ST. LOUIS METROPOLITAN
MEDICINE
VOLUME 40, NUMBER 3 JUNE / JULY 2018

# Team-Based Care

## Inside

**Team-Based Care**

10 ► Implementing a Team-Based Care Approach

14 ► Team-Based Care: It's a Worthwhile Journey

**Features**

16 ► Front Desk and Scheduling: The Face of Your Practice

20 ► Onerous Rules on Certification, Quality


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

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



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

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

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

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◄ **VOLUME 40 | NUMBER 3 | JUNE / JULY 2018** ►

## Cover Feature: Team-Based Care

**Implementing a Team-Based Care Approach** **10**
*How a practice can structure responsibilities to maximize physician time, improve quality of care and prepare for value-based payment*
► *By Karen S. Schechter, RHIA, MBA, CCS-P, CMPE*

**Team-Based Care: It's a Worthwhile Journey** **14**
*Observations on the benefits of team-based care and making the transition to it*
► *By Kathy Gibala*

## Features

**Front Desk and Scheduling: The Face of Your Practice** **16**
*Hiring and training the right people to give strong customer service and enter patient information accurately*
► *By Chastity D. Werner, CMPE, RHIT, NCP, CRCR*

*MGMA:* **Navigating MIPS in 2018** **19**
*Review your EHR to ensure proper information is being reported to Medicare*
► *By Derrick Weisbrod, MGMA of Greater St. Louis*

**Onerous Rules on Certification, Quality Adversely Impact Physicians** **20**
*They reward bureaucrats, undermine physician morale and do not improve patient care*
► *By Arthur Gale, MD*

**Serving the Next Generation of Physicians** **25**
*SLU medical students tutor youth at STEM high school*
► *By Dominic DeMarco and Parth Joshi*

## Columns

*President's Page:* **The Value of SLMMS** **2**
*Now is the time to reassert ourselves and demonstrate the value the Medical Society brings*
► *By Christopher A. Swingle, DO, Medical Society President*

*Executive Vice President:* **Another Successful "Resolution Season"** **5**
► *By David M. Nowak*

*Harry's Homilies:* **On Teamwork** **13**
► *By Harry L.S. Knopf, MD*

*Parting Shots:* **The Anthem Compromise: Heads, They Win; Tails, You Lose** **24**
► *By Richard J. Gimpelson, MD*

## News

**SLMMS Seeks Council and Committee Members** **6**
**Tackling the Opioid Epidemic** **8**
**Nominations Open for SLMMS Awards** **22**

## Departments

**18** New Members
**22** Alliance
**23** Obituaries

# The Value of SLMMS

## Now is the time to reassert ourselves and demonstrate the value the Medical Society brings

*By Christopher A. Swingle, DO, Medical Society President*

*Medical Society President Christopher A. Swingle, DO*

"Knowing is not enough; we must apply. Willing is not enough; we must do."

– Johann Wolfgang von Goethe

As a proud dues-paying member of the St. Louis Metropolitan Medical Society, you understand the value of membership and the mission of SLMMS. I sincerely thank you for your support. I am also going to need your help.

A major point of my installation speech in January was that the St. Louis community needs to again see SLMMS as the voice of the St. Louis physician. When a medical story hits the local media, who are the experts that people are looking to? Maybe it's a physician scientist from Washington University or Saint Louis University; maybe it's a hospital representative (who may or may not actually be a physician!), or possibly a media-savvy nationally prominent physician. Too often though, it isn't our Society. Why?

A few years ago, when I had been on SLMMS Council for some time, I made the acquaintance of the father of one of my son's friends. In talking, I found out that he is a surgeon at one of the large academic hospitals in town. I told him about my practice and that I was part of "slims." He gave me a strange look, thinking I was making a joke about his weight (for the record, he was in no way obese). Trying to laugh off the misunderstanding, I said, "No, no! The St. Louis Metropolitan Medical Society! You know… SLMMS!" To this, he furrowed his brow and responded, "What's that?"

I'd like to say this was an isolated incident, but as my journey in local and state organized medicine has progressed, ignorance of SLMMS is the rule and not the exception. Essentially all local physicians have heard of the AMA. Many have heard of the Missouri State Medical Association. It's a minority that has heard of the St. Louis Metropolitan Medical Society.

The other part of the equation is that among those who have heard of SLMMS, far too many misunderstand what we do or see inadequate value in membership. I had a colleague tell me that they weren't a member because they had no desire to be part of a group of doctors whining about their salaries. I hope I was sufficiently persuasive when I said that I would have no interest in being part of a group like that either, that is most definitely not how we spend the second Tuesday night of every month, and it is not the conversation we have in our magazine. Was this individual doctor an outlier with this kind of horrible impression? I sincerely hope so, but what if they aren't?

### What Value Do We Bring?

Happily, there is enthusiasm for what we do from physicians who understand our mission. Governmental organizations and other physician groups to which we have reached out are eager to partner with SLMMS on community health initiatives, medical student/resident education and physician development. I'm also glad to say that SLMMS still has cachet with several organizations in town that know us. But what also is obvious is that we have an uphill climb with them; when I ask what the barrier was to having their physicians become SLMMS members, I get variations of essentially the same answer: "I love what you do, but I only have so much to budget on journals, conferences and memberships. How am I supposed to squeeze in something else?" In other words, what value to we bring?

Many decades ago, sponsorship was a requirement to be considered for membership in the St. Louis Metropolitan Medical Society. I have also been told that there was even a time where membership was a prerequisite for privileges at some hospitals! The advantages of membership were obvious; it was career limiting and less prestigious to not be a member. We are a long way from those days and the time to reassert ourselves and demonstrate our value is right now. So how should this work?

I would ask that you spend a minute thinking about what our Society means to you and how you can articulate this to our non-member colleagues.

Let's start by increasing awareness. Recently, the SLMMS Council began to lay the foundation for a Media Relations Committee, the purpose of which will be to develop ongoing relationships with local print, radio, television and internet media sources. A medical society with strong local media connections can drive the conversation in a pro-patient and pro-physician direction, instead of simply reacting to the latest news when called.

The Membership Committee has been doing an outstanding job of defining what our value is, and articulating it in simple, easy-to-remember points. The idea here is to have a ready answer to the question, "Why should I be a member of SLMMS?" It gets a little complicated because different physicians are looking for different things. Many physicians prioritize political advocacy on behalf of their patients. Younger physicians might be looking for networking and mentors. Yet others are looking to develop their leadership potential. The goal is to have compelling propositions for all our St. Louis physicians.

### Furthering Physician Advocacy, Communication and Education

Countless other municipalities have seen their societies wither or shut their doors altogether over the past few years. It would be tragic if a society that has existed since 1836 folded because of a lack of imagination and failure to adapt. I'm pleased to say that the Strategic Planning Committee is closely examining and re-evaluating what it means to be a metropolitan medical society in the 21st century. How do we define membership, and how does that further physician advocacy, communication and education? It's a complex question that demands debate, but also input from our membership.

There is precedent for successful change; current AMA President David Barbe, MD, was kind enough to share his thoughts on attracting and retaining members at the recent MSMA convention. As you may remember, the AMA had an exodus of membership during the Affordable Care Act debates

*continued on page 4*

of the Obama administration. By refocusing on the value that the AMA provides, notching up legislative wins and overhauling their brand, the American Medical Association has enjoyed six consecutive years of membership growth.[1] In our conversation, Dr. Barbe agreed that the AMA's template for success can be adapted for the local medical society.

The changes being explored by your SLMMS Council and committees are certainly a work in progress. We will continue to develop both strategy and tactics in the coming months to ensure that the St. Louis Metropolitan Medical Society doesn't simply survive, but thrives in the coming decades. As a member, I would ask that you spend a minute thinking about what our Society means to you and how you can articulate this to our non-member colleagues. There are 6,100 actively licensed physicians in St. Louis City and County. Only about 1,100 are SLMMS members. We need your help to change that.

Some of the best advice I ever got as a medical student came from my neurology attending when I noticed that he always held an elevator or a door open for patients and families and always did so with a genuine smile. "It may or may not be fair, but patients are going to see doctors as cold, arrogant and aloof. Never miss an opportunity to prove otherwise." It is still great advice that I have always tried to live professionally. I invite you to join me in also applying this idea to our non-member physician colleagues and never miss an opportunity to prove the value of the St. Louis Metropolitan Medical Society. ◄

Reference

1. AMA membership up for 6th consecutive year. AMA Wire. May 11, 2017. https://wire.ama-assn.org/ama-news/ama-membership-6th-consecutive-year-annual-report

**ST. LOUIS METROPOLITAN MEDICAL SOCIETY**

**Mission**

To support and inspire member physicians to achieve quality medicine through advocacy, communication and education.

**Vision**

Physicians leading health care and building strong physician-patient relationships.

**Core Values**

Relationships, Professionalism, Leadership, Advocacy, Education, Communication

# Another Successful "Resolution Season"

*By David M. Nowak, Medical Society Executive Vice President*

*Executive Vice President David M. Nowak*

Bringing forth positive change for the practice of medicine by influencing policy is perhaps the greatest benefit of organized medicine.

Physicians from across the state gathered in St. Louis March 23-25 for the 160th annual convention of the Missouri State Medical Association (MSMA). Many thanks to the SLMMS members who served as delegates from District 3, participated in the many lectures, or attended gatherings of their specialty societies throughout the busy weekend. We had a standing-room-only crowd at our District Caucus luncheon on Friday, and another great turnout for the Sunday breakfast caucus meeting.

Reference committees heard testimony in support of 20 different resolutions this year, seven of which were written by SLMMS members and supported by your Medical Society. Five of our seven resolutions were recommended for adoption and approved by the House of Delegates, and the remaining two were referred to the MSMA Council for further analysis. Advocating for changes to benefit the practice of medicine is advantageous for all physicians; for the benefit of those who were unable to attend this year's meeting, here is our annual summary of the SLMMS-sponsored resolutions:

**Support for Legislation Creating Needle Exchange Programs in Missouri**, authored by Luis Giuffra, MD, PhD, resolves that the MSMA support legislation authorizing needle exchange programs in our state. With the recommended change of one word, the resolution was adopted by the House of Delegates.

**Statewide Adoption of the St. Louis County Prescription Drug Monitoring Program**, submitted by the District 3 Delegation from SLMMS and calling for MSMA to support legislation to adopt the St. Louis County Prescription Drug Monitoring Program (PDMP) as the State of Missouri's PDMP, received overwhelming support. Since it complements current MSMA policy, it was adopted with no modifications.

**Create Standardized Priority Menu for Physicians Calling in Prescriptions**, submitted by David Bean, DO, resolves that the MSMA, in partnership with the Missouri Pharmacy Association, work to create a standardized priority menu option across all pharmacies for physicians when calling in a prescription, and further resolves that this standardized menu concept be forwarded to the American Medical Association for implementation at the national level. Due to the investment of resources and cost restraints, there was pushback from the reference committee which recommended this resolution not be adopted. Believing earlier testimony had impacted the rightful intention of the resolution, the District 3 delegation was successful in getting this resolution referred to the MSMA Council for further analysis and discussion.

**Medical Records Custodial Storage**, also submitted by the SLMMS membership, advocates for the MSMA to work with the Missouri Board of Registration for the Healing Arts to address issues of custodial record storage upon a physician's retirement or relocation. The Reference Committee believed additional research was necessary on this issue, and the resolution was referred to the MSMA Council.

**Maternal Mortality Review Board**, authored by Ravi Johar, MD, calls for the MSMA to support the creation and funding of a Missouri Mortality Review Board, and further resolves that the MSMA encourage the State of Missouri to use the CDC WISDOM Database Program for analysis and storage of data. With substitute resolutions, this item was recommended for adoption.

**Opioid Continuing Medical Education Programming**, also submitted by Ravi Johar, MD, resolves that the MSMA promote or develop a voluntary web-based opioid

*continued on page 6*

**"Resolution Season"** ► *continued from page 5*

education program and make it available at no cost to MSMA members with continuing medical education credit. The resolution was recommended for adoption with a few wording changes, and the House of Delegates moved to add the word "voluntary" to the copy.

**Membership Applications Included with Licensing Information Packets**, written by Christopher Swingle, DO, asks that the MSMA approach the Missouri Board of Registration for the Healing Arts and request that MSMA and local component society member applications be included in the initial mailing to new physicians licensed to practice in the State of Missouri. This resolution was adopted as submitted.

In conclusion, it was another successful "resolution season" for SLMMS. As I have stated previously, bringing forth positive change for the practice of medicine by influencing policy is perhaps the greatest benefit of organized medicine. But please don't limit this advocacy work to the annual "resolution season." If you have an idea for a resolution, contact the SLMMS office and we will approach our MSMA colleagues in Jefferson City, or file it to consider for presentation at the 2019 convention. If you have any questions about the 2018 resolutions, or would like to review one in its totality, please contact me at the SLMMS office or email dnowak@slmms.org.

Also at this year's convention, SLMMS member George Hruza, MD, was elected chair of the MSMA Council for 2018-19. David Pohl, MD, was re-elected to continue as the MSMA treasurer. Elie Azrak, MD, and Inderjit Singh, MD, were nominated to serve as District 3 councilors, and J. Collins Corder, MD, was elected vice-councilor. Edmond Cabbabe, MD, was re-elected to serve as an AMA delegate from the state of Missouri. Earlier this year, William Huffaker, MD, announced his intention to step down after serving as an AMA delegate for many years, and Elie Azrak, MD, was elected to complete his term. Ravi Johar, MD, was named an alternate delegate to the AMA.

We congratulate these hard-working physicians who so very generously give of their time to work to improve the practice of medicine nationally, statewide and at the local level. We also invite you to join them by becoming more involved in your Medical Society. The SLMMS Nominating Committee will be meeting this summer to identify the slate of officers and councilors for leadership in 2019. Please refer to the article below to learn how you can be considered for the SLMMS Council, or to serve on a committee or as an MSMA delegate. ◄

# SLMMS Seeks Council and Committee Members

Each year, the St. Louis Metropolitan Medical Society invites any prospective leaders from within the membership to volunteer to continue to move our organization forward, to help fulfill our mission to support and inspire member physicians to achieve quality medicine through advocacy, communication and education, and achieve our vision of physicians leading health care and building strong physician-patient relationships.

The SLMMS Nominating Committee will meet this summer to consider candidates for leadership roles beginning in 2019. We need physicians from all specialties and practice settings to serve. Available positions include SLMMS councilors, delegates to the Missouri State Medical Association annual meeting, and appointments to SLMMS committees.

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

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

To be considered as a potential nominee or a committee role, please contact Ravi Johar, MD, chair of the Nominating Committee, at rkjohar@att.net or David Nowak, executive vice president, at the SLMMS office at 314-989-1014, ext. 105 or email dnowak@slmms.org no later than Monday, July 2. If you wish to nominate another member for a leadership position, please check with them first to confirm their willingness to serve. All recommendations will be given thorough consideration.

Per the Society's bylaws, the Nominating Committee will present its slate of officers and councilors at a General Society meeting on Tuesday, Sept. 11, at 7 p.m. to be held at the Society office on Craig Road. All members are welcome to attend the meeting.

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

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

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# Tackling the Opioid Epidemic

More than 80 SLMMS members and guests heard valuable insights toward solving the opioid epidemic at an April 21 seminar presented by the Medical Society, Clayton Behavioral and the Missouri Opioid State Targeted Response.


*Louis Giuffra, MD, PhD, SLMMS member and psychiatrist with Clayton Behavioral, presented much evidence showing that ongoing medical treatment with buprenorphine or methadone is much more effective than abstinence treatment in preventing addiction relapse.*


*R. Corey Waller, MD, MS, from the Camden, N.J., Coalition of Healthcare Providers, called for major improvement in how the health care system, particularly emergency departments, handles patients with opioid addiction. By comparison, hospital emergency departments have an extensive array of tests and protocols for cardiovascular emergencies. He encouraged all physicians to obtain the waiver enabling them to prescribe buprenorphine.*

*The seminar concluded with a panel discussion with, from left, Sam Page, MD; Douglas Pogue, MD; Evan Schwarz, MD; and Ravi Johar, MD. They suggested that patients change expectations about the amount of pain that is acceptable.*

**Buprenorphine prescription waiver training July 16 and Sept. 29. www.mocoalition.org/medication-assisted-treatment**

# Best Chance for Humane, Cost-Efficient System

In the April/May 2018 *St. Louis Metropolitan Medicine*, a letter from Drs. George Bohigian and Terence Klingele contains some points that I would like to dispute. The overhead of Medicare vs. private insurance is indeed about 3% vs.10%, but this does not reflect the administrative burden imposed on physicians, hospitals and other providers that brings the total for those dealing with private insurance to 25-30%. This is far higher than that imposed by Medicare.

U.S. Sen. Bernie Sanders and others who support "single-payer" do not propose abolishing Medicare but do support expanding and improving it and offering it to everyone. This would not be "inefficient and unaffordable" but would be far more efficient and affordable than the current hybrid system.

I would also dispute the idea that deductibles are "essential to control costs." Co-pays and deductibles have not been shown to control costs but do raise a barrier to necessary care for many middle- and low-income patients. Most countries with single-payer systems do not have such barriers and manage to deliver care superior to that which we have in the United States at a fraction of our cost.

We can learn a lot from studying the systems of other developed countries. Someday we will recognize that what we are doing isn't working and we will come to realize that "Medicare for All" offers the best chance to have a universal, humane and cost-efficient system.

William M. Fogarty, Jr., MD

# Implementing a Team-Based Care Approach

## How a practice can structure responsibilities to maximize physician time, improve quality of care and prepare for value-based payment

*By Karen S. Schechter, RHIA, MBA, CCS-P, CMPE*

The Centers for Medicare and Medicaid Services' transition from volume-based to value-based reimbursement is presenting challenges and opportunities to physicians. Strategic alliances are being formed via Accountable Care Organizations and other integrated models. These alliances focus on a team-based approach for addressing patient health.

However, the concept of team-based care can start at the grassroots level—the individual physician's office—to address specific patient populations, with a prescribed demonstrated approach that results in being able to move a patient through the system in an efficient manner while providing more support for the physician to be able to deliver the necessary care.

Team-based care is a concept/practice that is becoming popular, not just in primary care settings but also in specialist offices. Carefully planned and implemented team-based primary care embraces the Institute for Healthcare Improvement's Triple Aim, which addresses improvements in the quality, safety and reliability of care, along with reducing waste, and better addressing the needs of chronically ill patients.

Simply stated, team-based care is "the provision of comprehensive health services to individuals, families and/or their communities by at least two health providers who work collaboratively along with patients, family caregivers and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient and equitable."[1]

It is based on five principles, as stated in a 2012 discussion paper from the former Institute of Medicine (now the Health and Medicine Division of the National Academies):


Karen Schechter

*Karen S. Schechter, RHIA, MBA, CCS-P, CMPE is the director and assistant professor of the Healthcare Management and Health Administration programs at Maryville University. She is also the owner and senior health care advisor of Schechter Healthcare Advisors, LLC, which provides physicians and hospitals with practical solutions to address the ever-changing health care environment. She can be reached at kschechter@maryville.edu, 314-529-6593.*

- **"Shared goals:** The team—including the physician and staff, patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood and supported by all team members.
- **Clear roles:** There are clear expectations for each team member's functions, responsibilities and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
- **Mutual trust:** Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.
- **Effective communication:** The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
- **Measurable processes and outcomes:** The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time."[1]

### Operationalizing the Goals Within the Practice

The concept of team-based care starts with identifying "the team." In a primary care environment, the core team includes the practice's physicians, staff and patients (and caregivers, when appropriate). However, true team-based care extends beyond the walls of the practice and may include other providers and community support.

Operationalizing this concept in a medical practice requires an understanding of needs of the specific patient population(s) and the most optimal way to address them through the assignment of responsibilities in the most effective and efficient manner. Team-based care is an innovative approach to patient care that involves redesigning the traditional office visit, the "in-basket" tasks associated with the visit, along with the use of the internal care team, the extended care team and community resources to optimize population health management (Figs. 1 and 2).

## FIG. 1: ELEMENTS OF A SUCCESSFUL PRIMARY CARE TEAM

| Elements of Success | How it Happens |
|---|---|
| Clear roles and responsibilities | ► Top of license work with adequate training<br>► Flexibility<br>► Continuous evaluation of effectiveness |
| Genuine leadership support | ► Practice level support<br>► Team level support: leader encourages different perspectives from all team members |
| Psychological safety | ► Focus on relationships<br>► Learn from failure without blame<br>► Multiple forms of communication |
| Team structure | ► Small size<br>► Co-location<br>► Multi-disciplinary |
| Shared goals | ► Shared commitment to improve patient care<br>► Co-production |

Source: Fleishman-Ritter presentation to the 2018 Institute for Healthcare Improvement Summit.[2]

## FIG. 2: STRUCTURES AND ROLES IN PRIMARY CARE TEAM


| Patient Needs | Core Team | Extended Care Team | Community Resources |
|---|---|---|---|
| ► Paperwork<br>► Patient orders<br>► Preventative visits<br>► Acute visits<br>► Test results<br>► Chronic disease management<br>► Medication refills<br>► Referrals | ► Physicians<br>► NPP<br>► RN<br>► MA/LPN<br>► Registration/Front Desk | ► Diabetic educator<br>► Pharmacist<br>► RN care coordinator<br>► Case manager<br>► Behavioral health consultant<br>► Physical therapy<br>► Other | ► Skilled nursing facilities<br>► Payers<br>► Family care agencies<br>► Local pharmacists<br>► Other |

Adapted from Bellin Health (Green Bay, Wis.) presentation to the 2018 Institute for Healthcare Improvement Summit.[4]

There are several ways to configure your internal care team. Generally speaking, the practice workflow continues to be separated into two primary functions: front office/business office and back office/clinical. The difference in the team-based model is that the clinical care team assumes more enhanced roles to augment and support many of the tasks that are traditionally completed by the physicians or are decentralized among the staff.

Literature searches identify varying care team configurations but typically, the core team consists of a physician, a medical assistant or LPN who assumes the lead role in coordinating the team, and an RN with enhanced training to assume active patient management roles that are often done by the physician. The goal is to create an "internal community" for the patient to foster stronger relationships and trust that will result in better patient care and outcomes.

The key to attaining this goal is delegation. This means that the physician primarily performs the functions that only she/he is qualified to do. The rest is delegated to well-trained members of the care team. In their article, "Team-Based Care: Saving Time and Improving Efficiency," Kevin Hopkins, MD, and Christine Sinsky, MD, (both from Cleveland Clinic) identified four distinct stages of the majority of office visits:

(1) Gathering data

(2) Physical examination and synthesis of data

(3) Medical decision-making

(4) Patient education and plan-of-care implementation.[3]

In a traditional practice model, the physician assumes responsibility for most, if not all, of these stages. However, in the team-based care model, the physician shares these responsibilities. In their clinics, stage 1 is completed almost entirely by the clinical assistant. The physician completes stages 2 and 3, with the clinical assistant on hand to document/enter information into the EHR. The physician completes his/her assessment and treatment plan and answers patient questions, and leaves the exam room to review and file orders related to the visit. The clinical assistant takes over to review the physician's instructions, provide prescriptions and referral information, deliver education as appropriate and arrange for appropriate follow-up.[3]

Bellin Health Primary Care Clinics, a 140-member primary care group with 29 locations in and around the Green Bay, Wis., area, set up their care teams and delegated the tasks associated with the four stages of the office visit (and more) (Fig. 3).[4]

## FIG. 3: DELEGATION OF TASKS IN A PRIMARY CARE CLINIC

### Medical Assistant/LPN: Care Coordinator | *Patient navigator and workflow facilitator*

- Prior to visit: Reviews the patient's chart to ensure that information is up to date, identify any pending medication refills and health screenings (mammograms, colon cancer, diabetic eye exam, etc.) and other quality care gaps that need to be addressed with the patient.
- During visit: Gathers the chief complaint and other pertinent information for the physician to review, reviews medications with the patients and sets the agenda for the visit. If there are outstanding tests and/or screenings to be ordered, this can be discussed and possibly ordered at that time.

  The care team coordinator typically stays in the room when the physician enters to ensure a smooth transition and to make sure that all loose ends are tied up before the patient leaves. This may include, but is not limited to, setting up future appointments with the physician, initiating referrals to members of the extended care team and/or community resources as appropriate, and summarizing the visit (including next steps) with the patient.
- In between visits: Facilitate the daily huddle, plays an active role in "results management," handles patient calls and questions (non-triage) and completes forms as appropriate. She/he may also assume population health management activities such as contacting patients who are due for interventions, gathering records from outside facilities, updating health maintenance issues and working with the physician to identify opportunities to engage extended care team members as appropriate for high-risk and complex patients.

### The RN | *Advanced clinical assistant*

- Facilitate post-hospital discharge medication reconciliations.
- Triage patient calls.
- Complete forms that are beyond the scope of other staff members.
- Face-to-face patient visits: Annual Medicare Wellness Visits, blood pressure checks, diabetic education and other varying roles for specialty clinic RNs.
- Participates in outreach efforts to patients who are due for population health interventions and often play the lead role in quality measure improvement.
- Plays lead role in Chronic Care Management (CCM) and Transitional Care Management (TCM) workflow.

Source: Bellin Health presentation to the 2018 Institute for Healthcare Improvement Summit.[4]

## Implementation

Successful team-based care requires careful planning and training. The first step will be to identify the initial patient populations to include in this initiative and identify the care gaps.

The next step is to pull together the team, develop protocols and assign responsibilities to each of the team members. Delegation of duties that have traditionally been performed by the physician may be one of the most difficult challenges during the implementation/transition to the care team model. However, this situation may be addressed with training, making sure that clinical protocols and EHR capabilities are understood.

As with any implementation, it is important to start slow—a few patients a day—then build up to capacity for each segment of the patient population. Daily huddles may be extended during the implementation to ensure that everyone on the team is comfortable in their roles, that the goals of the initiative are being met and that any mitigating factors are addressed.

## Benefits

There are many benefits to the team-based care model that have been documented by various clinics/organizations that have adopted it.

Patients benefit from improved quality of care which can be associated with stronger relationships between the patient and the team and improved communications. Patient satisfaction surveys show improvement in scores as well.

The care team also realizes benefits that result in improved job satisfaction. The establishment of protocols and the related dispersion of work (especially the off-loading of tasks from the physicians to the rest of the clinical team) lead to better team dynamics and less stress for the team. Having the clinical assistants involved throughout the visit increases awareness of each patient's situation and improves communications among the team (including the patient).

Once properly implemented, there are financial benefits, both direct and indirect. Physicians will have the opportunity to see more patients. Practices will have the opportunity to experience improved patient engagement that may result in improvement of quality measures, decreases in cost of care, improved access for patients. Billable RN visits enhance revenue, while implementation of CCM and TCM programs improve patient care and contribute to decreased costs of care.

## Conclusion

Team-based care is a concept/practice that is becoming popular as new reimbursement models, such as Accountable Care Organizations (ACOs), are built around a value-based pay reimbursement approach that places financial incentives around patient outcomes and is drastically changing the way physicians must conduct business to remain financially viable. In addition to focusing on improving patient experience of care and reducing costs, physicians must also focus on improving the health of populations. Initiatives such as team-based care work to enhance and solidify relationships with patients, while improving efficiencies that will help drive population health and the Triple Aim. And, it will help provide physicians the opportunity to do what they do best: care for patients.


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# HARRY'S HOMILIES©


**Harry L.S. Knopf, MD**


## ON TEAMWORK

In an orchestra, each player must perform his part to make beautiful music.

Teamwork in medicine is not really a new concept. All of us have used "consultants" for many years. What may be new is the concept that "I cannot do this alone." Today's medicine is growing more and more complicated in diagnostic and therapeutic methodology. A team approach lessens the burden of care by dividing the task. It is not a defeat to admit you need help. Rather, it is a victory for patient care and a relief that you, the primary physician, can get much needed help. Try it: all for one (patient) and one for all (teammates). Let's make beautiful music—together.


*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.*

# Team-Based Care: It's a Worthwhile Journey

## Observations on the benefits of team-based care and making the transition to it

*By Kathy Gibala*

Why team-based care? Over the past several years a lot has been written and done around team-based care. A few of the reasons for this increased focus include: the changing health care industry landscape; the shift to value-based care; Quadruple Aim goals (improving population health, enhancing the patient experience, reducing waste/cost and elevating physician and care team well-being); the rise of the empowered consumer along with increased expectations regarding access, efficiency and high reliability; provider burnout; and the looming physician shortage.

All of these contribute to the need for greater coordination, collaboration and connection among providers with the patient at the center. "Health care is becoming more complex and as a result we need to be able to rely on trusted partners to keep us informed, share their expertise, provide emotional support and a sense of 'We know what you are going through,'" said Kathy Hardesty, RN, vice president and senior clinical executive with Navvis Healthcare.

Wherever you are on the journey from "working alone together" to a high-functioning, integrated care team, I hope you will find something helpful in the information that follows. As the saying goes, none of us is as smart as all of us and with this article I share comments from my colleagues at MEDI Leadership and individual practice members with whom we've worked.

### The Benefits

Team-based care benefits all involved—patients, families and care team members as well. In team-based care, physicians, nurse practitioners, physician assistants, nurses, medical assistants, dietitians, social workers and others function as an integrated team, jointly customizing care to a patient's individual needs. Patients actively participate in establishing and managing their care goals and all team members help support them in achieving their goals.

"From the patient's perspective, medicine has always been team-based care. It has never been the patient interacting solely with a physician. Coordination is what has been lacking," said Brent Wallace, MD, former chief medical officer of Intermountain Healthcare in Salt Lake City, Utah, and now a fellow MEDI Leadership coach.

He continued, "To provide cost efficient, effective care in today's environment, we need to utilize all members of the team to provide care. Primary care physicians often do things we don't need physicians to do."

Patients have long-complained about the lack of coordination and communication between caregivers. John Anderson, MD, MEDI Leadership colleague and former chief medical officer with Baylor University Health and CHI, commented: "Over the years, the most consistent patient concern is around communication. Patients may ask, or certainly think, 'Do you people ever talk with each other?' The ability to communicate effectively in real time, speaking with one voice, is key."

Another perspective was offered by Debra Harrison, MEDI colleague and former chief nursing officer for the Mayo Clinic in Jacksonville, Fla. "I believe it increases a patient's trust and confidence to see care team members working together. More minds are better than one. We come at it from different perspectives and working together helps us to think synergistically."

Mitchell Stucky, MD, a family practice physician with Parkview Physicians Group in Ft. Wayne, Ind., has been using a team-based care model for the past seven years. Of his experience, he said, "Patients see that we truly work together. These are OUR patients; we are one team, one mind."

There are definite benefits for care team members in the model as well. Shannon Tranquill, nurse practitioner in Dr. Stucky's office, added: "We lean on and help each other. We support each


Kathy Gibala

*Kathy Gibala is a leadership coach, trusted advisor and change catalyst to health care executive and physician leaders across the U.S. who are seeking to raise the bar on their leadership, build high-performance teams, facilitate transformative change and accelerate results. Based in St. Louis, she is a senior vice president with MEDI Leadership, a firm dedicated exclusively to the development of health care leaders and teams. She can be reached at kgibala@medi-leadership.org, 636-536-9443 or 904-543-0235.*

other around our patients' goals and care plans. It is much less fragmented than in the past."

Dr. Stucky agrees, "In my 35 years of practice, I have worked in solo, group practice, with advanced provider professionals (APPs) who, in the early days, saw overflow patients, and in this integrated team-based model. This is by far the most rewarding way to practice."

Dr. Anderson notes physicians' orientation to doing everything themselves. "Our traditional physician training reinforced working independently and that all decisions needed to go through us. Everyone wins when we shift to a more efficient, effective team-based approach," he said.

### Streamlining Processes and Workflows

Collaborating to streamline processes and workflows is a key step in implementing team-based care. Dr. Anderson said, "We need to ask ourselves what we want team-based care to feel like for our patients. It needs to be team-based through the eyes of patients and their families, not what we call a 'team' or simply conducting team huddles. We tend to design around our perception rather than engaging the voice of the customer."

"In my 35 years of practice, I have worked in solo, group practice, with advanced provider professionals, and in this integrated team-based model. This is by far the most rewarding way to practice."

By redesigning the experience to best meet patient needs, we can eliminate unnecessary steps and add value. Dr. Stucky recalls, "We sat down together and got on the same page about processes, workflows and protocols. We came together as a team with a goal to do what's best for our patients."

Nurse practitioner Lisa Foldesi in Dr. Stucky's office added, "As we watch what each other does, we become more aware of places to help each other, to reduce steps, eliminate duplication."

Another suggestion from our panel is to test new processes/workflows in a controlled environment before they are released in a larger context and to build in monitoring capabilities. Process flow maps, simulation, re-enactment and video are valuable tools in identifying process and workflow opportunities.

### Guiding Principles for Effective Team-Based Care

Highly effective team-based care requires more than streamlining processes and conducting huddles. It requires clear roles and responsibilities and building a high-performance, collaborative team.

"Identifying roles and responsibilities is just the start. The true functioning of a team comes through building trust and learning each other's work styles. It takes effort and time," Dr. Wallace said.

Dr. Anderson agrees, "The hard work is under the surface; building trust and staying connected so patients will see and experience the team as working together effectively on behalf of the patient."

So, how do you go about building a high-performance team? My colleagues and I have the pleasure of coaching and helping health care leaders across the country build high-performance teams. We recommend having a coach or facilitator assist with team-building to help accelerate the team's evolution to a state of interdependence, characterized by trust, shared responsibility, collaborative decision-making and commitment. Below are some suggestions:

- Establish a shared vision, purpose. Why team-based care? What are our goals and key success measures?
- Identify and develop a strong leader.
- Establish a foundation of trust. Get to know each other as people and professionals. Better understand individual and collective strengths.
- Develop the right culture. Establish agreements for how team members will work together.
- Help clarify roles and responsibilities, with a goal of having team members practice at the highest level of their role (within relevant state, scope of practice and licensure requirements).
- "Upsell" each other to patients. Introduce team members. Ensure that the person answering the phone helps patients with immediate access to advanced practice providers (not "extenders" or "mid-levels").
- Facilitate effective communication (open, transparent, timely); establish team huddles. Listen actively. Manage conflict constructively. Develop methods to support information sharing within the team.
- Foster accountability and commitment.
- Establish, monitor and regularly communicate progress toward shared goals, key measures. Celebrate successes and collaborate to continuously improve.
- Include administrative team members such as practice managers and front desk staff, who are key parts of a strong overall team.
- Keep learning—individually and collectively; learn from and share with each other.

### Common Challenges

Some of the common challenges encountered when implementing team-based care include: a lack of clarity around the meaning of "team-based care;" unclear responsibilities; and that it is a fundamentally different way of working. Physicians' training teaches them to be high-functioning individuals. Providing care as a team is a big shift, practically and behaviorally, that shouldn't be underestimated.

*continued on page 19*

# Front Desk and Scheduling: The Face of Your Practice

## Hiring and training the right people to give strong customer service and enter patient information accurately

*By Chastity D. Werner, CMPE, RHIT, NCP, CRCR*

Failing to plan is the same as planning to fail. This could not be truer in health care today. Twenty years ago, it was common for front desk and scheduling positions to be considered entry-level roles, and many times, one of the lowest paid and most stressful. Today, these positions have transitioned to becoming one of the most vital in setting the stage for the overall health of your business.

These positions are the face of your organization, expected to smile at all times and reflect at minimum: showing empathy for patient needs and situations, having 100% accuracy when capturing data and entering it into multiple platforms, collecting and posting money at the time of service, and keeping up with various physician preferences and schedules. Both require strong customer service, organization, patience and ability to move, think and process information quickly. It is understandable that these positions have one of the highest turnover rates and why many practices struggle with hiring the right person and keeping them long term.

**When you consider 90% of denials are preventable, and 57% of the data for your claims is captured between scheduling the appointment and registering your patients, these positions are more vital than they have ever been in previous years.**

While a clean claim can be processed and adjudicated as quickly as 14 days, it costs on average $25 to rework a denial that still results in a less than 40% success rate of being paid and lengthens your adjudication timeline by 30-45 days. Since time and accuracy are money, there is no other choice than to create an environment that is proactive rather than reactive.

Ensure that appropriate time and resources are invested wisely to increase revenue and improve your patient's experience. Start with a patient access check-up:

Chastity D. Werner

*Chastity D. Werner, CMPE, RHIT, NCP, CRCR, is a senior health care consultant with Anders CPAs + Advisors. Bringing more than 20 years of experience, she has successfully worked with practices, hospitals, clearinghouses and insurance companies on revenue cycle improvement, EHR/PMS implementation, reporting, benchmarking and claims processing. She may be contacted at 314-655-5561 or cwerner@anderscpa.com. The firm's website is www.anderscpa.com.*

- Do you have the appropriate people in the appropriate roles and do you pay them appropriately?
- Have you set proper expectations and do your policies and procedures match your actual processes?
- Do you have the proper technology and tools in place?
- Are you capturing all needed data during scheduling and verifying during registration?
- Trust but verify. Do you check the quality data and work performed during the patient access processes and provide feedback on performance to key stakeholders?

### Hire and Invest in the Right Team Members

These roles should not be taken lightly. If you are a busy practice like most, do not assume you will have the time or ability to train individuals that do not have adequate knowledge and experience. More importantly, do not have another team member that is not your "role model" train. Even when hiring the most experienced, be prepared and have training manuals with written steps and screenshots, processes and a job description that will set expectations.

After you have invested and found your next "Front Desk Rock Star," do not throw them to the wolves immediately and wonder why they are not performing adequately. The first few months of training and attention are vital to the longevity and success of their work. Create a planned timeline that can be utilized as a coaching and feedback tool as well. See the accompanying template (Fig. 1) of what the first week could look like.

Who's on first, who's on second? Outlining and setting the expectations of roles will eliminate duplication and internal frustrations. If everyone is on the same page and knows what is expected, there is no room for questions.

*"A bad process will beat a good person every time!"* said W. Edwards Deming. Have the proper policies and procedures as well as a map of the patient flow performed at minimum (Fig. 2).

Utilizing technology is no longer just an option, it's necessary. With patient responsibility increasing over the past 10 years by over 230%, it's vital to invest in tools that will pre-qualify and financially clear all of your appointments. In previous years it would be suggested to check eligibility only on all new patients and established patients every three months or annually.

**ORIENTATION SCHEDULE FOR NEW FRONT DESK AND SCHEDULING STAFF – FIG. 1**

| DAY | TIME | DESCRIPTION |
|---|---|---|
| Day 1 | 8:30 – 9:30 AM | Meet with business office manager |
| | 9:30 –10:30 AM | Tour of practice and introduction to services by liaison |
| | 10:30 AM – 12:00 PM | Review policies, procedures, website and other pertinent information regarding the practice |
| | 12:00 – 1:00 PM | Welcome lunch with practice and providers |
| | 1:00 – 3:00 PM | Shadow front desk and take notes |
| | 3:00 – 4:00 PM | Meet manager - ask questions and discuss current day and next day's schedule |
| Day 2 | 8:30 – 11:00 AM | Shadow clinic provider(s) and nurse(s) |
| | 11:00 AM – 12:00 PM | Shadow scheduling |
| | 12:00 – 1:00 PM | Lunch with liaison |
| | 1:00 – 3:30 PM | Shadow clinic provider(s) and nurse(s) |
| | 3:30 – 4:30 PM | Meet manager - ask questions and discuss current day and next day's schedule |
| Day 3 | 8:30 – 10:00 AM | Shadow coding |
| | 10:00 AM – 12:00 PM | Shadow charge entry and billing |
| | 12:00 – 1:00 PM | Lunch with manager |
| | 1:00 – 3:30 PM | Shadow payment posting, AR follow-up and patient collections |
| | 3:30 – 4:30 PM | Meet manager - ask questions and discuss current day and next day's schedule |
| Day 4 | All Day | Full-day training and shadowing front desk |

Today, practices should be performing eligibility checks and verification on 100% of their appointments.

Your clearinghouse and billing platform offer eligibility automation as part of your monthly package or for minimal costs. The system can be set up to check eligibility two or three days in advance and the team would then check all patients that are scheduled within the two- or three-day window. This will allow your team to reach out to patients that have issues with their coverage or may have a higher financial responsibility. Preparation and planning are key.

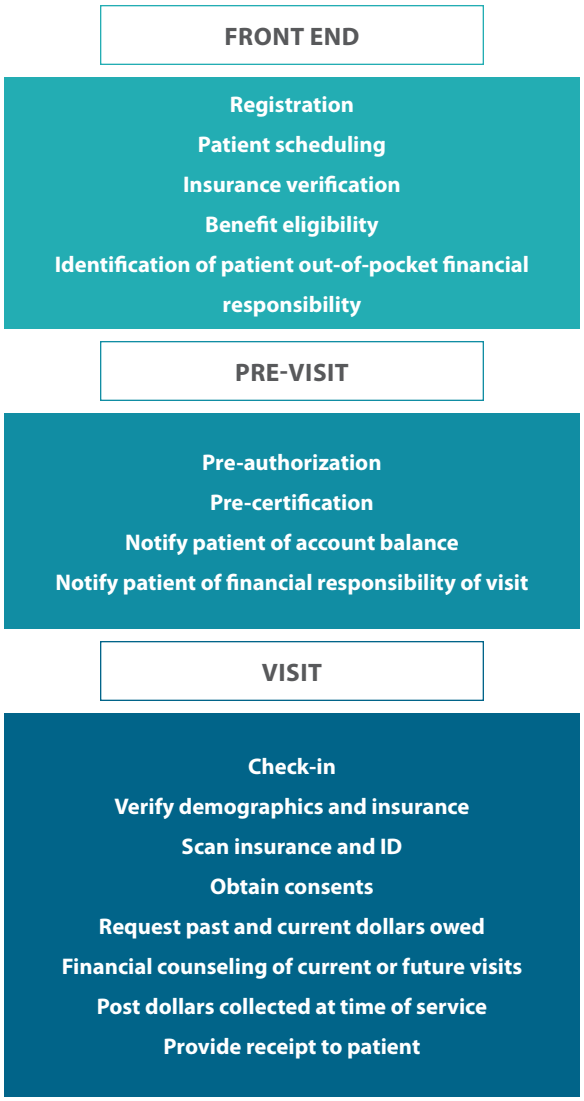
When setting up these processes, invest initially to save in the future. According to the 2016 Council for Affordable Quality Healthcare Index, the cost differential between checking eligibility and benefits electronically versus manually is $8.41 per transaction. On average it costs 49 cents to check electronically versus $8.90 to check manually. If your practice schedules 100 patients a day that could be a savings of $790 a day or $189,000 a year. More importantly, if your reimbursement on average is $100 per patient and you have on average a 20% denial rate, it could save you roughly $480,000 in lost revenue.

## Trust, But Verify

Creating scorecards and verifying quality of work is important in all the roles within the practice and the front desk is no exception to the rule. Thomas S. Monson once said, "Where performance is measured, performance improves. Where performance is measured and reported, the rate of improvement accelerates."

*continued on page 18*

**MAP OF PATIENT FLOW – FIG. 2**




This feedback should contain all key areas:

- Customer surveys
- Quality of data entered
- Collection of expected dollars
- Organization skills, time and efficiency of work
- Claim edits and scrubbing data and denial data

Though the data and information many times will be required to be pulled from several data sources, it is only fair that valid and consistent feedback be given if expectations are set. Never assume that the employee knows when they are doing poorly or, on the other hand, when their performance is exceptional.

Health care is now a service industry in which patients expect exceptional service, the ability to know their financial responsibility, and to feel valued. Start with the face of your practice and invest in your team that will provide patients the WOW experience they deserve. ◄

## ◄ WELCOME NEW MEMBERS ►

**Ethan J. Baughman, MD**
4901 Forest Park, #630, 63108-1444
MD, Univ. of Texas Southwestern, 2013
Born 1983, Licensed 2013 ► **Active**
*Plastic Surgery*

**Suresh Chode, MD**
12277 DePaul Dr., #403, 63044- 2536
MD, Armed Forces Med. Coll., Univ. of Pune, India, 2000
Born 1977, Licensed 2012 ► **Active**
*Cert: Endocrinology & Diabetes*

**Megan M. Gau, MD**
12303 DePaul Dr., #310, 63044-2512
MD, Indiana Univ., 2005
Born 1974, Licensed 2008 ► **Active**
*Cert: Diagnostic Radiology*

**A. Mary Guo, MD**
2315 Dougherty Ferry Rd., #200B, 63122-3383
MD, Univ. of Arkansas for Medical Sciences, 2006
Born 1971, Licensed 2010 ► **Active**
*Cert: Dermatology*

**Sushant P. Kale, MD**
10355 Bowles Ave., #200, 63026-2308
MD, B.J. Medical College, India, 2002
Born 1978, Licensed 2008 ► **Active**
*Cert: Neurological Surgery*

**Tyler R. Krummenacher, MD**
633 Emerson Rd., #100, 63141-6739
MD, Saint Louis Univ., 2009
Born 1982, Licensed 2015 ► **Active**
*Cert: Orthopedic and Hand Surgery*

**Ashish Nanda, MD**
10355 Bowles Ave., #200, 63026-2308
MD, Dayanand Medical College, Punjab, 2001
Born 1977, Licensed 2010 ► **Active**
*Cert: Neurological Surgery*

**Anna R. Niesen, MD**
1034 S. Brentwood Blvd., #100, 63117-1210
MD, Saint Louis Univ., 1975
Born 1950, Licensed 1978 ► **Active**
*Cert: Gastroenterology*

**Natalie L. Semchyshyn, MD**
2315 Dougherty Ferry Rd., #200C, 63122-3383
MD, Columbia Coll. of Physicians & Surgeons, 1999
Born 1968, Licensed 2004 ► **Active**
*Cert: Dermatology*

**Yan Yang, MBBS**
232 S. Woods Mill Rd., 63017-3654
MBBS, Capital Medical School, Beijing, 2016
Born 1990, Licensed 2017 ► **Resident/Fellow**
*Internal Medicine*

### WELCOME STUDENT MEMBERS

**Saint Louis University School of Medicine**

Dominic M. DeMarco

# Navigating MIPS in 2018

## Review your EHR to ensure proper information is being reported to Medicare

*By Derrick Weisbrod, MGMA of Greater St. Louis*

The Medicare Access and Chip Reauthorization Act (MACRA) was passed in 2015, and since then, providers have navigated a new system of collecting and reporting data. If you see a portion of your patients through Medicare, the Merit-based Incentive Payment System (MIPS) is the best way to ensure you are not losing money in the process. Based on their 2017 data, providers could see their Medicare payments increase or decrease starting in 2019. It's important to not let this long lead-time breed complacency. This system is currently working to determine how much you will get paid based on how well you collect and report your data—don't leave money on the table by ignoring it until the last minute.

We checked in with Kyle Haubrich, an attorney with Sandberg Phoenix who focuses his practice on assisting providers in navigating government programs like MIPS. According to Haubrich, the biggest hurdle for providers in adapting to MIPS is collecting and reporting data that MIPS uses to generate a score that determines what a provider will be paid.

Haubrich stressed that most doctors and providers rely on their electronic health record (EHR) program to collect their data. Most EHRs have well-designed dashboards that spell out what must be done to report each activity. However, problems occur when a provider relies solely on this system and it falls short. Some EHRs are not updated enough to encompass all the quality measures available, which can present a problem if an EHR only collects data on quality measures that might not apply to a specific provider or specialist. Because of this, it is important to check what is and is not being tracked by your EHR.

MIPS requires a commitment of time and resources. Haubrich notes that over the last year, some providers only reported the bare minimum of what's required, but in reality they were doing more than enough in their practices to increase their score and secure a positive payment adjustment. They just failed to include those activities in their reporting.

The most important thing for providers to know in 2018 is that they cannot fully rely on their EHR system. Providers who do this tend to fail because the EHR doesn't report and monitor everything correctly, is not updated, or doesn't train staff on how to report. Your staff must be informed about what is and is not reported through the EHR and find ways to close the gap through other reporting measures.

The best way to do this is to assign one person on staff to monitor reporting and ensure that all aspects of MIPS are being fulfilled, or to hire an outside source to help you achieve that. Through diligent reporting, providers can see up to a nine percent increase in Medicare payments through this system by the year 2022, starting with a four percent increase or decrease in 2019.

Not reporting on actions you are already taking is leaving money on the table. Though it may be difficult to navigate at first, learning this system will help your practice achieve better results and returns in 2019 and beyond.

Derrick Weisbrod

*Derrick Weisbrod is a founding advisor at Healthcare Technology Advisors, where he provides expert support and guidance for medical providers in the areas of information technology, security and HIPAA compliance. He is vice president of extension outreach for MGMA of Greater St. Louis. He can be reached at derrick@htadvisorsllc.com or 314-312-4701.*

### Team-Based Care *continued from page 15*

"We've been in a historically hierarchical model. Using terms like 'my practice,' 'my patient' or 'mid-levels,' needs to change," said Dr. Anderson.

Other common challenges are not getting patient input and resistance to change, in general.

#### Final Advice/Tips for Successfully Transitioning to Team-Based Care

Dr. Stucky suggested, "Focus on being one team. We each bring different skill sets and perspectives that together help us provide better care and a better experience for our patients. We emphasize with our patients that we work as a team."

To learn more about team-based care, consult the Institute for Healthcare Improvement (www.ihi.org) or the National Center for Interprofessional Practice and Education (https://nexusipe.org).

Wishing you success on your team-based care journey.

# Onerous Rules on Certification, Quality Adversely Impact Physicians

## They reward bureaucrats, undermine physician morale and do not improve patient care

*By Arthur Gale, MD*

Rules issued by the American Board of Internal Medicine (ABIM) on Maintenance of Certification (MOC) and mandates on quality developed by the National Quality Forum (NQF) are onerous. The rules for MOC and the quality metrics required by so-called evidence-based medicine have been major factors in causing burnout and depression in physicians. Meanwhile executives in these organizations have been compensated with huge salaries and the industries that they have spawned have gained enormous profits.[1]

### The American Board of Internal Medicine

Board certification by the ABIM was initially for life. Doctors were required to keep up with expanding medical knowledge through continuing medical education (CME). In recent years the ABIM has required Maintenance of Certification (MOC) exams. MOC has been required by increasing numbers of hospitals and insurance companies. The ABIM even hired lobbyists who contacted Obamacare officials to attempt to make MOC a requirement for reimbursement.

A recent pass rate for ABIM recertification was 78%.[2] If a physician failed the recertification process, he or she was essentially deprived of practicing medicine and making a living. This scenario is not hypothetical. Some doctors have been forced out of practice.

One example was a single father with a handicapped child who could not afford the steep fees of thousands of dollars for study materials and the recertification exam. He had to discontinue practicing medicine when he failed his board examination. He had received excellent reviews from his patients. He was reduced to looking for a job as a high school chemistry teacher.[3] There is no proof that MOC improves a physician's performance in practicing medicine.[4]

Arthur Gale, MD

*Arthur Gale, MD, is a past president of SLMMS and frequent contributor to St. Louis Metropolitan Medicine and Missouri Medicine. His writings over the past five-plus years have been compiled into a recent book, A Doctor's Perspective on Medical Practice in the Twenty-First Century, available on Amazon.com. Dr. Gale can be reached at agalemd@yahoo.com.*

In an exposé of the corruption and conflicts of interest at the ABIM, *Newsweek* investigative reporter Kurt Eichenwald wrote: "Millions have been paid out to senior officers of the ABIM with additional amounts for deferred compensation." The ABIM "has made millionaires of [its] top officers, financed a ritzy condominium, limousines and first-class travel, all the while sucking huge sums of cash out of the health care system." Despite these high salaries, the ABIM is in deep debt due to its lavish spending and fiscal mismanagement. While "the ABIM's net assets were ***negative*** $47.9 million on June 30, 2014, staff expenses for the fiscal year ended that same day climbed 13%, $3.5 million, to $30.7 million."[1]

According to Eichenwald, a major reason for increasing the number of and costs of certification exams and educational materials was to pay for the inflated salaries of ABIM executives and staff as well as debts due to mismanagement.

Outraged at the actions of the ABIM, a few courageous physicians decided that they had had enough. They set up an alternative internal medicine certification board to compete with the ABIM.[5] Some excellent and well known hospitals have accepted certification by this alternate board. And the costs of physician recertification by this board are miniscule compared to the ABIM.

Other physicians have sought to combat the excesses of MOC through legislation. Oklahoma was the first state to eliminate MOC requirements for state licensure.[6] Missouri, through the efforts of the Missouri State Medical Association (MSMA), passed a similar law. Current legislative efforts by the MSMA seek to broaden the current law to apply to hospitals and insurance companies.

As a result of physician backlash, the ABIM has modified some of its more onerous and arbitrary rules on recertification but has not eliminated them entirely. Herein lies a lesson. Physicians facing unfair rules and regulations don't have to just give up and accept them as a fait accompli. The successes in the fight against the abuses of the ABIM show that physicians—when aroused and proactive—can win.

## The National Quality Forum

Most physicians have probably never heard of the National Quality Forum (NQF) or understand what it does. The NQF has its roots in the Institute of Medicine (IOM) 1999 report *To Err is Human; Building a Safer Health System*. (The Institute of Medicine is now called the Health and Medicine Division of the National Academies.) The report concluded that the nation had "an epidemic of medical errors." It estimated that from at least "44,000 to 98,000 persons die in hospitals each year as a result of medical errors that could have been prevented."[7] These numbers were picked up by the press and are still reported today as absolute fact.

The IOM report was based on two poorly researched studies that were never verified and hardly noticed when they were published. One was a study from Colorado and Utah that had not yet been published at the time of the IOM report, and the other was the Harvard Medical Practice Study published in 1991 in the *New England Journal of Medicine*.[7]

I remember reading the Harvard study shortly after it was published. I thought the research and the conclusions were unimpressive mainly because there was a lack of agreement on what constituted a medical error between the various teams of doctors and nurses who defined and measured errors. Also, most of the patients were extremely ill, often near the end of their lives, and it was uncertain whether errors or disease caused their deaths.

The main author of the Harvard study, Troy Brennan, MD, was highly critical of the IOM report and wrote that the conclusions of the study did ***not*** support the report of the IOM.[8] Another prominent author wrote a stinging rebuttal to the IOM report in the NEJM.[9]

Nevertheless, the damage had been done. The quality zealots and quality police immediately set to work. Despite the fact that the figures in the IOM report were based on faulty evidence, the NQF was formed and eventually procured millions of dollars to develop programs to improve "quality."

The IOM "sky is falling" report on errors in medicine created a fake medical crisis. The public accepted the crisis as real. The main goal of the report, however, was to control doctors and create a new "quality" industry. This new bureaucratic industry would then reap huge profits for its academic and business leaders. The NQF receives tens of millions of dollars annually to provide the Centers for Medicare and Medicaid Services with measurements of quality.

The creation of a fake medical crisis to enrich certain industries in the medical-industrial complex is not new. A fake crisis over health care costs in the 1970s was the impetus for the creation of managed care. Health care costs only rose ***after*** the advent of managed care, not before.[10]

Despite all the money being spent to improve quality, none of the quality initiatives have been shown to result in meaningful improvements in clinical outcomes or a meaningful decrease in adverse events. A prominent researcher who initially strongly advocated for value-based purchasing and pay for performance (P4P) recently wrote an article in *JAMA* stating that after years of study, P4P has had little or no effect on improving patients' outcomes.[11]

The same can be said of electronic health records (EHRs) and Meaningful Use. In 2009, the government spent $30 billion for implementation of electronic health records (EHR) and Meaningful Use to improve quality. Despite this massive expenditure, a major comprehensive 2014 study concluded that EHRs and Meaningful Use have not been shown to improve quality.[12]

To summarize, independent studies do not show that evidence-based medicine, pay for performance, Meaningful Use and EHRs improve quality. But one thing is certain: these programs have enhanced the profits of the NQF and the medical "quality" and EHR industries and their well-paid executives. And as noted above, these ineffective programs are responsible for significant physician frustration, burnout and depression. They are also a major cause of physician shortages in certain medical specialties such as primary care.

After successfully combating some of the worst abuses of MOC by the ABIM, physicians might consider directing their efforts to combating some of the abuses of P4P, meaningful use and EHRs. If successful, physicians would be able to stop their useless box checking and devote more time to listening to and caring for their patients—and even once again enjoy practicing medicine.

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## 2018-19 Officers Installed

The SLMMS Alliance installed its 2018-19 officers on May 11. Pictured, from left: **Jo-Ellyn Ryall, MD**, vice president-legislation; **Gill Waltman**, vice president-foundation and recording secretary; **Sue Ann Greco**, co-president; **Kelly O'Leary**, co-president and co-vice president-membership; **Angela Zylka**, vice president-health; **Sandra Murdock**, treasurer and co-vice president-membership; and **Jean Raybuck**, corresponding secretary. The Alliance looks forward to another busy year of community service programs, particularly in schools.

## Students Honored for Medicine, Health Projects

As part of an effort to encourage high school girls to choose careers in medicine and health, the Alliance is presenting awards to high school juniors for their STEM projects related to the health care field.

*Pictured, Alliance members Sue Ann Greco, left, and Sandra Murdock, right, honor five juniors at St. Joseph's Academy. Similar awards were presented to a group of University City High School students.*

### INSTALLED AS STATE ALLIANCE PRESIDENT

SLMMS Alliance member Gill Waltman was installed as 2018-19 president of the Missouri State Medical Association in March. She will lead state Alliance programs and provide leadership and support to Alliance chapters across Missouri.

# SLMMS Seeks Nominations for Annual Awards

Nominations are now being accepted for special awards to be given by the St. Louis Metropolitan Medical Society for 2018. The awards will be presented at the Society's Annual Meeting and Installation Dinner on Saturday, Jan. 26, 2019. The Council invites the membership to nominate a physician colleague for one of the following awards:

***Robert E. Schlueter Leadership Award.*** The Schlueter Award is given, when appropriate, to a member who meets the following criteria: demonstrated leadership in organized medicine; demonstrated scientific attitude through excellent clinical practice; has been an advocate for patients on social, economic, and political matters; and involved in community service on behalf of the medical profession. This is the highest honor bestowed by the Medical Society, and it has only been presented 20 times previously.

***Award of Merit.*** The Award of Merit is to be given, when appropriate, to recognize outstanding and distinguished contributions to scientific medicine in the St. Louis community.

The nominee must be a physician; preference will be given to current or former SLMMS members, but the nominee need not be a member of SLMMS.

***President's Award.*** The President's Award is for outstanding service to the medical profession by a member of the St. Louis Metropolitan Medical Society.

To submit a nomination for any of the three awards, provide a brief narrative (150-300 words) explaining why the nominee should be recognized; if possible, include the nominee's biographical sketch or curriculum vitae. Include contact information of the person submitting the nomination, and forward all materials to Dave Nowak, executive vice president, in the SLMMS office or email dnowak@slmms.org

The deadline for nominations is Friday, June 29, 2018. All nominations will be reviewed by the SLMMS Nominating Committee in July, with a recommendation subject to final approval by the SLMMS Council in September. Recipients will be notified this fall.

## Bernard S. Loitman, MD

Bernard S. Loitman, MD, a radiologist, died March 7, 2018, at the age of 94.

Born in Chesea, Mass., he earned his undergraduate degree from Harvard University and his medical degree from Tufts University School of Medicine. He completed his internship at the University of California-San Francisco. He continued his education at Cornell University Medical Center, Memorial Hospital for Cancer in New York and the Hospital for Specialty Surgery in New York.

Dr. Loitman served as a pilot in the U.S. Navy from 1942-1946 and then served in the Navy Reserve. He was on staff with Scott Radiological Group at the former St. Elizabeth Hospital in Granite City. He also was on the faculty of Saint Louis University School of Medicine.

Dr. Loitman joined the St. Louis Metropolitan Medical Society in 1959, and became a Life Member in 1993.

He was predeceased by his wife, Charlotte Kamberg Loitman and son, George Loitman. SLMMS extends its condolences to his children, Deborah Sanchez; Robert Loitman; Jane Loitman, MD; and Carol Greenspun; and his twelve grandchildren and two great grandchildren.

## Matthew Newman, MD

Matthew Newman, MD, an ophthalmologist, died March 22, 2018, at the age of 81.

Born in New York, N.Y., Dr. Newman received his undergraduate degree from Vanderbilt University and his medical degree from Columbia University College of Physicians and Surgeons. He completed an internship at King County Hospital System, Seattle, Wash. and his residency at Washington University School of Medicine, then post graduate work at Harvard.

Dr. Newman served in the U.S. Navy from 1961 through 1963. He was in private practice and served on staff at Barnes-Jewish Hospital and the former St. Luke's Hospital-West.

Dr. Newman joined the St. Louis Metropolitan Medical Society in 1968, and became a Life Member in 2004. He served as a SLMMS Councilor in 1981 as well as on several committees.

SLMMS extends its condolences to his wife, Jane R. Newman; his children, Lee Newman, Andrew Newman and Betsy Dennig; and his five grandchildren.

## Frank R. Mohs, MD

Frank R. Mohs, MD, a board-certified internist with a subspecialty in cardiovascular disease, died April 9, 2018, at the age of 89.

Born in Webster, S.D., Dr. Mohs received his undergraduate and medical degrees from Saint Louis University. He completed an internship at SSM Health St. Mary's Hospital and a residency at the Veterans Administration Hospital, along with a residency and cardiology fellowship at the University of Missouri-Columbia. He served in the U.S. Air Force from 1955-57 and later was a medical officer in the National Guard.

After a decade in private practice, he was chief of staff in Veterans Administration hospitals in several states and then became vice president for medical affairs at SSM Health DePaul Hospital from 1980-1989. He also was a medical director for General American Life Insurance and Medicare Services of Missouri.

Dr. Mohs joined the St. Louis Metropolitan Medical Society in 1981, and became a Life Member in 1999.

Dr. Mohs is predeceased by his wife, Pat Mohs and his son, Daniel Mohs. SLMMS extends its condolences to his children: Ann Cray, Michael Mohs, Tom Mohs, Peggy Stickney, Phil Mohs, Elizabeth Cobb, Patrick Mohs, Peter Mohs and John Mohs; his 21 grandchildren and five great-grandchildren.

## Arturo C. Montes, MD

Arturo C. Montes, MD, a family practitioner, died April 11, 2018, at the age of 88.

Born in Manila, Philippines, Dr. Montes received his undergraduate and medical degrees from the University of Santo Tomas in Manila.

Dr. Montes was in private practice and also served as the medical director for the Little Sisters of the Poor Nursing Home. He served on staff at Christian Hospital and SSM Health DePaul Hospital.

Dr. Montes joined the St. Louis Metropolitan Medical Society in 1966, and was an active member for more than 50 years. He also served as a SLMMS Councilor. He was also active in the American Academy of Family Physicians and the Philippines Medical Association of St. Louis.

SLMMS extends its condolences to his wife, Mary Etta Montes; and his children, Michelle Cowsert, Amelia Strawbridge, Maria Cabonce and Rebekkah Montes; his five grandchildren and three great-grandchildren.

PARTING SHOTS

# The Anthem Compromise: Heads, They Win; Tails, You Lose

*By Richard J. Gimpelson, MD*

The Missouri House and Senate have been busy trying to work out a solution to the Anthem Blue Cross Blue Shield of Missouri (Anthem) rule in which a patient must pay the total emergency room (ER) bill if Anthem retroactively considers the visit to have been for non-emergency problems. I covered the ramifications of this policy in the last issue of *St. Louis Metropolitan Medicine*, and now I want to discuss some of the solutions offered by Anthem.

Anthem offered a list of additions that they believed would be beneficial, but I consider these offers self-serving and of no significant improvement in their policy. I have taken the liberty to add critical commentary to these additions.

Anthem agrees to pay:

1. *If a patient was directed to the ER by a provider.*
   Who is a provider?
2. *If the patient received IV fluids or medication, or had a MRI or CT scan.*
   What about an EKG, troponins or diagnostic X-ray?
3. *If services are provided to a patient under the age of 15.*
   What about a 15-, 16- or 70-year-old? An arbitrary age makes no sense. What if a 14-year-old with a time of birth at 11:45 p.m. comes to the ER on the day of their 15th birthday at 1 p.m.? Realistically, they are still 14 years old.
4. *If a patient's home address is more than 15 miles away from an urgent care center.*
   What if the home address is 14.5 miles away or 13 miles away? Just like age, this is an arbitrary distance, and what if the urgent care center is closed?
5. *If a visit occurs between 8 p.m. Saturday and 8 a.m. Monday or on a major holiday.*
   I guess Anthem does not believe that emergencies do not occur between 8 p.m. and 8 a.m. on weekdays. What constitutes a major holiday? I always considered Martin Luther King Day a holiday and closed my office, but was open on President's Day. People celebrate different holidays. This rule is just stupid. I am sorry that I cannot think of another word to describe this rule that this magazine will print.
6. *If a patient is traveling out of state.*
   What if the patient lives on the Missouri border, but went to dinner or shopping in Illinois, Nebraska, Iowa, Kentucky, Tennessee, Arkansas, Kansas, or Oklahoma?
7. *If a patient received any kind of surgery.*
   Does a splinter count?
8. *If the visit was billed as urgent care.*
   This is the free pass. I recommend that all ERs post this rule on a sign in every room.
9. *If an ER visit is associated with an outpatient or inpatient admission.*
   What if the hospital considers the admission as an observation bed?

U.S. Sen. Claire McCaskill agreed with my prior column in that the policy requires patients to self-diagnose which can be dangerous. In addition, Sen. McCaskill requested that Anthem explain the rationale of their policy. Anthem's answer was that there has been an increase in inappropriate uses of the ER. However in my prior article, I explained that this concern is minimal and may have negligible influence on medical costs.

In disputed bills, Anthem will have a physician peer-review the visit. The Missouri Legislature proposes that a board-certified emergency physician review the patient's medical history regarding the ER visit. I think this is still weak because it does not take into account that Anthem still requires self-diagnosis before going to the ER.

There is one very important legal issue that has not been taken into account by Anthem. This is the Emergency Medical Treatment and Labor Act of 1986 (EMTALA). This legislation requires the ER to screen, stabilize and treat anyone showing up at the ER regardless of their ability to pay. Essentially Anthem will have the ER screen their patient, but Anthem will not guarantee that they will pay for evaluation and treatment.

As a final note, you should be aware that Sen. McCaskill and Maryland Sen. Ben Cardin have written to the Department of Health & Human Services and the Department of Labor to rule on the legality of Anthem's ER program.

I wonder if Anthem has ever refused to pay for any of their executives' ER visits.


Dr. Richard J. Gimpelson

*Richard J. Gimpelson, MD, recently retired from his gynecological surgery practice and is a past SLMMS president. He shares his opinions here to stimulate thought and discussion, but these do not necessarily represent the opinion of the Medical Society. Your comments on this column are most welcome and may be sent to editor@slmms.org.*

# Serving the Next Generation of Physicians

## SLU medical students tutor youth at STEM high school

*By Dominic DeMarco and Parth Joshi*

As medical students, we are preparing for careers focused on helping others to improve their lives. For many of us, the idea of service transcends medicine and informs many other aspects of who we are.

As tutoring leads of Doctors for Diversity at Saint Louis University School of Medicine, we co-lead a group of medical student volunteers who tutor high school students at the Collegiate School of Medicine and Bioscience Magnet High School. The high school, located adjacent to the School of Medicine campus, is a diverse Saint Louis Public School focused on preparing students for careers in health professions and STEM.

With the support of the School of Medicine's Office of Diversity and Student Affairs, Doctors for Diversity is an organization whose mission is to increase diversity in health care by coaching students interested in careers in the medical field. In partnership with our fellow mentoring and teaching co-leads, we seek to fulfill this mission through tutoring, mentoring and hands-on supplemental curriculum in health topics. This broad scope of service allows us to have a unique impact at the high school. Most students here have a stated interest in the sciences, with many of them having aspirations of becoming physicians, which gives us an opportunity to influence students beyond the classroom.

One experience at Collegiate School of Medicine and Biosciences that we remember fondly is teaching students how to tie surgical knots. This is a skill that we practiced during surgical skill sessions at SLU. We asked the students if they would be interested in learning this skill and they all said yes, excitedly. So, after one of our tutoring sessions, we sat down with the students and taught them how to tie both surgeon's and square knots with their hands. The students were shown the correct way to hold the suture and how to use proper hand techniques to create the knots. We even gave them extra sutures so that they could practice by themselves at home. Through experiences like these, we don't just help kids with their homework; we also play a special role in increasing their interest in medicine.

As current medical students, we represent the future that many of our high school students seek. As such, we have an opportunity to help them get closer to their dreams—today.


*Dominic DeMarco, left, and Parth Joshi are first-year students at Saint Louis University School of Medicine and student members of the Medical Society. They can be reached at dominic.demarco@health.slu.edu and parth.joshi@health.slu.edu.*

Through tutoring, we can provide our students with an immediate context for what they are learning in class by showing them how that knowledge can be directly applied to medicine. One of the most common questions students ask is, "Why is this important?" As tutors and medical students, we get the chance to give them an answer. We act as liaisons by helping students pursue the knowledge they need to realize their dream of helping others through health care.

The field of medicine is grounded in the privilege of being educated by experienced practitioners and the importance of passing down that knowledge to the next generation throughout one's medical career. Through tutoring, we as medical students are starting on the ground floor by impacting the education of many students who will one day be our colleagues in the medical field. In turn, we are also honing essential skills that will allow us to positively affect not only our patients but also the communities in which we will be practicing. The School of Medicine and Doctors for Diversity have given us the opportunities to develop these skills and we will carry them with us for the rest of our careers.

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