efforts range from free vaccine to emergency medical transportation to the 2-1-1 helpline. In early 2007, MFH earmarked $11 million to purchase enough **human papilloma virus (HPV) vaccine** so that it could be given for free to Missouri girls/women ages 9-26 who cannot either afford the vaccine or are not eligible for the Vaccines for Children program. The vaccine series, which normally costs $360, protects against the most common HPV strains that cause cervical cancer and genital warts. A network of 135 health centers/clinics in the MFH service area provide the free vaccine, helping thousands of young women avoid a future health threat. MFH's action also inspired the Health Care Foundation of Greater Kansas City and the Reach Foundation to provide a $2.5 million grant to support a free HPV vaccine program in that metropolitan area. Through those efforts, Missouri stands as the only state in the country in which the vaccine is free to all eligible females, without the expenditure of any state funds.

MFH strongly supports the development of integrated, coordinated **statewide emergency medical services** that will improve health outcomes for all Missourians. Following MFH's four years of work to draw interest and support for this effort, a 100-member task force of experts from across Missouri is working to design a system to improve health outcomes for victims of trauma, stroke and STEMI.

MFH also has partnered with the United Way of Greater St. Louis to develop a free telephone helpline that links all residents within the MFH service area to local health/human services, social service agencies and other area nonprofits. This **2-1-1 telephone service** is expected to annually connect 150,000 residents with services that they need.

Investing in the Health of Missourians *(continued)*

Long-range funding from MFH targets three of Missouri's most critical health issues – tobacco prevention and cessation, obesity prevention, and access to health care.

The **Tobacco Prevention & Cessation Initiative (TPCI)** is a nine-year, $40 million funding effort that began in 2004. Missourians smoke at a higher rate than the national average, yet the state ranks last in funding tobacco prevention and cessation programs. This initiative provides grants to regional and community-based programs that target tobacco prevention in schools and workplace cessation efforts. MFH also funded the most comprehensive county-level survey to date in Missouri on tobacco use and the prevalence of chronic diseases associated with such use and secondhand smoke.

With 25 percent of Missouri adults reported as obese, MFH's **Healthy & Active Communities Initiative (HAC)**, funds 33 organizations around the state with community wellness and behavior change programs. Those efforts include school-based events, walking trails, community gardens, senior citizen physical activity, nutrition programs for disabled individuals and social marketing campaigns to increase awareness about good physical activity and nutrition. Just entering its third year of funding, this initiative also hopes to develop and strengthen efforts to implement local public policies that promote physical activity and healthy eating.

MFH's **Primary Care Access Initiative (PCI)** focuses on one of Missouri's most critical challenges – lack of access to quality health care faced by nearly all Missourians who live outside the state's urban areas. In its second year, this multi-year initiative funds expansion and start-up of federally qualified health centers and look-alikes, as well as support to other community health centers. Future funding will focus on rural health clinics. This initiative is an outgrowth of MFH's 2005 support of the St. Louis Clinic Affiliation Project, which bolstered the health care safety net in the St. Louis metropolitan area.

Several other health issues also stand as MFH priorities – diabetes, childhood asthma, mental health and substance abuse, oral health care, violence against women, and health literacy. Recognizing that chronic health issues plague many Missourians, MFH's **Chronic Care** funding effort is based on the nationally accepted model that patients who are actively engaged with their health care and providers are better able to manage chronic illness. This funding first focused on diabetes, the seventh-leading cause of death in Missouri. In 2008, this program's focus shifts to childhood asthma, an especially critical health concern in Missouri's urban areas.

For the estimated 80,000 Missourians with both a serious mental illness and dependency on alcohol or illegal drugs, the lack of health care coordination impacts both adequate treatment options and success rates. MFH's **Mental Health and Substance Abuse** funding program helps community organizations collaborate to provide integrated treatment, and also provides funding for suicide and substance abuse prevention programs for youths.

Missouri also has a serious shortage of resources to provide adequate **oral health care**. MFH's efforts in this area first focused on funding school-based or school-linked dental sealant programs, a key element in children's preventative dental care and to reduce the need for more costly treatments later. The next funding effort addresses the lack of dental professionals in the state's rural areas.

MFH's most recent priority targets one aspect of **women's health** – the shortage of adequate community services for women and their families coping with sexual assault and intimate partner violence. With half of the state's counties having little or no existing services, funding focuses on expanding access to serve more women in more communities.

For the majority of people in the U.S. and in Missouri understanding health-related information is a struggle. MFH's **Missouri Health Literacy Enhancement** program supports developing ef-

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FEATURE

Public Health Officials Take Aim at

Diseases impact teenagers, African-Americans most

Facing some of the nation's highest rates of sexually transmitted diseases (STDs), St. Louis-area public health officials are intensifying education and community outreach efforts. They point to STDs as the region's number-one public health issue.

STDs are especially a concern because they disproportionately affect minorities, young people, and economically disadvantaged, public health officials say.

The St. Louis city and county health departments are conducting education and outreach to young people about STD prevention. The city health department has formed a Youth Empowerment Advocates for Health (YEAH) team made up of student employees. Pictured, members of the group with their supervisor Aaron Morris (seated) at an April "Youth Health Explosion" at Mercenary Tabernacle Baptist Church.

How serious is the problem locally? The St. Louis metropolitan area ranks sixth in the nation in rates for chlamydia and fifth for gonorrhea, according to the 2006 annual surveillance report by the Centers for Disease Control and Prevention. When comparing just the city of St. Louis to other independent counties and large cities, St. Louis has the highest rates in the nation for both chlamydia and gonorrhea – an indication of how the problems of poverty in the urban core are magnified in any data on the city of St. Louis. This data sent an alarm signal to the local community.

What's more, the incidence of these STDs has been growing. The number of chlamydia cases in the metropolitan area grew 47 percent from 2002 to 2006, according to CDC figures. Gonorrhea cases increased by 13.9 percent. However, the trend may be beginning to change – the city of St. Louis reports a 5.7 percent decline in chlamydia cases and a 10.7 percent drop in gonorrhea cases in 2007.

In St. Louis city and county in 2007, reported cases were 9,244 for chlamydia, 4,837 for gonorrhea and 88 for syphilis.

A National Public Health Concern

The CDC regards STDs as a major public health challenge nationally. The CDC estimates that approximately 19 million new sexually transmitted infections occur each year, almost half of them among young people ages 15 to 24. In addition to the physical and psychological consequences, these diseases consume an estimated $15 billion in medical costs annually, the CDC says.

In St. Louis County, about 39 percent of the 7,300 STD cases reported in 2007 occurred among teenagers, even though they comprise only 10 percent of county residents. In St. Louis city, 71.8 percent of chlamydia cases were among the 15-24 age group in 2007. Youth ages 15-24 represented 60.1 percent of gonorrhea cases.

Also in the city, the overwhelming number of cases occur among African-Americans – 93.7 percent of chlamydia cases, 96.4 percent of gonorrhea cases and 92.5 percent of syphilis cases.

A CDC report released in March stated that one in four (26 percent) of female adolescents ages 14-19 in the United States has at least one of the more common sexually transmitted infections (STIs). These include not only sexually transmitted bacterial diseases, but also human papillomavirus, herpes and others. By race, African-American teenage girls had the highest prevalence, with an overall rate of 48 percent compared to 20 percent among other ethnicities.

The high incidence of STDs among African-Americans is a symptom of other health, mental health and social issues such as lack of access to comprehensive health care, the effects of poverty,

and lack of knowledge among youth as to their risks and treatment options, said Pamela Rice Walker, acting director of health for the City of St. Louis.

"No level of STDs is acceptable, especially among our youth. It is time to work together in the region in both the public and private sectors to eliminate the risk of these disabling and life-threatening illnesses," she said.

STDs have costly health consequences as well. These include cervical cancer, infertility and ectopic pregnancy, said Richard Knaup, manager of communicable disease services for the St. Louis County Department of Health. STDs increase the transmission of HIV; women with chlamydia are up to five times more likely to become infected with HIV, he said.

What's Being Done

The St. Louis city and county health departments have a number of programs and initiatives under way to help reduce the incidence of STDs.

Youth Education. The city health department has established the Youth Empowerment Advocates for Health (YEAH) program in which student employees of the department provide community education. In December, YEAH helped organize The Body & Soul Project at St. Louis Community College - Forest Park. The goal was to create a youth-centered event aimed at increasing awareness among teens about STDs, the benefits of abstinence and the consequences of risky behavior. Over 200 young people attended along with 30 parents. The Juvenile Court and Youth Empowerment Services helped plan the event. More than 60 attendees signed a commitment pledge to carry on the message of sexual responsibility.

In St. Louis County, presentations have been made since November 2007 to some 1,900 youth in high schools, middle schools, family court and other community settings.

Screening in Non-Traditional Settings. Both the city and county are working to expand screenings. St. Louis County Jail inmates have been offered tests since 2004; in that time 1,001 chlamydia cases and 254 gonorrhea cases have been identified. In St. Louis city, nearly 400 youth in juvenile detention have been tested from December 2007 through April. At the city's Minimum Security Institution, over 445 individuals have been screened for HIV since September 2007. The city also utilizes the Accenion Cares mobile clinic.

Clinical Services. The county provides free, walk-in STD clinical services and treatment at the North Central Community Health Center in Pine Lawn. The city makes services available through ConnectCare on Delmar Boulevard. In addition, the city participates with a community collaboration led by BJC HealthCare on a teen drop-in clinic.

Advice to Physicians

Proper screening and testing can help detect STIs and STDs in the early stages.

Richard J. Gimpelson, MD, SLMMS past president and *St. Louis Metropolitan Medicine* columnist, suggests that physicians ordering pap smears include tests for HPV, chlamydia and gonorrhea for any patient who is sexually active.

These tests are also recommended by the CDC in its guidelines, which are available through the local health departments or at www.cdc.gov/std.

Insurance reimbursements also need to be revised to make HPV vaccinations a pharmacy benefit instead of a medical benefit, so physicians are not required to purchase and stock supplies of the vaccine, Dr. Gimpelson said. (See his column on this subject in the May-June 2007 issue of *St. Louis Metropolitan Medicine*.)

Public health officials are hopeful that with continued education and screening, the STD picture in the St. Louis area will improve in the years ahead.

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