

ST. LOUIS METROPOLITAN MEDICINE

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Becoming a Physician Leader

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Top of the Met

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"I Got Your Pay," by Barack & Hillary

By Richard J. Gimpelson, MD

Now that the election is over, President-Elect Donald Trump is working on his plans to either change the Affordable Care Act or get rid of it. Since it was such a historic piece of legislation, I feel it needs to be memorialized in a song. The following is to the tune of Sonny and Cher's "I Got You, Babe." I am inspired.

I Got Your Pay

They say we will not pass the bill
There are not the votes on the Hill
Pass the bill to know what's in it
So Democrats voted in one minute

(Chorus)

Pay!

I got your pay

I got your pay

They say that you can keep your Doc
And keep your plan, 'cause it's been locked

The cost will save you lots of money

Twenty-five hundred dollars will keep things sunny

(Repeat chorus)

The exchange will pay if cash is tight
The healthy well will make things right
And when you're sick, the care is cheap
The promise of Obamacare will keep

(Repeat chorus)

Now six years later, it's all a joke
Exchange and Co-ops are up in smoke
The average premium increase will be twenty-five percent
Arizona goes up one hundred sixteen for money spent

(Repeat chorus)

I got you to buy my bill
I got you to take the pill
I got you to vote for me
I got you to pay the fee
I got you to lose your Doc
I got you to get in hock
I got you to lose your plan
I got you to sell your van

I got your pay

I got your pay

I got your pay

I got your pay

I got your pay

I got your pay

I got your pay

I got your pay

I got your pay

Now that the election is over, we will be looking at change, for better or worse.

I Hope You Voted!!! ▶



Dr. Richard J. Gimpelson

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

HARRY'S HOMILIES®

Harry L.S. Knopf, MD

ON RIGHT AND WRONG

A WRONG turn may lead to the RIGHT destination . . . eventually.

By the time you read this, we will have completed the transition from the Obama era to the Trump era. Whether you viewed the election of Donald Trump as a "right" turn or a wrong turn, he is The President (POTUS), and we are committed to go forward (?) under his leadership. I was not a supporter of Trump, the nominee, but I will support President-Elect Trump, while scrutinizing his activity. With some good luck, this "turn" may still get us to as a desired destination. I can only hope! But wherever we are going, I suspect the journey to be very interesting. GOOD LUCK to ALL of us. ▶

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.

David M. Nowak
Executive Editor
dnowak@slmms.org

James Braibish
Braibish Communications
Managing Editor
editor@slmms.org

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On the Cover: Radiation oncologist Michael G. Beat, MD, MPH, MBA, center, with two members of his care team, radiation therapist Paul Becker, BS RT, left, and practice navigator Molly Boschert, RN. A 2015 graduate of the Physician Leadership Institute, Dr. Beat is involved in a variety of volunteer leadership roles through SLMMS and various oncology and prostate cancer organizations. See features on physician leadership starting on page 12.

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Wanted: Your Ideas for Resolutions

As the New Year approaches, and the Missouri Legislature prepares for its 2017 session, we begin the process of preparing resolutions for the 2017 MSMA Annual Convention, scheduled for March 31-April 2 at the Sheraton Kansas City Hotel at Crown Center. The deadline to submit resolutions to MSMA is Monday, Feb. 13, 2017, for publication in the convention materials.

Our resolutions represent organized medicine at work. If you're considering a topic for a 2017 resolution, even if it's still in the conceptual stage, please bring it forward to SLMMS in accordance with the following schedule.

For a resolution to be introduced and sponsored by SLMMS, it must be presented and reviewed twice by our delegate body. The first opportunity will be at the SLMMS Delegates' Briefing Session on Tuesday, Jan. 17, 2017, at 7:00 p.m. in the dePazzi Bentley Room in the von Gontard Conference Center at Mercy Hospital St. Louis.

Resolutions accepted by the SLMMS delegates at the Briefing Session go forward to a second review held in conjunction with the monthly SLMMS Council meeting on Tuesday, Feb. 7. (*Please note the February Council meeting will be held one week early to*

meet the MSMA resolution deadline.) Resolutions receiving final approval at the second meeting will be submitted as sponsored by SLMMS.

If you are planning a resolution, notify the SLMMS office as soon as possible to have it added to the meeting agenda. It is preferable, but not required, that the author attend both meetings to defend and explain the resolution. Visit the SLMMS website to link to MSMA's Guidelines on Resolution Writing. For more information, contact the SLMMS office at 314-989-1014 or email dnowak@slmms.org. —

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Would You Encourage Your Child to Follow in Your Footsteps and Become a Physician?

By Samer Cabbabe, MD, FACS, Medical Society President



Medical Society President
Samer Cabbabe, MD, FACS

Physicians are generally unhappy and many desire to leave the practice of medicine. Medical students often select high-paying specialties with the goal of early retirement.

It is no secret that physicians are disenchanted with the changes in medicine and can be overheard saying that they do not want their children to go into medicine. Has the practice of medicine deteriorated to the extent we say it has, and are there more appealing options?

According to a Doctors Company survey of 5,000 physicians, 9 out of 10 physician respondents indicated an unwillingness to recommend health care as a profession. In addition, 43 percent of respondents indicated that they were contemplating retiring within the next five years as a result of transformative changes occurring within America's health care system.¹ What factors are influencing these physicians' decisions?

Emotional Stress

Doctors have the highest rate of suicide of any profession. Every year, between 300 and 400 physicians take their own lives, approximately one per day. In contrast to the general population, where male suicides outnumber female suicides four to one, the suicide rate among male and female doctors is the same. While the rate of depression over a lifetime is basically the same for male physicians and the general population of men, about 12 percent, doctors' suicide rate is 1.4 times higher. Female physicians have twice the rate of depression and 2.3 times the rate of suicide compared with the general population of women. Doctors worry that if they admit to a mental health problem, they could lose respect, referrals, income and even their licenses. Some depressed physicians also have substance abuse problems, another major risk factor for suicide.²

Physicians are generally unhappy and many desire to leave the practice of medicine. Medical students often select high-paying specialties with the goal of early retirement. Physician MBA programs are flourishing;

more than 50 percent of medical schools offer a joint MD/MBA degree program. In 2014, health care had more students in MIT's executive MBA program than any other industry, accounting for about one in five members, or 20 percent, of the class of 2014.³ Physicians are leaving clinical practice to work as hospital administrators, or for health insurance companies, hedge funds or investment firms.

Financial Burdens

Physicians have seen declining reimbursement and increased expenses. The average medical student graduates with \$183,000 of debt,⁴ and an average resident earns a salary of only \$56,500 for over 60 hours of work per week.⁵ This amounts to an earning wage of only \$18 per hour. Health care reimbursement from Medicare has decreased every year when adjusted for inflation. Cost burden has been shifted to physicians to collect co-payments and co-insurance, maintain EMRs, take care of uninsured and under-insured, and provide ancillary staff for the EMRs and billing operations. In order to make ends meet, physicians have gradually had to increase the number of patients they see. The end result is that the average face-to-face clinic visit lasts about 12 minutes.⁶ The focus of health care has shifted toward not only patient wellness but also patient satisfaction scores, despite the fact that high scores are correlated with worse outcomes and higher costs.⁷ Unfortunately, the response of medical leadership is to call for more physician testing in the form of Maintenance of Certification (MOC).

As a result of the financial burden being placed on physicians, private practice physicians are essentially being forced into hospital employment and now, many private primary care physicians may be forced into Accountable Care Organizations (ACOs).

While the majority of physicians (56.8 percent) worked in practices that were wholly owned by physicians in 2014, this majority decreased slightly from 60.1 percent in 2012. In contrast, the share of physicians who worked directly for a hospital, or in practices that had at least some hospital ownership, increased from 29 percent in 2012 to 32.8 percent in 2014.⁸

Physicians are no longer regarded with the same respect they enjoyed in years past. Patients are unhappy with their financial responsibilities (deductibles and co-pays), unhappy waiting for physician services, unhappy seeing mid-level providers, unhappy at the limited time they are allowed in their visit, unhappy or non-compliant to follow our recommendations (weight loss, smoking cessation), unhappy when they do not receive what they anticipate (narcotics or antibiotics) and unhappy when complications arise (and may seek lawsuits as a result). Nurse practitioners are attempting to assume the role of physicians despite the lack of physician education and experience.

There appears to be a media narrative that blames physicians for things the doctor has no control over such as increased health care costs, which are mainly a result of medication expenses and increasing hospital administrative costs. The implication is that doctors are getting away with something and need constant training, watching and regulating. With this in mind, it's almost a reflex for policymakers to pile on the regulations, much as CMS has done.

What We Cherish About Medicine

Given all of these negatives, why would we ever encourage our children to pursue medicine? We must consider what we cherish in our profession when considering the alternatives: Medicine is a wonderful profession. It is one where you can repeatedly help and be of service to many people. The special role a physician has in healing and comforting patients is inspiring. It means working and being directly involved in deeply meaningful human interactions. There are many chances to make a difference, and not many professions can bring this type of personal satisfaction.

In addition, the profession demands and presents intellectual stimulation and requires a constant learning challenge to keep up with new procedures, types of drugs, approaches and frequent modifications in the diagnosis and treatment of common and new conditions. Most physicians chose medicine because they grew up admiring the physicians who treated their families. These physicians later served as role models and sources for encouragement when today's physicians were initially considering a career in medicine. People respect, value and pay for our opinions.

Although physician pay has been relatively unchanged or decreased commensurate with inflation, physicians remain in the top one percent of American earners. Doctors enjoy job security; although our contracts may not be 100 percent secure,

it is highly unlikely that we would ever be out of work for an extended period, barring injury or illness. Physicians may have (chronic) work-related injuries like neck and back pain, but we are certainly not doing heavy manual labor. We have energy to do things we enjoy after work and are able to work later into life or retire early.

Finally, physicians have the opportunity to use their degrees and training outside of clinical practice such as in the role of hospital administrative duties, working for insurance companies or medical startup companies. Physicians have become necessarily involved in politics and are councilmen, senators and representatives.

Solutions for the Next Generation

What can we do to help aspiring medical students achieve their goals? We can improve their educational plight by preparing them for the rigors of business and the hard realities of economics. Education, pre-medical and medical, that speaks to aspiring doctors about the glories of caring for the sick, that tells them only about their economic security, is entirely unfair and unrealistic if we do not teach them that medicine is also a business.

Medical students should have exposure to management and business classes in their pre-medical days, so that they can have those concepts in mind as they consider their economic futures. The cost of their educations, balanced against their own assets and motivations, will have to be factors in their educational process. And universal health care, if passed, won't change this reality. It will only change the customer from the patient to the government.

Medical student debt needs to be restructured to lower interest rates and young physicians need to get credit towards those loans for non-paying patients they see. Over a few years, they could work off that student loan debt. Residents need reasonable salaries, commensurate with physician assistants and nurse practitioners performing the same role. Residents deserve mileage reimbursement and overtime pay for on-call duties. Work hours need to be reasonable in terms of time off and shift length. Food should be available, and lockers should be provided to all residents so they have somewhere to put their personal belongings instead of on a bed in a call room.

For future physicians to succeed, they need to be freed from the tyranny of ideas imposed upon them by those not working at the bedside of the patient. —

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Choosing the Path to Leadership

David M. Nowak



Executive Vice President
David M. Nowak

I believe that leaders are developed and encouraged, and programs like the PLI and the physician-led insurance survey give doctors the opportunity to realize their potential and improve the practice of medicine for all.

We're all familiar with the saying "lead, follow, or get out of the way." Over the years, it's been attributed to a number of people, from General George S. Patton to American patriot Thomas Paine, and from media mogul Ted Turner to businessman Lee Iacocca. All of them chose not to get out of the way, and instead forged new paths and brought about positive change.

Physicians practicing medicine today are faced with this same dilemma. As it relates to dealing with insurance companies and the challenges of reimbursement, we see that big business and the government often want to force physicians to follow or get out of the way. Bravo to those who choose to blaze new trails as leaders.

SLMMS chose the leadership path recently with the launch of its first-ever physician insurance survey in the St. Louis marketplace. The project was chaired by SLMMS Councilor David Bean, DO, who observed that many sources were grading the performance of physicians, but why weren't doctors objectively evaluating the performance of insurance companies? Dr. Bean led a committee of SLMMS physicians who, with the help of our research partner the Prell Organization, developed an electronic survey tool designed to capture the perspectives of physicians (and their office staffs) on the pre-certification process and dealing with insurance companies.

With assistance from a number of partnering physician organizations and hospital medical staffs, SLMMS launched the survey in early September, and by mid-October had reached our objective with 302 completed questionnaires. As I write this column, we're still crunching the data and performing the final analysis, but allow me to share a few top-line results (a more comprehensive summary of results will appear in a future issue of *St. Louis Metropolitan Medicine*):

- St. Louis area physicians give the overall insurance industry a rating slightly above a "C" grade (3.19 on a five-point scale), with most individual insurance companies falling in a narrow range around an average grade as well;
- The grade range varies by procedure, with pre-certification of surgical and radiological procedures rated higher, and pain management and medications rated lower;
- Working with insurance companies is not easy for physician practices and the barriers created are negatively impacting the care of patients;
- Insurance company restrictions often cause treatment plans to be altered to the disadvantage of the patient;
- Physicians believe insurance company mergers have the capacity to negatively impact patient care.

This data will help inform the work of a newly-invigorated Payer Relations Committee that SLMMS is resurrecting in partnership with the Medical Group Management Association of Greater St. Louis. Several highly-engaged practice managers are already on board, and combined with the support of the SLMMS Physician Grievance Committee, we'll be better equipped to address the issues and frustrations physician practices encounter working with insurance companies.

In addition to Dr. Bean, I'd like to recognize the SLMMS members who chose the leadership path and worked diligently as members of our survey committee: Ravi Johar, MD; Mary Klix, MD; Dan Scodary, MD; Toniya Singh, MD; and Stephen Slocum, MD. From design to testing to distribution, they all helped move this project forward.

I would also to acknowledge the 14 organizations—either physician groups or hospital medical staffs—who joined us as partners to distribute the survey to their physician members: Christian Hospital, SSM Health DePaul Hospital, Esse Health, Mercy Hospital St. Louis; Mercy Hospital Jefferson, Mercy Medical Group, Missouri Baptist Medical Center, SLU Care, SSM Health Medical Group, St. Anthony's Medical Center, St. Louis Association of Osteopathic Physicians, St. Louis Physician Alliance, SSM Health Saint Louis University Hospital and St. Luke's Hospital. Thank you to each of you.

Elsewhere in this issue, you'll read about other examples of physician leadership, from commentaries by physicians who are leading the effort to establish a prescription drug monitoring program in the greater St. Louis area, to leadership profiles of several doctors who have completed our Physician Leadership Institute (PLI) over the past two years. I'm thrilled to announce that SLMMS will continue our relationship with Anders Health Care Services to launch a third PLI class later in 2017, with the addition of a new partner, Maryville University. Stay tuned for more details.

I believe that leaders are developed and encouraged, and programs like the PLI and the physician-led insurance survey give doctors the opportunity to realize their potential and improve the practice of medicine for all.

Shifting gears, we stand on the brink of 2017 and a new year brings new leaders to SLMMS. I hope to see all of you at our annual meeting and installation dinner on Saturday, Jan. 28, at Kemoll's Top of the Met when we will honor and recognize these leaders and several physician award winners. Invitations have been mailed to members' home addresses; please contact the SLMMS office if you did not receive one.

Lastly, I again thank you for your generous support of our Medical Society this past year, and for the opportunity to serve as your Executive Vice President. I wish you a happy holiday season and a new year filled with good health and much happiness. —

President's Page — continued from page 5

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INNOVATION CORNER



Spotlighting the work of the SLMMS
Innovation Committee with the growing
biotechnology startup community in St. Louis

Epharmix

Epharmix, a digital health startup, provides automated patient monitoring services to identify at-risk patients, prioritize services and improve outcomes. Founded approximately two years ago, their subscription services enhance physician-patient communications, and improve quality metrics and reimbursement. According to Blake Marggraff, chief executive officer, their current roster of 32 clinical advisors includes 21 physicians in various specialties including cardiology, nephrology, pulmonary and more. Joseph A. Craft, III, MD, a SLMMS past president and Innovation Committee member, has been a physician advisor to Epharmix since March 2015.

"I dialogue regularly with the founders and Epharmix's medical student investigators," explains Dr. Craft. "We discuss physician and patient needs, and I try to connect the team with thought leaders in the medical community who may offer additional insights. These young companies benefit tremendously just from doctors' day-to-day experience on running a practice, work flow management, diagnosis and treatment. Doctors often have more to offer these groups than either party realizes."

Marggraff agrees, and explains the single best word to describe a physician's role with Epharmix is 'patron,' drawing an analogy to the days when patrons supported artists beginning their careers. "Our physician patrons provide guidance and consulting in many roles—as mentors, investors, and early stage customers," he added. "We cannot underestimate the value these patrons provide."

"In St. Louis, health technology innovation has grown at an extraordinary rate in the last few years," adds Dr. Craft. "Despite the vast talent pool driving this change, there is a deficit of clinical insight and patient care experience. Physicians can help fill this gap easily with either small or substantial time commitments. Doctors often develop new skills and find new professional inspiration along the way. What a fun way to contribute to this great St. Louis story!"

Want to get more involved in the St. Louis biotech innovation community? Take the Innovation Committee's survey. To learn more about the SLMMS Innovation Committee and available opportunities, contact the SLMMS office. —

A New Tool to Combat Opioid Addiction in the St. Louis Region

Prescription Drug Monitoring Program targets April 2017 rollout

By Sam Page, MD, St. Louis County Councilman

Prescription drug addiction and abuse have exploded in the St. Louis region over the past decade. Heroin use continues to grow, with some emergency departments seeing heroin overdose and naloxone rescue on a daily basis. Four of five heroin users start with prescription medications.

A Prescription Drug Monitoring Program (PDMP) is the backbone of a community effort to battle opioid and heroin addiction. It was first discussed in the Missouri Legislature in the 2004 session. During each session from 2004 to 2008, I sponsored a PDMP bill, with some success moving it through the legislative process. Unfortunately, it never received final passage.

Over the past 12 years, every state has adopted this program except Missouri. We remain the only state in the union that does not have this program in place through state legislative action. Missouri remains in the top five states for opioid consumption per capita and prescribes more opioid medications than any other state in the Midwest, earning the reputation as “America’s Drug Store.”

In the spring of this year, I successfully sponsored a bill in St. Louis County to create our own PDMP, with an option to allow other county and large city jurisdiction to subscribe for a nominal cost of \$7 per prescriber or pharmacy. St. Louis County Executive Steve Stenger has been a strong supporter of this legislation. His nephew struggled with prescription drug and heroin addiction before losing his life to a fatal overdose in 2014.

Our program was built on the PDMP Center of Excellence at Brandeis University—the resource for all state-run PDMPs. Physicians, dentists and anyone licensed to prescribe scheduled

medications will soon have the opportunity to access this database for patients under their care.

To date, St. Louis City, St. Charles County and Jackson County have passed bills to join our program. Kansas City, Independence and Columbia are in the process of joining as well. In October representatives of 11 rural southeastern Missouri counties attended a meeting with St. Louis County public health leaders to discuss joining the program. For other jurisdictions to join, it only requires passing of an enabling bill and then signing a user agreement with St. Louis County. The system will be HIPAA compliant and is subject to all local, state and federal privacy laws and regulations. Sharing with other states is built into the structure of this program and is a second-step function that will be added once the program is operational for a few months.

How the Program Will Work

St. Louis County has contracted with Appriss, the PDMP vendor in 25 states. The PDMP concept has a long multi-state track record of privacy and security in the other 49 states where it functions. St. Louis County hopes to begin the data collection phase in January, and be available for use by physicians (and all other prescribers) and pharmacists in April.

The unique approach taken by St. Louis County to affiliate with each county in Missouri is cumbersome, but unfortunately the only way to accomplish the task at hand in the current legislative environment.



Dr. Sam Page

Sam Page, MD, is a physician anesthesiologist at Mercy Hospital St. Louis and a SLMMS member since 1996. He is a member of the St. Louis County Council representing the 2nd District. He served in the Missouri House of Representatives from 2003-2009.

Some PDMPs are built as a law enforcement tool, and some are built as a public health tool—in reality an extension of an electronic medical record. The St. Louis County PDMP (with optional statewide participation) is a public health tool. Law enforcement access is granted with a court order for

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The Prescription Drug Monitoring Program and Challenges in the Fight Against Opioid Abuse

By Lawrence F. Kuhn, MD, SSM Behavioral Health – St. Louis

The St. Louis region will soon have a prescription drug monitoring program in place. This attempt at a PDMP is a first for Missouri, the only state not to have a statewide program.

This monitoring program will likely have limited benefit. It should not be too difficult for some individuals to go outside of St. Louis City, St. Louis County or St. Charles County to obtain their prescriptions to avoid monitoring. This type of avoidance is already occurring when prescriptions from neighboring states are filled in Missouri. However, the programs to be put in place in the St. Louis area are at least an initial attempt to safeguard the public. These will allow physicians to check to see if their patients may be obtaining scheduled drugs from other prescribers.

PDMPs can allow physicians to detect such prescribing patterns more easily. This can provide for diversion prevention as well as diagnosis and treatment of abuse before more serious problems develop.

Patients will “doctor shop” for a variety of reasons. Some will share their medications with friends and family or will personally use more than their physician intends. Others have been known to supplement their income with prescription drugs diverted for resale.

People can go to extreme lengths to hide their narcotic use. Some years ago, when I was involved in an anesthesia-assisted detox program, I treated a rather wealthy young woman from Texas, who for years, routinely drove many thousands of miles each year, going from one physician to another to get medications for her chronic back pain. This was prior to Texas having a PDMP. This woman kept extensive records for herself to avoid detection. Her records included which physician she saw for what complaint, office and phone hours, the names of

receptionists, and the offices’ specific prescription policies and patterns. I was amazed at her detailed notes. They were certainly more complete than my own medical records.

PDMPs can allow physicians to detect such prescribing patterns more easily. This can provide for diversion prevention as well as diagnosis and treatment of abuse before more serious problems develop. Such programs can offer a level of protection for the prescriber as well.

Safeguards to protect patient privacy are a part of all PDMPs. Some states mandate that a physician access the system before prescribing scheduled medications. Other states have a voluntary program.

Heroin Becomes More Accessible and Potent

We must not be too complacent to think that this will solve all our problems. At least the federal government recently admitted that its earlier efforts to make all patients “pain free” has been part of the problem. Unfortunately, illegal drugs such as heroin, can often be less expensive than prescription pain medications. The cartels have cut the price of heroin over the past few years to favorably compete with diverted pharmaceutical drugs. Increased competition between the Mexican drug cartels has also made a difference. Over the past few years, the price of a kilo of pure heroin in New York City has dropped from \$200,000 to \$50,000. Relatively inexpensive Chinese fentanyl can then be added to the mix, and both potency and profit increase dramatically. As a result, some patients dependent on prescription opiates have switched to heroin, with even more deadly results.

It would be beneficial if more physicians became familiar with medical treatments for opiate use disorders. Medications such as naltrexone and buprenorphine have saved many lives, and have allowed dependent patients to get off of their drugs of abuse. Patients are often more willing to receive treatment initially from their primary care physician than to go to an addiction specialist.

For years, antidepressants were eschewed by many psychiatrists as a less effective treatment than psychotherapy. It took 20 years or so for antidepressants to be generally accepted. Methadone has been used for treatment of opiate use disorders as a result of Richard Nixon signing the Drug Abuse Office and Treatment Act of 1972. Naltrexone has been approved for treatment of both opiate as well as alcohol use disorders. Buprenorphine has been



Dr. Lawrence F. Kuhn

Lawrence F. Kuhn, MD, is network medical director for SSM Behavioral Health – St. Louis. He can be reached at Lawrence.Kuhn.MD@ssmhealth.com.

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“A Good Kid” Lost to Opioid Abuse

Painkiller for broken arm leads to addiction; mother warns of dangers

By Jim Braibish, St. Louis Metropolitan Medicine

The impact of the opioid crisis struck within the membership of the St. Louis Metropolitan Medical Society on Dec. 15, 2014. That's the day when just two months shy of his 30th birthday, Derek succumbed to an opioid overdose. Derek was the son of longtime SLMMS Alliance volunteer Kelly O'Leary.

By normal standards, Derek was well-accomplished for his age. He had graduated from college, earned an MBA and served for five years in the U.S. Navy. He was engaged to be married. But, over the last 12 years, he had also struggled off and on with opioid addiction.

“He was a good kid. He was very smart, and didn't want this to happen,” Kelly said. “His death was completely unnecessary.”

Derek's involvement with opioids began innocently. In 2002, after breaking his arm playing high school football at age 17, he was prescribed Oxycontin as a normal course of pain relief. Then, playing football a year later, he broke his arm in the same place. He was prescribed Oxycontin again.

At the time, Kelly and her family—and most people—didn't know the risks. “Purdue Pharma marketed Oxycontin to physicians as safe. Actually, it is nothing but legalized heroin,” Kelly said. “If you give an opiate to anyone under the age of 25, the risk of addiction is much higher. The brain is still developing.”

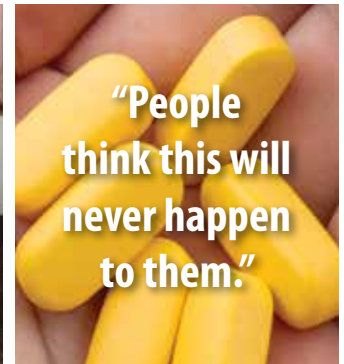
Derek had described to his mom how, beyond pain relief, the Oxycontin made him feel different.

After high school, Derek attended the University of Florida where he earned a bachelor's degree. But Kelly could see things were not right. Following college, the family urged him to enter outpatient treatment. Kelly recalled: “He had been drinking a lot and abusing prescriptions. They found Vicadin in his system. He had liver failure at age 22 from Vicadin.”

Fortunately, the outpatient treatment was successful. Derek worked for a year and then joined the Navy where he handled radar and sonar. In the Navy, sailors are drug tested regularly, Kelly noted.

“He loved the Navy. I had my son back,” she said. Derek took courses and earned his MBA while in the Navy.

But in his fifth year in the Navy, he ran into bad luck and injured his knee. Navy surgeons performed an experimental surgery. Unaware of Derek's history or in spite of it, they prescribed



Kelly O'Leary with a portrait of her late son, Derek.

Oxycontin. The addiction returned. Derek continued to get prescriptions from the nurse practitioner.

“He was still receiving Oxycontin four months after surgery. They gave him anything and everything he wanted,” Kelly said.

Eventually the Navy did realize he had a problem and got him into treatment which he continued after his enlistment ended. “Unfortunately, the Veterans Administration did not handle the situation well. He was released too soon and relapsed,” according to Kelly.

Eleven months after leaving the Navy, Derek was living in Toronto with his girlfriend. They planned to marry and move to St. Louis.

But the addiction took over. Derek was found dead in his apartment that December. The toxicology report showed his system had fentanyl, the high-potency synthetic form of heroin. They also found five prescription medications he was obtaining through the VA as a disabled veteran.

Living With Loss

“After my son died, it was the absolute lowest point in my life,” Kelly said. “You don't imagine seeing your child in a casket.”

She joined a grief support group specifically for survivors of loved ones lost to substance abuse. She continues to attend the group every Sunday.

Now, she warns others about the dangers. “After my son died, I needed help. Many people were there for me. Now, I am trying to give back to others.”

She presented her story to Alliance members and friends at an Oct. 6 gathering at a Kirkwood restaurant. She has spoken three times to patients at the Harris House Treatment and Recovery Center in south St. Louis. She also volunteers for the St. Louis office of the National Council on Alcoholism and Drug Abuse (NCADA). She appears in a video produced by Mercy and the Greene County Medical Society Alliance (available on YouTube).

What recommendations does Kelly offer?

For individuals, she suggests, “The best way not to become addicted is not to take opioids. When my daughters were given prescriptions for Vicadin by a pediatrician and an oral surgeon, we did not fill them. The girls got by on Advil instead.”

She also reminds people that if they have unused prescription medicines, to safely dispose of them at a site such as NCADA or various pharmacies and police stations.

A New Tool to Combat Opioid Addiction... — *continued from page 8*

an ongoing investigation of a specific prescriber or patient. Prescribing patterns that generate concern, by standards set by the PDMP technical advisory committee, will be referred to the appropriate licensing board for investigation by that body. Patients may also request a copy of their own prescribing history. De-identified data will be made available for community reporting and research purposes.

The PDMP database is populated by automated transmittal of Schedule II through IV prescription information as a copy of information sent to third party payers when a prescription is filled. The pharmacist does not manually enter additional data. In the 25 states where Appriss provides PDMP operational services, no additional switch fees are charged to participating pharmacies.

Some states have made physician participation in PDMP mandatory. In St. Louis County we do not require physicians to check the PDMP prior to writing a controlled substance, but referring to this database is prudent, especially in light of medical liability associated with scheduled medication. Physicians do not enter data into the PDMP. Only filled prescription data from a pharmacy is automatically reported to the PDMP.

The best answer continues to be a PDMP that covers the entire state of Missouri, through state legislative action. State Rep.

For physicians, she says, “Think about the consequences of these drugs before writing prescriptions. Opioids are a tragedy that causes lifelong pain. Physicians have the power to prevent exposure to these drugs with their prescription pads.”

Physicians should screen patients for family histories of addiction before writing prescriptions for opioid painkillers, she added.

In the public arena, she would like to see more long-term, residential treatment programs. “It takes five years to fully recover from addiction. In Germany and the Netherlands, they have five-year programs where the patient stays at the facility while working in the community.”

She warns, “We were so naïve. People think this will never happen to them.” —

Holly Rehder (R-Sikeston), the sponsor of state legislation to create a PDMP for Missouri, will continue to pursue this legislation and should continue to receive medical community support. House and Senate leadership have indicated continued support for this solution as well.

The unique approach taken by St. Louis County to affiliate with each county in Missouri is cumbersome, but unfortunately the only way to accomplish the task at hand in the current legislative environment. We have concerns that patients with addiction disorders or drug-seeking behavior will migrate from the participating urban areas to nonparticipating and non-reporting counties.

Once passed, the state program will require two to three years to become functional, depending on appropriation of adequate funding and development of supporting regulations. When the state finally passes a PDMP built on best practices that are equal to or greater than the St. Louis County PDMP, our intention is to roll our county collaborative system into the statewide program.

Please email your questions and suggestions to me at spage@stlouisco.com. As this program is adopted we hope to give physicians another tool in the fight against opioid addiction, diversion and abuse. This is a work in progress and we will depend on the active engagement and participation of the members of the St. Louis Metropolitan Medical Society. —

The Prescription Drug Monitoring Program... — *continued from page 9*

available in Europe for opiate use disorder treatment since 1996, and in the U.S. since 2002. These are hardly “new” treatments. We know, that without such medical assistance, the chance of a patient with opiate use disorder staying drug free for one year is in the neighborhood of 10 to 25 percent. A number of our patients will likely die without treatment. There simply are not

enough addiction specialists available to treat everyone.

As with all medical illnesses, early identification and appropriate treatment of substance use disorders usually makes for better outcomes. A prescription drug monitoring program is one more tool we can use to help those in our care. —



Becoming a Physician Leader

Today's health care environment demands that physicians possess a broad set of leadership skills

By Rik Nemanick, Ph.D.

Today's physician is expected to have a broad set of skills beyond the clinical. As health care has become more complex due to advances in medicine, technology and public policy, health care organizations have had to adapt in kind. Hospitals and group practices have responded with new and complicated systems, processes and structures, all of which place new demands and pressures on the medical practitioner. It is not enough to possess the clinical skills that make for an excellent physician. Today's environment demands a broad set of leadership skills to be effective in delivering patient care.

Unfortunately, these skills are not often emphasized in medical school or residency programs, leaving most physicians to rely on whatever skills they already possess, as well as examples of good and bad leadership, on which to build their leadership skill set. In addition, many physicians get moved into positions of increasing responsibility because of their effectiveness as a practitioner and not for displaying good leadership. Medicine is not alone in this regard. Other highly trained professionals, such as attorneys, accountants, engineers and professors, suffer from the same pattern of rewarding technical skill with leadership positions. But, the rapid changes in the

practice and business of medicine make the gap even more urgent today.

Reading a book or taking a course on leadership will not transform you into an effective leader. To develop the skills, you also need to blend in a mix of practice and feedback.



Medical schools and residency programs have begun to address this issue. For instance, Washington University School of Medicine is collaborating with the Olin School of Business and BJC HealthCare to offer leadership training for physicians. However, the change in how we systematically prepare physicians for leadership will take some time.

Developing Knowledge and Practice

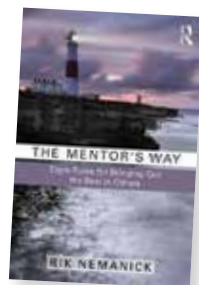
What, then, can you do to develop your own skills as a leader in the meantime? The first step is to recognize that developing leadership skills is like developing any skill set: it is a combination of knowledge and practice. You need to both know what to do and how to do it. Reading a book or taking a course on leadership will not transform you into an effective leader. To develop the skills, you also need to blend in a mix of practice and feedback.

The question, of course, is, "What do I need to learn as a leader?" You can approach this part of development several ways. Many people begin by examining the best (and sometimes the worst) leaders and thinking about what they did. You can start that exercise now by listing the name of two or three of the best physician leaders you have seen (and maybe one of the worst). For each of them, list the behaviors or qualities they exhibit that put them at the top of your list. Look for common themes among them as well as the different ways they approach leadership. This list can be a starting place for building your own leadership competence.



Rik Nemanick

Rik Nemanick, Ph.D., is a co-founder and principal consultant with The Leadership Effect, a strategy and leader development firm based in St. Louis. His practice focuses on helping leaders develop through assessment, coaching, training and mentoring. His clients include BJC HealthCare, Massachusetts General Hospital and Catholic Health Initiatives. He has also taught in the MBA program at Saint Louis University and the Masters of Human Resources program at Washington University. He earned his doctorate in organizational psychology from Saint Louis University. He has been a speaker at the SLMMS Physician Leadership Institute for the past two years. Rik's forthcoming book, *The Mentor's Way*, is due out this December from Routledge. His website is www.leadership-effect.com.



It is important to recognize the fact that this list will be confounded by what you prefer in a leader. You should also recognize that the people you lead may have different definitions. To round out your list, consider some other sources of leadership behaviors. The Academy of Medical Royal Colleges in the U.K. maintains a list of physician leadership qualities that you may want to consider. They group leadership competencies into five areas:

- Demonstrating Personal Qualities
- Working with Others
- Managing Services
- Improving Services
- Setting Direction

Within each of these areas is a subset of competencies, such as Working within Teams, Encouraging Improvement and Innovation and Developing Self Awareness. Between your own starter list and other sources, you should be able to identify a list of leadership competencies that you can use as your model of the type of leader you want to be.

One way to get this feedback is through the 360° feedback process, where a third party collects confidential feedback from subordinates, peers and supervisors to provide you with a more comprehensive view of your leadership.



Soliciting Feedback on Your Leadership

With this list in hand, you can begin the more challenging part of this process: getting honest feedback on how well you manifest these behaviors. This step is challenging for a few reasons. First, many of us do not want to hear feedback on our weaknesses. Many of us can become defensive or argumentative when our flaws are brought to light. Rather than looking at our strengths and thinking of how to improve them or seeing what effect our weaknesses have on our leadership, we devote our energy to explaining why our shortcomings are not real or not really a problem.

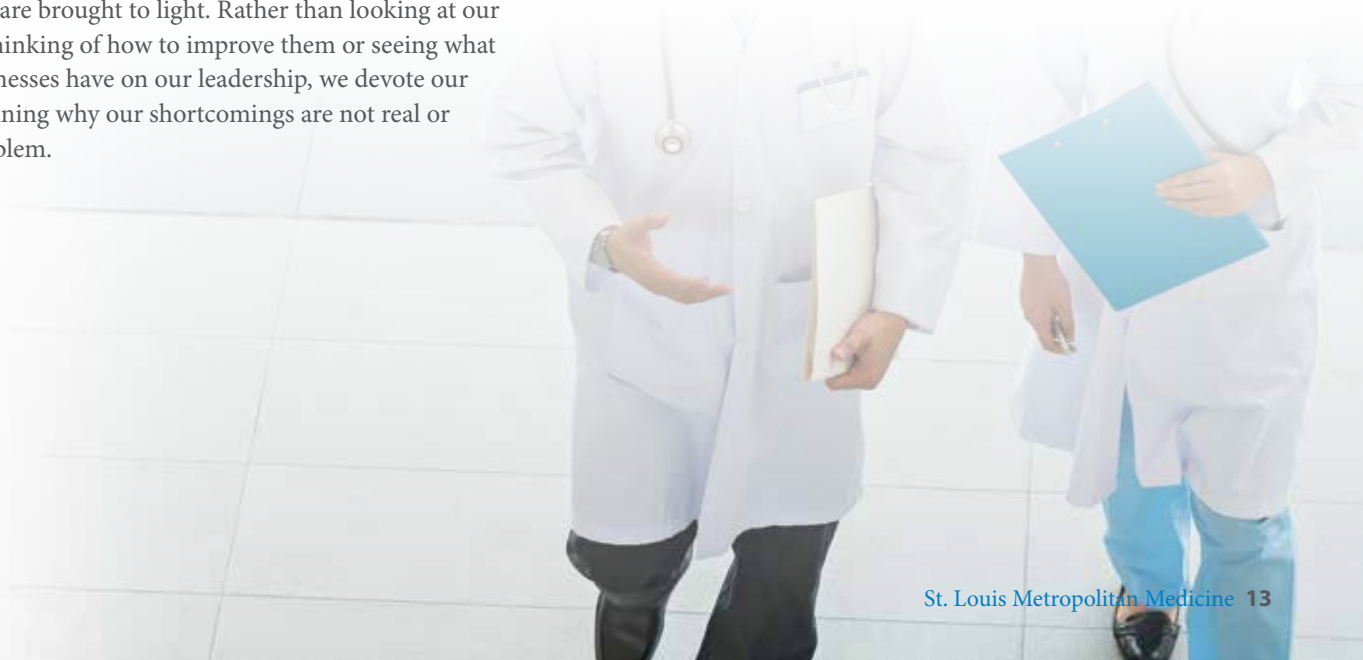
The other impediment to quality feedback is the fact that many people are hesitant to deliver it honestly. Some fear the reaction described above. No one wants an argument when trying to give you feedback that is for your benefit. Furthermore, there can be a power imbalance between you and those from whom you need feedback. One way to get this feedback is through the 360° feedback process, where a third party collects confidential feedback from subordinates, peers and supervisors to provide you with a more comprehensive view of your leadership. If you prefer a less formalized process, you can sit down with a trusted peer who is in a position to see you operate in your role as a leader. Ask her or him for specific feedback on your leadership skills using your own leadership model to probe for examples of where you demonstrate strength and where you can improve.

Once you have your list in hand, it is time to go to work. The good news is there are countless sources of excellent leadership books, training, articles and workshops that can help you with your particular needs. The bad news is there are so many, it can be hard to know where to start. I would recommend finding a mentor or two who can help you with your learning journey. If you look at your list of leaders from earlier, with which of those could you schedule a few meetings to discuss your growth as a leader? They could point you to the resources that have helped them grow in their own roles, as well as be a confidant with whom you can explore your own growth and development. In fact, most leaders can point to their own mentors who helped them through their journeys of leadership.

Becoming a physician leader can be a long process. It takes a constant investment in your skills and a regular diet of feedback to let you know how you are progressing. But, the investment can pay off for you, your team and your patients. As we move into the new year, set a goal of thinking about your role as a physician leader and commit to growing in at least one area. ➤

Reference

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Profiles in Leadership: Physicians Share Their Thoughts

Recent Physician Leadership Institute graduates discuss the rewards of leadership and why leadership is especially important today

Leadership skills are becoming more necessary for physicians today. Instead of being “captain of the ship,” the physician often is working in a large health system or with a patient-care team. Value payment will push the growth of team-based care.

According to a 2014 white paper by the American Association for Physician Leadership (www.physicianleaders.org), about five percent of hospital CEOs are physicians, and that number is expected to increase rapidly. Physician leadership makes a difference in health systems. A 2011 study published in *Social Science & Medicine* found that overall hospital quality scores

are 25 percent higher when a physician leads the hospital; the percentage increases to 33 percent for cancer hospitals. Yet 66 percent of hospitals in an American Hospital Association survey said physicians comprise only 10 percent of their senior leadership teams.

The Physician Leadership Institute is helping physicians build leadership skills that, until recently, were not taught in medical school. Three SLMMS members who completed the Physician Leadership Institute share their thoughts on leadership. ■

Coming in 2017: An All-New Physician Leadership Institute

SLMMS has demonstrated its commitment to developing strong physician leaders for the past two years through its sponsorship of the Physician Leadership Institute (PLI). Again in 2017, SLMMS will partner with Anders Health Care Services to present the high-intensity, multi-week program. We are excited to announce the addition of Maryville University as a new partner for the third annual program.

The PLI, open to physicians only, was launched in 2015. A total of 38 doctors from throughout the St. Louis metro area as well as outstate Missouri have graduated from the program to date. The curriculum, based on the Medical Group Management Association (MGMA) Body of Knowledge, places its emphasis on the business aspects of medical practice, with the objective of developing leadership and management skills. The faculty for the sessions comes from throughout the health care business community.

As you can see in the accompanying leadership profiles, physicians who have completed the PLI are putting their newly developed skills to work in a variety of leadership capacities. Participants have served in leadership roles in

associations at both the state and national level, on their respective hospital medical staffs, or within their own medical practices.

“This program has exceeded all expectations during its first two years,” explains Dave Nowak, SLMMS executive vice president and one of the program organizers. “We found that there is a real demand for leadership training for physicians, and have witnessed program graduates utilizing their skills in many new and unique ways.” The PLI is continually developing, as input from participant evaluations and physician focus groups each year help drive the content. “With Maryville coming on board in 2017, we expect to take the program in new directions in terms of classroom training and content delivery,” he added.

Program dates and session content will be announced early in 2017. Continuing medical education hours will again be awarded. Tuition for SLMMS members will once again be discounted significantly, and group rates for hospitals or medical practices will be available. Watch for information in future issues of *St. Louis Metropolitan Medicine* or on the SLMMS website.



Michael G. Beat, MD, MPH, MBA

Radiation oncologist Michael G. Beat, MD, has been medical director of Arch Cancer Care for the past seven years. He leads a team of health care professionals specializing in the treatment of prostate cancer. He previously was chief of radiation oncology at Brooke Army Medical Center in San Antonio, and was a partner with St. Louis Cancer & Breast Institute.

Besides his practice, Dr. Beat provides leadership through committee service with the US Oncology Network and the ZERO Prostate Cancer Run/Walk. He is a board member of The Empowerment Network, a support organization for men with prostate cancer.

Being able to engage a diverse group of individuals with unique talents and unite them in a fashion that creates a functional team or organization ... motivates me to lead.



He has taken a leadership role with the Medical Society as chair of the ad hoc Innovation Committee dedicated to supporting life science and medical startup companies. He joined the SLMMS Council in 2016.

A member of the 2015 SLMMS Physician Leadership Institute class, he also has received leadership training from the US Oncology Network, through his service as a U.S. Army physician, and during his studies for his MPH and MBA degrees.

What attracts you to leadership, and what do you find fulfilling?

I recognize that my individual efforts at patient care (or any other endeavor) are limited in their effectiveness by sheer time, energy and resources. Being able to engage a diverse group of individuals with unique talents and unite them in a fashion that creates a functional team or organization—one that can produce a superior product or deliver optimal patient care that I would not be able to provide by myself—motivates me to lead.

What did you learn about your leadership style and abilities through the Physician Leadership Institute, and how is that training beneficial to you today?

It is very difficult to influence an individual's personality, but one can alter their behavior through the right persuasive

incentives. In order to accomplish that goal, one must have an ability to adapt their own leadership style to effectively manage many different circumstances and situations. This requires a clear understanding of the strategic goals of an organization. Without that guiding vision, leading change simply reverts to managing chaos and crisis.

In today's health care environment, why is it more important that physicians possess leadership skills? Do we need more physicians in leadership roles?

Change always has and always will be inevitable. We can often foresee the (health care, technology, regulatory) changes coming, but all too frequently simply react to the new developments instead of proactively preparing for the transition or even engaging and working toward altering the trajectory of those changes. Physician leadership roles—particularly through national and local organized medicine activities like SLMMS—are important conduits to claim some ownership and responsibility in shaping today's and tomorrow's health care environment.

What are the key attributes of a good physician leader?

We often get so involved with the acute concerns of our patients and the day-to-day details of their health, that it can be a difficult transition to step back and look at the bigger picture over a longer time frame. One must think strategically about the future and critically analyze the performance of our past. Other key components of physician leadership are collaborative communication, team development, and effective delegation and supervision. The delivery of optimal individual patient or population health today relies on a team effort. Physicians are well suited to direct these tasks and quite accustomed to giving (or writing) orders, but we may need to develop additional skill sets to more effectively function in these leadership roles.

What advice would you offer physicians aspiring to leadership roles?

The Physician Leadership Institute is an excellent opportunity to gain a high-level overview of the many different aspects of physician leadership available without committing to a more expensive and prolonged academic leadership program. This provides a platform from which to tailor further training or refine and formulate entry into another leadership role. If you don't like an important aspect of our health care profession or are concerned about the direction medicine is moving, get involved at another leadership level and work to lead the change. If we as physician leaders do not participate in the process, someone else will make the decisions for us. —



Profiles in Leadership ➤ *continued from page 15*



David L. Pohl, MD, FACR

David L. Pohl, MD, FACR, has been director of radiology at SSM Health St. Joseph Hospital-Lake St. Louis since 2005. He also serves on the hospital medical executive committee, along with the peer review, credentials, citizenship and informatics committees. He is a member of the SSM Health St. Louis radiology directors committee.

He has been very active in organized medicine. He was 2013 president of the St. Louis Metropolitan Medical Society, and has held officer or councilor positions for seven years. He currently chairs the political advocacy committee and has been involved in various other committees. At the state level, he is Missouri State Medical Association treasurer and has been a councilor since 2013. He chairs the budget and finance committee.

Physicians must be involved or the decisions affecting your profession and professional life will be made for you by others who may not have your best interests in mind.



Dr. Pohl is president-elect of the Missouri Radiological Society. He is a past president of the Greater St. Louis Society of Radiologists. He has been a councilor for the American College of Radiology since 2014.

Besides completing the 2015 Physician Leadership Institute, he has attended training for hospital and medical executive committee leadership presented by the Greeley and Horty Springer programs.

What attracts you to leadership, and what do you find fulfilling?

Physician involvement today is critical. If you're not involved, decisions will be made for you that affect your life. There is the saying, "If you are not at the table, you are on the menu." I also enjoy the camaraderie with other physicians, particularly from a variety of specialties. It recalls when I was in medical school and there were friendships with those from many areas of interest.

What did you learn about your leadership style and abilities through the Physician Leadership Institute, and how is that training beneficial to you today?

I learned how to approach situations to achieve best possible outcomes for all involved. The other person wants something as well. How can we make the pie bigger so we all can benefit? Also, it helped me appreciate how each person brings a different perspective to a situation, and each of us has different things that are important to us.

In today's health care environment, why is it more important that physicians possess leadership skills? Do we need more physicians in leadership roles?

Physicians must be involved or the decisions affecting your profession and professional life will be made for you by others who may not have your best interests in mind. Certain decisions regarding medicine should be made by medically trained individuals. Just doing what we are told and not being involved means we may not be able to practice good medicine. I want to make sure the medicine I practice is what I would want my family to receive. If we had been involved years ago in the design of electronic health records, they would have been designed more for the doctor and help in patient care. Instead, they are designed for the bean counter. As we move toward patient-centered medical homes and value-based payment, we need to be involved. We need to take a long-term view of the coming changes. Involvement is more critical than ever.

What are the key attributes of a good physician leader?

Be determined but flexible. Understand the other person's viewpoint and why they see things this way. Be willing to listen and compromise, but also remain true to your values. And, the willingness to get involved is essential.

What advice would you offer physicians aspiring to leadership roles?

Get involved—"If not me, who? If not now, when?" Also have patience, because nothing happens overnight. Don't focus just on the endgame, but on the journey. Even if you don't come to an agreement, at least achieve an understanding that you are working toward the same goal. And, maintain good relationships around the organization. Always keep the lines of communication open. ➤



Toniya Singh, MD, FACC

Toniya Singh, MD, FACC, has been a partner practicing invasive non-interventional cardiology with St. Louis Heart and Vascular since 2003. In addition to her practice, she serves on the board of directors of Gateway Regional Medical Center in Granite City, Ill., one of the three hospitals where the 16-physician practice has offices.

She is active in the American Heart Association of St. Louis, where she serves on the board of directors and chaired the auction committee for a fundraising luncheon. She is current president of the Women in Cardiology Missouri chapter, and is national lead for the organization's private practice workgroup.

The attractive part of leadership is that it gives you an opportunity to change hearts and minds and work with others toward achieving common goals. And the satisfaction of getting an idea translated to action gives me great joy.



She is a member of the 2016 class of the Physician Leadership Institute. She credits her husband, Inderjit Singh, MD, SLMMS Councilor and fellow 2016 class member, for encouraging her to attend the PLI. She also has attended leadership workshops with Women in Cardiology and the American Heart Association.

What attracts you to leadership, and what do you find fulfilling?

I like to believe that in order to make a change, one needs to be present and advocate for things one believes in. I have always believed that one has to have a voice. The attractive part of leadership is that it gives you an opportunity to change hearts and minds and work with others toward achieving common goals. And the satisfaction of getting an idea translated to action gives me great joy.

What did you learn about your leadership style and abilities through the Physician Leadership Institute, and how is that training beneficial to you today?

I believe the PLI provided a great forum to take time out of our busy lives and sit back and contemplate the mechanics of our thought processes. It led us to ponder how we really function and reflect on the pros and cons of the particular styles of leadership as well as learn how the various leaders we know function. I believe I have a collaborative leadership style which really thrives on encouraging everyone on the team to do their best, and recognizing and encouraging and acknowledging everyone's contributions. I also like to lead by example.

In today's health care environment, why is it more important that physicians possess leadership skills? Do we need more physicians in leadership roles?

In today's environment it is even more important that physicians take leadership roles to help them control their destiny. Alone, we are weak and together, we are strong. It does not matter if we work for ourselves or for a hospital system; part of being a good leader in my mind is staying flexible while working on collaboration and negotiation to achieve better outcomes for our patients as well as ourselves. The absence of strong leadership on the physician end can lead to an imbalance of power. The lack of role models for younger physicians can also lead to a vacuum of power.

What are the key attributes of a good physician leader?

Someone who is thoughtful, pragmatic, charismatic, flexible, realistic, has good negotiation skills, and is well versed in the art of having difficult conversations. They should be a collaborator but not a pushover. They should be open-minded, be constantly learning and improving, and be building bridges with all parts of the organization. They need to understand their strengths and weaknesses and be a team builder.

What advice would you offer physicians aspiring to leadership roles?

Start locally. See what issues and problems move you, and engage with your peers. Be kind, not arrogant. Attend a leadership workshop. The PLI was excellent. Talk to leaders you know. Learn from their experiences, show interest, show up, be present, network and, above all, keep an open mind and keep learning. ➔



Physicians Must Help Lead the Change

With further change inevitable in health care, physicians must help lead the change, said Jay Want, MD, to Medical Society members at the annual Hippocrates Lecture on Oct. 27. Dr. Want, of Denver, is a consultant and the chief medical officer of the nonprofit Center for Improving Value in Health Care.

Dr. Want showed data on how per capita health care costs in the U.S. have more than tripled since 1980, while their share of the gross domestic product has grown from 8% to 17%. "Costs are increasing at an unsustainable rate. This has canceled out all growth in the GDP in the 2000s. We will feel the pain as it takes away from other needs, like roads and bridges."

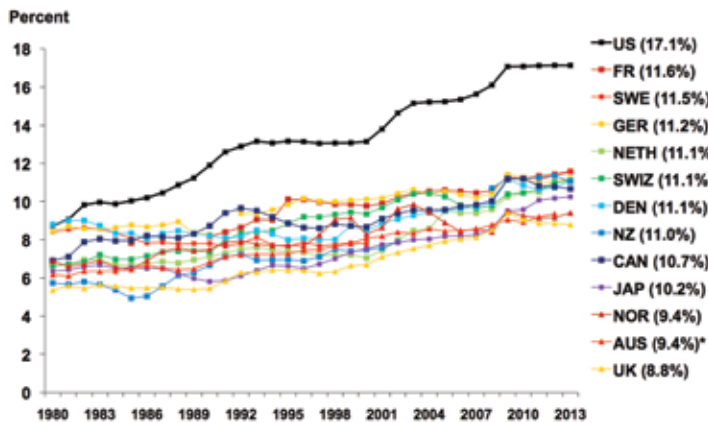
We are losing global competitiveness, he added, "partly because it costs too much to provide health care to our people relative to other countries."



Dr. Want suggested that physicians look beyond the financial rewards of medicine. "What is our purpose and contribution to society?"

Besides the growth in health care expenses, another key macro trend we face is big data and the amount of data available. The third "tsunami" is "the empowered individual," who with the help of the Internet has much more information at his or her disposal to make decisions.

Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.



SLMMS President Samer Cabbabe, MD; speaker Jay Want, MD; SLMMS Hippocrates Society President Arthur Gale, MD.

Physicians should help interpret and define the realities our nation faces, he said. "Physicians remain one of the most respected professions. We have the role to lead the change."



Hannah Bucklin; Melissa Wehrmann, MD; Daniel Wehrmann, MD; Adrienne Childers, MD.

Dr. Want suggested that physicians look beyond the financial rewards of medicine. "What is our purpose and contribution to society?" To get younger physicians involved, he recommended that the appeal be based on the sustainability of the profession.

He concluded, "It will take integrity, courage and persistence for leaders to help us all get to a better place. The question to ask is, 'Will you help us, and each other?'"

The annual Hippocrates Lecture is sponsored by the St. Louis Society for Medical and Scientific Education, the Medical Society's charitable foundation.

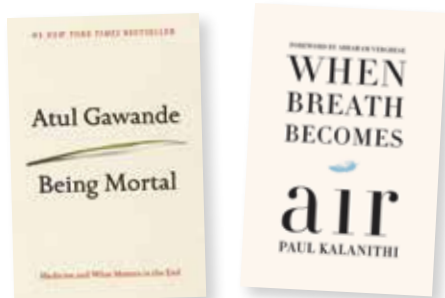
Book Reviews: Physicians and the Dying Patient

By George Bohigian, MD

Woody Allen once said “I’m not afraid of death; I just don’t want to be there when it happens.”

We cannot escape death, neither that of some of our patients nor our own. But we physicians have very little training on counseling the dying patient. We learn to treat and manage diseases, but we are rarely schooled on the most important thing to a terminal patient: compassionate care and support in their final days. Many medical students do not study geriatrics.

Two best-selling books concern the physician and the dying patient. I recommend them.



Dr. George Bohigian

A past SLMMS president, Dr. Bohigian is professor of clinical ophthalmology at Washington University School of Medicine.

- *Being Mortal: Medicine and What Matters in the End*, by Atul Gawande, MD (Metropolitan Books 2014). A surgeon at Brigham and Women’s Hospital in Boston, Dr. Gawande states, “We have come to medicalize aging, frailty and death, treating them as if they were just one more clinical problem to overcome. ... American medicine has prepared us for life but not for death.”
- *When Breath Becomes Air*, Paul Kalanithi, MD (Random House 2016). This is a profoundly moving, exquisitely written memoir by a physician who, at age 36, was on the verge of completing a decade’s worth of training as a neurosurgeon when he finds he has stage IV lung cancer. He attempts to answer the question: What makes a life worth living? (Editor’s note: See discussion of this book in the *Executive Vice President* column in the August-September St. Louis Metropolitan Medicine.)

A third book I recommend is *Last Wishes* by L. Knox (Ulysses Press 1995). A practical guide for families and survivors, the book provides instructions, funeral details and special messages.

Perhaps these books will fill the gaps left in our education. Remember the words of Benjamin Franklin: “Nothing in life is certain except death and taxes.”

J. Collins Corder, MD, FACP, Named BJC Physician of the Year



Dr. J. Collins Corder

J. Collins Corder, MD, FACP, was honored as BJC Medical Group Physician of the Year for 2016.

Specializing in geriatrics, Dr. Corder practices at West County Medical Associates at Missouri Baptist Medical Center. He also is SLMMS president-elect.

In presenting him with the award, he was praised for his dedication to his patients and the extra effort he provides. In one case, he went to the parking garage to examine a patient with dementia who had refused to get out of the car and come into the office.

He was also praised for the mentorship he provides to his staff and other members of the care team. ➤

CALENDAR

DECEMBER

- 13** SLMMS Council, 7 p.m.
- 23-26** Christmas Holiday, SLMMS office closed
- 30** New Year’s Holiday, SLMMS office closed

JANUARY

- 2** New Year’s Holiday, SLMMS office closed
- 10** SLMMS Council, 7 p.m.
- 17** SLMMS Delegates’ Briefing, 7 p.m., Mercy Hospital St. Louis
- 28** SLMMS Installation Banquet, 6:00 p.m., Kemoll’s

Point of Service Collections

By Melanie Reed, MGMA of Greater St. Louis



Here are some things that are overheard when discussing patient balances that show the patient mindset:

“My insurance pays everything.”

“I always get billed by the office after insurance pays.”

“I will pay later.”

“They won’t bill me/care because it’s such a small amount.”

“They get enough money from my insurance company.”

“If they don’t ask for money, I’m not going to volunteer to pay.”

“I thought the government (Affordable Care Act) pays for everything now.”

Sound familiar?

Avoiding collections necessitates that you get patients to pay their bills in full—up front when possible. That means your staff must be firm when discussing balances with patients, which is a substantial challenge in some offices. You have invested time, money and effort into the quality of care you provide; it’s only reasonable to expect your patients to recognize and meet their financial commitments to you. It is crucial to make that concept part of your office’s collection culture.

The benefits of collecting at point of service include carrying less accounts receivable on your books, lower collection costs, reduced bad debt, and improved cash flow.

The fewer times you have to touch an account, the more valuable that account is. If it only takes one request (at the front desk) to obtain payment, you dramatically reduce costs associated with collections.

Think of it this way. If you are looking at a \$100 account, when is it most valuable? Today. When is the next most valuable point? The next day. As time goes on, the account loses value. According to the Department of Commerce, statistically 95% of the accounts are still collectible at 30 days, but time is not on

your side. By the time an account reaches 90 days, 25% of those accounts are no longer collectible, by any means, and by 180 days when it is common for practices to give up and turn patients over to a collection agency, only 30% of the accounts that remain are collectible ... 70% will never be collected.

The challenge is that the public is used to laid-back or nonexistent collection efforts, staff may not be adequately trained to maximize recovery of Point of Service (POS) dollars, management has been focused on back end recovery, and POS dollars have gone unaddressed.

Additionally, the staff often have a mindset regarding point of service collections.

“The front desk is really busy and I don’t have time to ask for money.”

“I’m uncomfortable asking for money.”

“That’s not my job.”

“The back office is responsible for collections.”

“It doesn’t do any good to ask, the patient is going to say no.”

This perception influences how the front desk is asking for money.

If the staff say, “You have a \$35 copay and a balance of \$20 from your last visit. Are you going to pay that today?” they subtly imply that the patient has a choice whether to pay or not to pay.

A better way to state this would be “You have a \$55 balance today which includes your copay and a small past due balance. We accept debit cards and credit cards, check or cash. How would you like to take care of your balance today?” This implies that the payment is expected today and in full. Staff need to understand that the best time to get a patient to pay their balance is right now.

As you focus on POS cash collections, know your daily average opportunity to collect and compare that to what you are actually collecting. If you track these numbers, it is easier to gauge success. For example, if someone is bringing in \$700 per day at the front desk out of a possible \$1,000, that’s 70% success, pretty good, right? But if the daily average opportunity to collect is \$2,000, the percentage drops to 35% success. Know and track these numbers and encourage staff to collect more at the point of service.

Sales-Oriented Front Desk

Hiring a front desk receptionist/administrator who is appropriate for the job is key. They do a lot more than answer the phone and schedule appointments. These team members play a large role in your accounts receivable and patient collection processes. Hire someone with a background in sales. They are often good communicators and have experience



Melanie Reed

Melanie Reed is a senior representative with Transworld Systems, Inc. She can be reached at melanie.reed@transworldsystems.com or 618-977-1555. Transworld Systems is a 16-year national MGMA partner, and has recently become an affinity partner of the American Medical Association. This communication is for informational purposes only and is not intended, and should not be taken, as legal advice on any particular set of facts or circumstances. This agency is licensed by the NYC Department of Consumer Affairs: License number 2012412-DCA.

with awkward conversations around money because the same techniques can be applied whether closing a sale or selling the patient on paying their bill. When the front desk approaches the patient by emphasizing benefit of financial freedom from having a paid bill, patients will be much happier to settle their accounts.

The best opportunity to get a payment is before the patient has seen the doctor.

The second best opportunity is as patients are checking out of your office.

Make sure the front desk is reviewing accounts and payment histories to confirm that patients are current on all past bills, and that no previously provided services have not been paid in full. Train receptionists to understand patient account summaries as well as your processes and accepted forms of payment so that payments can be collected without confusion. Often a friendly reminder is all it takes to get a patient to pay their bill.

Here are some further suggestions provided by the MGMA of scripts to use while asking patients for money: <http://www.mgma.com/blog/patient-collection-check-in-scripts-for-medical-practices>.

When a patient fails to pay a balance within a reasonable amount of time—e.g., 30 days—begin following up the mailing of the first statement with a call from your office. On such calls, be firm but generous: request payment in full. Failing that, offer

to set up the patient on a payment plan that gets the account paid in full in a time frame that works for the patient and your office. A level as low as \$10 per month on a \$5,000 balance is not an appropriate plan.

If that doesn't work and another month has passed, follow up statements with both phone calls and warning letters, which outline the fact that the patient will be dismissed from your practice's care if they do not pay the balance by a designated date.

When that date arrives, send the letter of dismissal. At that point you have the option to write off small balances as losses if you would rather not deal with an agency—an advisable choice in some cases. If you decide to move into debt recovery with an outside company, make sure to use a trusted, vetted agency. Ask colleagues for referrals before contracting with a collection agency and ensure that they know exactly how you'd like your accounts to be handled. Use your association membership as well. The MGMA, HFMA, AMA and RHA have screened collection agencies for their members. Take advantage of these vetted resources.

It may not be possible for your practice to collect 100 percent of what you're owed from patients—especially in today's economy—but implementing firm payment policies is the best way to avoid issues. Tighten up your processes for the benefit of your cash flow. ◀

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MedjetAssist is available to SLMMS members for \$250 for an individual (under age 75) membership and \$375 for a family, a \$20 discount off of regular prices. Medjet also now offers a Horizon option featuring travel security and crisis response along with other benefits.

For more information or to enroll online, go to www.medjet.com/slmms or call 800-527-7478 and mention you are a SLMMS member. ▶

READER SURVEY PRIZE WINNER

Thanks to the 75 SLMMS members who completed the recent *St. Louis Metropolitan Medicine* reader survey. Your comments are most appreciated. Medical Society Past President George Bohigian, MD, won the survey participant drawing for a \$100 gift card. Dr. Bohigian, right, is pictured with SLMMS Executive Vice President David M. Nowak. He donated the card back to the Medical Society to take the staff to lunch. Thanks, Dr. Bohigian. ▶



Opiate Misuse, Reform and Recovery

By Gill Waltman, SLMMS Alliance

On Oct. 6, the Alliance hosted a well-attended awareness program on prescription opioid misuse. Alliance board member Kelly O'Leary shared her family's tragic experience of losing her very accomplished 29-year-old son to an accidental opioid overdose. His addiction began when he was prescribed a "safe" pain medication after a football injury in high school, and despite the discipline of five years in the U.S. Navy, and achieving a master's degree in business, he was still vulnerable. (See article on page 10)



From left, Alliance Co-Presidents Gill Waltman and Sandra Murdock, Chad Sabora, Kelly O'Leary.

Invited speaker Chad Sabora, co-founder of the Missouri Network for Opiate Reform and Recovery, described his own path through addiction. After earning his undergraduate and law degrees, he began his career as a prosecutor for Cook County, Ill. In 2006, with the pressure of work and the loss of both parents from cancer, he became addicted to prescription pain medication (opiates). When his physician was no longer willing to prescribe for him, he turned to heroin. He lost his job, home, fiancée, family support and the rest of his savings. By June 2011, after several attempts at rehab, he was finally able to stay clean and now devotes his time to helping other heroin addicts.

In 2013, he and Robert Riley II, another former heroin addict, formed the Missouri Network (www.monetwork.org). Currently, the network places about 40 individuals into treatment each month in the greater St. Louis area. He also uses his considerable legal knowledge to write legislation and lobby legislators in Jefferson City to pass bills that help people with addiction. —

Coming Event

Valentine's Dinner

Friday, Feb. 10, Hilton St. Louis Frontenac

A SLMMS physician will be honored as "Doctor of the Year"

Voices of Excellence



Twelve students from Loyola Academy presented their winning speeches in the annual Voices of Excellence program. Prior to the Oct. 25 luncheon, Alliance members and friends worked with the youth to prepare their speeches. Pictured with the youth speakers are Alliance members Sandra Murdock and Angela Zylka, left, and Claire Applewhite and Dianne Joyce, right.

John B. Cadice, MD



John B. Cadice, MD, board certified in obstetrics and gynecology, died Oct. 4, 2016, at the age of 81.

Born in St. Louis, Dr. Cadice received his undergraduate and medical degrees from Saint Louis University. He completed his internship and residency at St. Louis City Hospital.

While maintaining a private practice, Dr. Cadice was on staff at SSM Health DePaul Hospital, SSM Health St. Mary's Hospital, Christian Hospital and Mercy Hospital St. Louis.

Dr. Cadice joined the St. Louis Metropolitan Medical Society in 1960 and became a Life Member in 2003.

SLMMS extends its condolences to his wife, Yota Cadice; and his children, Monique Cusumano, John Cadice Jr., Alexandra Landry and Chris Cadice; and his 11 grandchildren. —

Albert M. Huggins, MD



Albert M. Huggins, MD, a board certified internist, died Nov. 5, 2016, on his 92nd birthday.

Born in East St. Louis, Ill., Dr. Huggins received his undergraduate degree from Carleton College in Northfield, Minn., and his medical degree from the University of Illinois College of Medicine. He completed his internship and residency at Saint Louis City Hospital. Dr. Huggins served in the U.S. Navy.

He was in private practice and served on staff at SSM Health St. Mary's Hospital and Mercy Hospital St. Louis as well on the faculty of Saint Louis University School of Medicine.

Dr. Huggins joined the St. Louis Metropolitan Medical Society in 1951, and was made a Life Member in 1994.

He was preceded in death by his wife, Dorothy C. Huggins, and his daughter, Nancy. SLMMS extends its condolences to his children, Dan Huggins, Tom Huggins, Jim Huggins, John Huggins, Joe Huggins and Mary Temperelli; his 17 grandchildren and eight great-grandchildren. —

Joseph K. McKinney, MD



Joseph K. McKinney, MD, a psychiatrist, died Nov. 2, 2016, at the age of 84.

Born in Muskogee, Okla., Dr. McKinney earned his undergraduate degree from Westminster College in Fulton, Mo., and his medical degree

from Washington University School of Medicine. He completed his internship at Barnes Hospital, and his residency at Barnes Hospital and at the University of Oregon. Dr. McKinney served in the U.S. Navy from 1962 to 1964.

He was in private practice and also on staff at Barnes-Jewish Hospital, and was an associate professor of clinical psychiatry at Washington University School of Medicine.

Dr. McKinney joined the St. Louis Metropolitan Medical Society in 1964, and was made a Life Member in 2002.

SLMMS extends its condolences to his wife, Barbara McKinney. —

Thanks to Holiday Sharing Card Contributors

The following SLMMS and Alliance members and friends contributed to the 2016 Holiday Sharing Card with donations to the American Medical Association Foundation and the Missouri State Medical Foundation.



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Gill and Stephen Waltman, MD

Mrs. Angela Zylka



Advice on Issues You May Encounter in Your Practice



By Jessica Flora, PHR, Research and Solutions Analyst, AAIM Employers' Association

Q Is there a maximum number of days or hours an employee can work in a day or week?

➤ **Answer**

The Fair Labor Standards Act (FLSA) does not limit the number of hours per day or week that employees aged 16 years and older can be required to work. However, certain states have more stringent regulations in place. For example, Illinois has an act (One Day Rest in Seven Act) that requires employees a minimum of 24 hours of rest in each calendar week and a meal period of 20 minutes for every 7.5-hour shift beginning no later than five hours after the start of the shift. It is important to ensure your company is following federal as well as state regulations. ➤

Q Must I provide COBRA benefits during an employee's FMLA leave?

➤ **Answer**

No. The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the FMLA is not COBRA coverage, and taking FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work. ➤

Q How do I handle a non-exempt employee who is working more hours than they are reporting?

➤ **Answer**

You must immediately communicate to the employee they must report all hours they work. If they continue to not report hours, you can take the employee through your disciplinary process for not following your rules. Even though the employee probably has good intentions, a lawsuit, fines, or penalties may be charged to you as the employer for not paying all hours worked. Ensure your handbook communicates that all employees must accurately record their hours. ➤

Q How long must I keep resumes and applications on file?

➤ **Answer**

Under both state and federal law, you must keep resumes and applications on file for a minimum of one year. However, the OFCCP and other laws and regulations require certain employers to keep resumes and applications for a longer period of time. It is important to check with all of your state and contract requirements on specific recordkeeping regulations. ➤

Q How long must I keep Form I-9 on terminated employees?

➤ **Answer**

According to the U.S. Citizenship and Immigration Services (USCIS), "Employers must retain Forms I-9 for three years after the date of hire or one year after the date the individual's employment is terminated, whichever is later." ➤

Q How long do I have to allow an employee to breastfeed after having a baby?

➤ **Answer**

An employer must allow the employee to express breast milk as frequently as needed for the nursing mother, for up to one year following the birth of the employee's child. For more information, please see Fact Sheet #73: Break Time for Nursing Mothers under the FLSA from the Department of Labor. ➤



Jessica Flora

AAIM Employers' Association is an association of over 1,600 member organizations in the St. Louis region and throughout Illinois. AAIM provides tools for its members to foster organizational growth and develop the potential of individual employees. For more information about AAIM, call 314-968-3600 or visit www.aaim.org.

Alexander W. Aleem, MD

660 S. Euclid Ave., #8233, 63110-1010
MD, Washington Univ., 2010
Born 1983, Licensed 2016 ▶ **Active**
Orthopedic Surgery

Vincent L. Boston, MD

1 Barnes-Jewish Hospital Plz., 63110-1003
MD, Fiu Herbert Wertheim College of Medicine, 2016
Born 1983, Licensed 2016 ▶ **Resident/Fellow**
Emergency Medicine

Lawrence V. Boveri, MD

1011 Bowles Ave., #215, 63026-2387
MD, Univ. of Missouri-KC, 1988
Born 1964, Licensed 1991 ▶ **Active**
Cert: Obstetrics & Gynecology

Stephen A. Boveri, MD

1011 Bowles Ave., #215, 63026-2387
MD, Saint Louis Univ., 1993
Born 1963, Licensed 1997 ▶ **Active**
Cert: Obstetrics & Gynecology

Alison G. Cahill, MD

660 S. Euclid Ave., #8064, 63110-1010
MD, University of Connecticut, 2002
Born 1975, Licensed 2005 ▶ **Active**
Cert: Obstetrics & Gynecology

Patricia L. Cole, MD

450 N. New Ballas Rd., #270-W, 63141-6850
MD, Harvard Medical School, 1981
Born 1950, Licensed 1986 ▶ **Active**
Cert: Interventional Cardiology

Troy A. Dowers, MD

36 Four Seasons Shopping Ctr., #146, 63017-3103
MD, St. George's Univ., Grenada, 2005
Born 1976, Licensed 2012 ▶ **Active**
Cert: Family Practice

Sheila E. Drnec, DO

1203 Smizer Mill Rd., 63026-3483
DO, Des Moines School of Osteopathy & Surgery, 2011
Born 1973, Licensed 2016 ▶ **Active**
Obstetrics & Gynecology

Amy C. Eichholz, MD

1011 Bowles Ave., #215, 63026-2307
MD, Saint Louis Univ., 2000
Born 1974, Licensed 2009 ▶ **Active**
Cert: Obstetrics & Gynecology

Jackie L. Groszklos, MD

450 New Ballas Rd., #270-W, 63141-6850
MD, Univ. of Texas Med Sch., Houston, 1987
Born 1961, Licensed 1988 ▶ **Active**
Cert: Cardiovascular Disease

Anthony H. Guarino, MD

969 N. Mason Rd., #240, 63141-6338
MD, Univ. of Maryland, Baltimore, 1992
Born 1964, Licensed 1998 ▶ **Active**
Cert: Anesthesiology, Pain Management

Lucy Y. Hormberg, MD

18 S. Kingshighway Blvd., #15-L, 63108-1331
MD, Univ. of Missouri-Columbia, 2013
Born 1987, Licensed 2016 ▶ **Resident/Fellow**
Emergency Medicine

Susan M. Irvine, MD

1035 Bellevue Ave., #400, 63117-1844
MD, Saint Louis Univ., 1993
Born 1967, Licensed 1996 ▶ **Active**
Cert: Pediatrics

Carolyn M. Jachna, MD

3009 N. Ballas Rd., #227-A, 63131-2322
MD, Northwestern Univ., 1998
Born 1971, Licensed 2005 ▶ **Active**
Cert: Internal Medicine

Ahmed H. Jafri, MD

3660 Vista Ave., #303, 63110-2540
MD, King Edward Medical College, Pakistan, 1982
Born 1958, Licensed 1991 ▶ **Active**
Cert: Neurology

Rashmi Jain, MD

615 S. New Ballas Rd., 63141-8221
MD, Gauhati Medical College, Assm, India, 2005
Born 1980, License 2016 ▶ **Active**
Cert: Neuroradiology

W. David Kistler, MD

950 Francis Pl., #113-S, 63105-2465
MD, Washington Univ., 1966
Born 1940, Licensed 1970 ▶ **Active**
Cert: Internal Medicine

Alexander S. Krupnick, MD

660 S. Euclid Ave., #8234, 63110-1010
MD, Univ. of Michigan, 1996
Born 1969, Licensed 2004 ▶ **Active**
Cert: Surgery

Lindsay M. Lombardo, DO

3635 Vista Ave., #3rd Fl., 63110-2539
DO, A.T. Still Kirksville Coll. of Osteopathic Med., 2009
Born 1982, Licensed 2015 ▶ **Active**
Urology

Jonathan L. McJunkin, MD

660 S. Euclid Ave., #8115, 63110-1010
MD, Thomas Jefferson University, 2005
Born 1979, Licensed 2011 ▶ **Active**
Cert: Otolaryngology

Clark R. McKenzie, MD

450 N. New Ballas Rd., #270-W, 63141-6850
MD, Univ. of Missouri-KC, 1989
Born 1965, Licensed 1991 ▶ **Active**
Cert: Cardiovascular Disease, Internal Medicine

Christopher P. O'Boynick, MD

12639 Old Tesson Rd., #115, 63128-2786
MD, Univ. of Kansas, 2008
Born 1981, Licensed 2015 ▶ **Active**
Orthopedic Surgery

Yi Pan, MD

3660 Vista Ave., #303, 63110-2540
MD, Peking Univ. Health Science Center, 1982
Born 1955, Licensed 1997 ▶ **Active**
Cert: Neurology

Matthew R. Schill, MD

660 S. Euclid Ave., #8109, 63110-1010
MD, Washington Univ., 2013
Born 1986, Licensed 2015 ▶ **Resident/Fellow**
Surgery

Jeffrey E. Siegler, MD

660 S. Euclid Ave., #8072, 63110-1010
MD, Ross University School of Medicine, 2012
Born 1982, Licensed 2015 ▶ **Resident/Fellow**
Emergency Medicine

William F. Southworth, MD

450 N. New Ballas Rd., #270-W, 63141-6850
MD, Washington Univ., 1975
Born 1945, Licensed 1976 ▶ **Active**
Cert: Cardiovascular Disease

Daniel O. Young, MD

5601 Grinnell Ct., 63304-1083
MD, Creighton Univ., 2000
Born 1973, Licensed 2016 ▶ **Resident/Fellow**
Nephrology

Omar M. Young, MD

660 S. Euclid Ave., #8064, 63110-1010
MD, Columbia University, 2008
Born 1982, Licensed 2015 ▶ **Active**
Obstetrics & Gynecology

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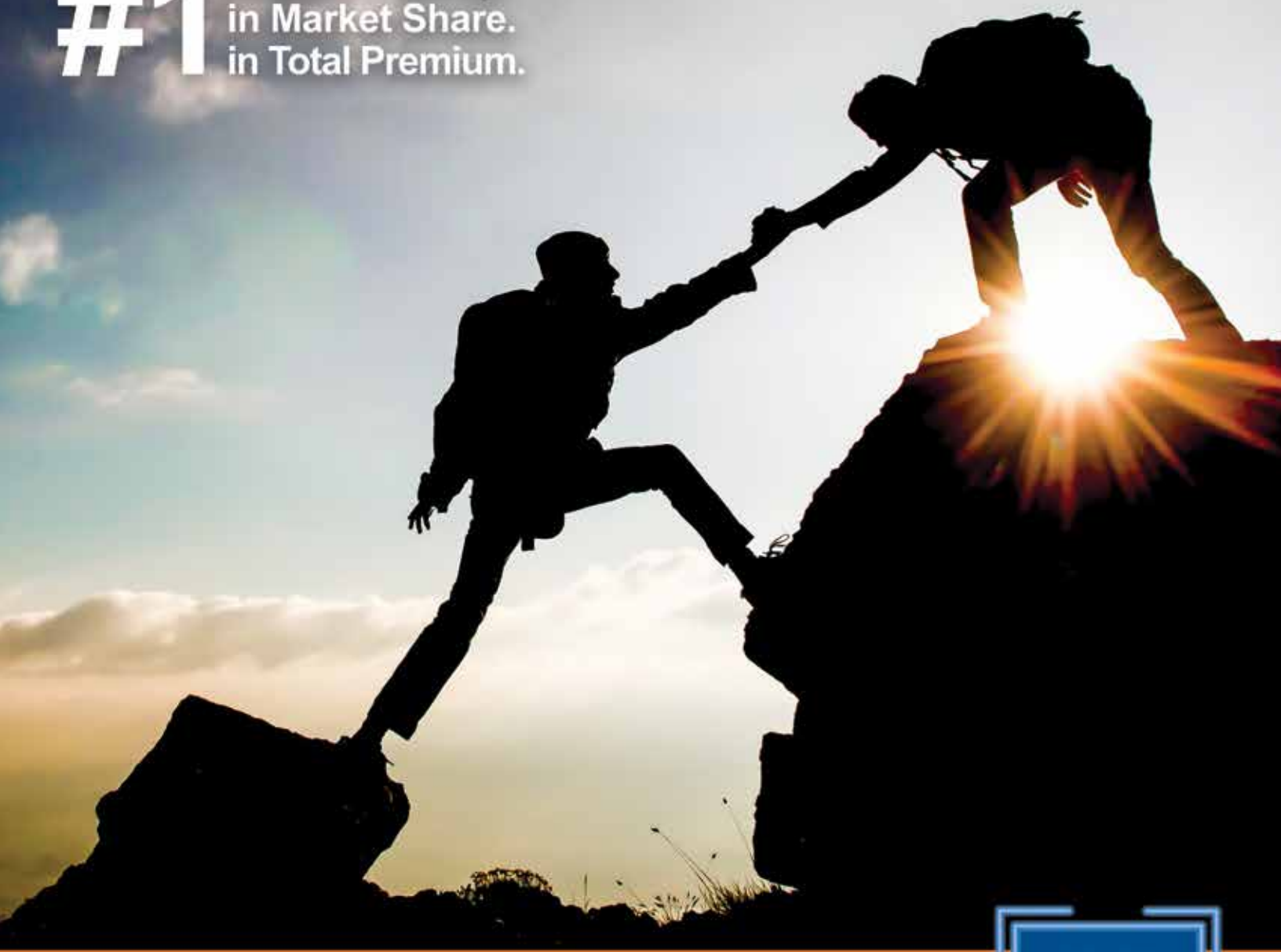
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