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Telemedicine Expands Reach

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MACRA, May I Practice Medicine? – Part I

By Richard J. Gimpelson, MD

MACRA is the new acronym the federal government will use to control the delivery of medical care in the United States.

MACRA is the Medicare Access and CHIP Reauthorization Act. MACRA is responsible for repealing the Sustainable Growth Rate (SGR). This sounds great, but the devil is in the details. The SGR is gone, but it has been replaced with two new and unknown plans. These new plans are the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM). In a nutshell, MIPS payments will rate physicians on four factors: clinical quality, resource use, health IT meaningful use and clinical practice improvement activities (CPIA). I suspect government bureaucrats will decide what makes up these four factors. I suspect they will figure some way to stick it to physicians. I doubt if clinicians will have much input into these four factors.

MACRA will allow practices to propose APMs to CMS.

The kicker is these practices must accept two-sided financial risk and use electronic health records and quality measures. Clinicians in Medicare-approved APMs will receive bonuses totaling five percent of Medicare pay to develop systems that have an ability to improve quality. Who will decide the success? Of course, the bureaucrats will!

There are other aspects of MACRA written into the over 900 pages of proposed regulations that are supposed to reward physicians who can achieve or surpass local and national benchmarks. Will the bureaucrats avoid messing up MACRA before it takes full effect in 2019?

Over the next several issues of *St. Louis Metropolitan Medicine*, I will attempt to give a full overview of MACRA; that is, if I can sift through all the 900-plus pages of regulations that CMS has proposed.

One final important message:

For those of you unfamiliar with the television program “Dr. Who,” the Macra were a gigantic crustacean race that fed on unclean gases which were poisonous to humans. The Macra resembled crabs. They would consume humans when possible. Eventually, the Macra fell into evolutionary decline, reverting to mindless creatures. In other words, they became congressmen and senators. More information on the Macra will be coming in the next issue. —



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 TWITTER

All that “twitters” isn’t “gold.”

I recently joined the 21st century by opening a Twitter account. My son and daughter-in-law and granddaughter thought I should to familiarize others with “Harry’s Homilies.” I was (and I am) hesitant to play in the mass media, because I have seen how unkind people can be online. But I opened @harryhomily and posted a few of the homilies. However, I kept my account very “closed” to avoid mass media noise. Now I get to see (hear?) “tweets” from major media exporters and some professional colleagues. As the homily says: All the information is not “gold,” but it is immediate and interesting. Got time to fritter? Try Twitter. —

Dr. Knopf is editor of Harry’s Homilies.® He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

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On the Cover: A nurse at Mercy's Virtual Care Center provides home monitoring with a Sullivan, Mo., patient suffering from COPD. The home monitoring program has helped the patient track and manage his symptoms and avoid emergency hospitalizations. This patient and the home monitoring program recently were featured on KSDK-TV.

The advertisements, articles, and "Letters" appearing in St. Louis Metropolitan Medicine, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. SLMM reserves the right to make the final decision on all content and advertisements.

SLMMS Seeks Nominees for Council and Committees

The St. Louis Metropolitan Medical Society serves as the collective voice for area physicians at the local, state and national levels. Strong leadership is necessary for SLMMS to continue to fulfill our mission to support and inspire member physicians to achieve quality medicine through advocacy, communication and education, and achieve our vision of physicians leading health care and building strong physician-patient relationships.

To sustain our impact, your Medical Society needs volunteer leaders willing to help move our organization forward.

The SLMMS Nominating Committee will meet later this summer to consider candidates for leadership roles beginning in 2017. We need physicians from all specialties and practice settings to serve. Available positions include SLMMS councilors, delegates to the Missouri State Medical Association annual meeting, and appointments to SLMMS committees.

To sustain our impact, your Medical Society needs volunteer leaders willing to help move our organization forward.



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

With physicians challenged and threatened from all directions, there's never been a more important time for organized medicine than the present. As more physicians become employed by hospitals and health systems, there are even more reasons to represent your interests. Yet securing volunteer leaders continues to be a challenge. While you and other physicians are busier than ever, please consider

the social and networking opportunities that also come with SLMMS leadership. **Organized medicine benefits you, your profession, your practice and your patients.**

To be considered as a potential nominee or a committee role, please contact Ravi Johar, MD, chair of the Nominating Committee, at rkjohar@att.net or David Nowak, executive vice president, at the SLMMS office at 314-989-1014, ext. 105 or email dnowak@slmms.org no later than July 1. If you wish to nominate another member for a leadership position, please check with them first to confirm their willingness to serve. All recommendations will be given thorough consideration.

Organized medicine benefits you, your profession, your practice and your patients.



SLMMS committees seeking 2017 appointees include: Continuing Medical Education, Membership, Peer Review, Physician Grievance, Political Advocacy and Publications.

The Nominating Committee will present its slate of officers and councilors at a General Society meeting on Tuesday, Sept. 13, at 7 p.m. at the Society office at 680 Craig Rd. All members are welcome to attend the meeting.

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

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

2016 MSMA INSURANCE CONFERENCE

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Visit www.msma.org to download the registration form. MSMA will extend to SLMMS members and their staffs the MSMA member conference fee of \$75 per person. The nonmember fee is \$150 per person. Reduced rates are available for multiple attendees from the same office. Contact Patrick Mills at 800-869-6762 for more information. ◀

Telemedicine: A Tool for 21st-Century Consumer-Driven Medicine

By Samer Cabbabe, MD, FACS, Medical Society President



Medical Society President
Samer Cabbabe, MD, FACS

Telemedicine laws vary nationwide but are being addressed. As of January 2016, 29 states including Missouri have parity legislation, providing similar reimbursement to an in-person visit.

Telemedicine is the inevitable consequence of 21st-century consumer-driven medicine and telecommunication and information technology. It has been proposed as a way to increase access to health care, decrease health care costs, generate revenue and shift toward value-based care.

Proponents argue that telemedicine is beneficial to patients with limited access to providers, either due to geographical reasons or physical limitations. They believe that there may be reduced transmission of infectious disease in these settings. Finally, chronically ill patients can be monitored closely by being allowed to upload data for provider review.

Opponents cite the increased cost of telecommunication and data management equipment and the prerequisite training required for technicians. There is concern for increased errors in this setting and the possibility of protected health information (HIPAA) compromise through electronic storage and transmission. Quality assurance risks are present due to technology restrictions such as poor images, records or reports. Furthermore, there is concern that the service may be over-utilized, resulting in higher costs to programs such as CMS. Finally, reimbursement issues may arise as well as liability concerns.

Growing Field

Telehealth is expected to be worth \$34 billion by 2020.¹ In 2015, Mercy opened the world's first Virtual Care Center, a \$54 million four-story, 120,000-square-foot facility. The building houses Mercy SafeWatch, TeleStroke, Virtual Hospitalist and Home Monitoring. SafeWatch, begun in 2006, is an electronic ICU that monitors vital signs in 30 ICUs across five states. TeleStroke allows patients

who come into the ER with signs of a stroke to be evaluated by a neurologist. Virtual Hospitalist provides services to hospitals around the clock. Finally, Home Monitoring allows for monitoring of chronically ill patients in their homes.²

Elsewhere, the Cleveland Clinic provides customers of a CVS MinuteClinic in Ohio with access to its experts for both online and mobile doctor visits. Patients can enter a MinuteClinic and receive a virtual consultation with a Cleveland Clinic Nurse Practitioner in as little as 5-10 minutes. They can receive a vaccine or other appropriate test or be referred to a physician at the Clinic. The whole visit can range in cost from \$80-\$190.¹

A 2010 *New England Journal of Medicine* article found that telemonitoring (telephone-based monitoring) of recently hospitalized heart failure patients by clinicians did not improve outcomes.³ A 2016 *JAMA Internal Medicine* article studied the variation in quality of urgent health care during commercial virtual visits. In the study, 67 standardized patients completed 599 commercial virtual visits for conditions including ankle pain, pharyngitis, lower back pain and female UTI. The study found a significant variation in quality among companies providing virtual visits for management of common acute illnesses.⁴

Laws and Regulations Governing Telemedicine

Telemedicine laws vary nationwide but are being addressed. As of January 2016, 29 states including Missouri have parity legislation, providing similar reimbursement to an in-person visit. Another eight states are considering parity legislation.⁵

In 2015, the AMA expressed its support for telemedicine to the U.S. House Committee on Energy and Commerce:

The AMA strongly supports the Committee's efforts to remove restrictions on Medicare coverage of telemedicine services that limit beneficiary access to telehealth services with a strong clinical evidence base. Specifically, the AMA supports removing Medicare geographic restrictions on coverage of telemedicine services; allowing dual eligibles to benefit from such services where Medicaid programs cover telemedicine; and removing all Medicare telemedicine restrictions in the context of alternative payment models. The AMA also recommends that the committee include a technical modification which would allow CMS to consider concurrently new CPT codes for adoption and coverage as a telehealth service. (The Agency currently has to include the CPT code on the relevant fee schedule and wait until the subsequent year to include it as a covered telehealth service.) The AMA opposes federal legislation that would preempt or waive licensure and medical practice laws for telemedicine encounters and strongly affirms that physicians must be licensed in the state where the patient receives services.⁶

Cigna has been covering care through telehealth provider MDLIVE for its self-insured employer customers since 2014. UnitedHealthcare followed suit by announcing coverage for virtual visits to its self-funded employer customers in 2015.



In Missouri, the Legislature sent to the Governor SB 579 which provides a definition of telehealth or telemedicine. This measure, supported by MSMA, allows for doctors to practice remotely via a computer or telephone connection, and for the transfer of still images, videos and other data from the originating site to the provider. This will also give patients access to specialists and advanced technologies without leaving their hometowns. Physicians, nurses and others may prescribe drugs or treatments within their scope of practice only if a previously established and ongoing valid physician-patient relationship exists. It also specifies telehealth activities to be covered under MO HealthNet including home telemonitoring.⁷

Insurance Coverage

Cigna has been covering care through telehealth provider MDLIVE for its self-insured employer customers since 2014. UnitedHealthcare followed suit by announcing coverage for virtual visits to its self-funded employer customers in 2015, and will expand the benefit to individual and employer plans this year. UnitedHealthcare is partnering with Doctor On Demand, Optum's NowClinic and American Well's Amwell to provide video-based virtual visits in 47 states and Washington, D.C. Aetna, Anthem and Humana are poised to offer comparable coverage.^{8,9}

Medicare covers telehealth only in rural areas at qualifying originating sites, but adoption among various government programs is set to expand in 2016. The Medicare Telehealth Parity Act of 2015 aims to improve parity nationwide and broadens the list of providers.⁹ However, escalating health-care costs from over-utilization of services has slowed progress for this bill.

The future implementation of telemedicine is in the lawmakers' hands. In order for telemedicine to be successful, there must be fair laws that provide parity and reasonable liability. Telemedicine should become another tool for physicians to treat patients conveniently and efficiently in the era of consumer-driven medicine. ➡

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Agents for Change

David M. Nowak



Executive Vice President
David M. Nowak

The practice of drafting, introducing and debating resolutions is a prime illustration of physicians leading change by influencing policy. I maintain that it is perhaps the most valuable benefit of organized medicine membership.

Physicians from across the state gathered in St. Louis March 18-20 for the Missouri State Medical Association (MSMA) annual convention. Speakers shared knowledge on topics such as Medicare payment changes, physician burnout and prescription drug pricing; and 2015-16 AMA President Steven Stack, MD, addressed the House of Delegates. When the convention is held in St. Louis, as it is every other year, it is convenient for SLMMS members to attend, resulting in more participation and greater networking among the delegates from our District 3.

The MSMA Reference Committees heard testimony concerning 14 different resolutions this year, and all were then debated by the House of Delegates. Two of these resolutions were brought forward by District 3 delegates and supported by SLMMS.

Private Ambulance Services, authored by Ravi Johar, MD, called for MSMA to support the continued requirement that all ambulance services be compelled to follow existing state law, which requires the ambulance service to take patients to their preferred hospital in non-life threatening situations when logistically feasible. After a slight wording change recommended by the Reference Committee, this resolution was adopted.

Nurse Practitioners, introduced by J. Collins Corder, MD, was revised by the Reference Committee to read “that MSMA advocate for the licensure of advanced practice registered nurses (APRNs) by the Missouri State Board of Registration for the Healing Arts,” acknowledging that APRNs play an important role in patient care and the health-care team, and that because of our common goals and close working relationship, we believe they should be regulated by the same licensing board as physicians and physician assistants. Following considerable debate, the resolution was referred to MSMA Council for further study.

Additional resolutions on topics such as improving access to medical care for rural Missourians, minimal age for tobacco and vapor product purchase, generic medication price control, medical marijuana usage, and humanities in the medical school curriculum were all adopted at the annual convention. Other resolutions on medical ethics, non-compete clauses and parental leave were referred to the MSMA Council or sub-committees for additional study. (To see the full list of 2016 resolutions, visit the MSMA website at www.msma.org or contact the SLMMS office).

The practice of drafting, introducing and debating resolutions is a prime illustration of physicians leading change by influencing policy. I maintain that it is perhaps the most valuable benefit of organized medicine membership. Many thanks to those who authored and sponsored resolutions, participated in the Reference Committees, or represented our district as a delegate. We will continue to keep all SLMMS members apprised of further developments on all 2016 resolutions.

The other major event at this year's convention was the inauguration of Ravi Johar, MD, 2006 SLMMS president and longtime District 3 councilor, as 2016-2017 MSMA president. Dr. Johar has been a leader in organized medicine and an advocate for positive change throughout his entire distinguished medical career. It was a pleasure to celebrate his inauguration with him and his wonderful family. (See story on page 8.)

Also at the convention, David Pohl, MD, was elected MSMA treasurer. Elie Azrak, MD, and George Hruza, MD, were elected to two-year terms on the MSMA Council, and Stephen Slocum, MD, was re-elected as District 3 vice councilor. Our delegation nominated Edmund Cabbabe, MD, to another term as

an AMA delegate from Missouri, and Nathaniel Murdock, MD, and Dr. Azrak were nominated to serve as alternate delegates to the AMA. Best wishes to all these physicians as they embrace these leadership roles and continue to work as “agents for change.”

As I write this column, the 2016 Physician Leadership Institute has just come to a close. I had the privilege of spending five Saturdays over the past three months with a group of 13 highly engaged and informed physicians (including five SLMMS members) seeking to improve their business acumen and develop their leadership skills (see page 9). As a Medical Society, we have so much to be proud of in the development of this program and in our members who have completed it. They are working to become the agents for change that will continue to move medicine forward.

I invite others to grab the torch and become a positive force in organized medicine. The SLMMS Nominating Committee will be meeting this summer to identify the slate of officers and councilors for leadership in 2017. Please refer to the article on page 3 to learn how you can become more involved in your Medical Society not only as a council member, but also by serving on a committee or as an MSMA delegate.

In closing, while it seems the 2016 election season has dragged on forever with all the presidential debates and candidate posturing, it's actually just getting started. With our upcoming Missouri primary in August and the general election in November, this is a prime opportunity to make your voice heard through the ballot box. This is the easiest way to influence change.

Vote. Volunteer. Lead. Become an agent for change. ➔

GET LATEST MACRA UPDATES FROM SLMMS WEBSITE, SOCIAL MEDIA

What are seven basic summary points about the proposed MACRA rules? How could MACRA hit small practices hard, including a chart from the proposed rules showing the costs by practice size?

Keep up with these and more current discussion on MACRA and its proposed rules open for public comment through June 27. Links to news articles from national medical publications are regularly posted on the SLMMS website (www.slmms.org), along with our Facebook page ([saint.louis.metropolitan.medical.society](https://www.facebook.com/saint.louis.metropolitan.medical.society)) and Twitter account (@STLMedSociety).

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St. Anthony's Amends Bylaws and Will Not Require MOC

St. Anthony's Medical Center will not require Maintenance of Certification (MOC) and recertification for continuation of hospital privileges for existing staff, according to a change recently adopted in the Medical Staff bylaws. Also, the bylaws clarify that MOC or recertification is not a requirement for holding medical staff office or department or section chief status. The bylaw changes were approved overwhelmingly by the hospital's medical staff via written ballot, and the St. Anthony's governing board has approved them as well.

Board certification is required for new appointments to staff, who may obtain recertification through the National Board of Physicians and Surgeons, an alternative certification program started by physicians in 2015. Recent trainees have a window of opportunity to complete board certification.

Robert McMahon, MD, SLMMS past president, gastroenterologist and current chairman of the St. Anthony's Bylaws Committee, said this sends a statement to the American Board of Medical Specialties and the American Board of Internal Medicine. Physicians nationally have objected to the cost and intensity of these groups' MOC requirements.

"The response to the ABMS forcing MOC and recertification should not be cerebral, compromised or delayed. The organized medical staff of hospitals should act decisively to control qualifications," Dr. McMahon said.

"The organized medical staff as a whole is responsible for the quality of the staff, and participates in peer review through

its structure," he added. "Local action by hospital staffs, as St. Anthony's has done, may be the best expression of organized physicians."

John Marino, MD, SLMMS member, a practicing internist and current member of the St. Anthony's Bylaws Committee, concurs. "Instead of letting third parties dictate how we practice medicine, we decided it was best to let our physicians do what we can to address this within our own medical staff," he said.

"Continuous MOC is not useful to gauge the quality of care provided by our physicians. Much more accurate is our vigorous peer review process, combined with the continuing medical education within our specialties," added Dr. Marino. "MOC is big business, has made its own market and receives payment from physicians so we can participate, albeit unwillingly, in that market. It's out of hand and self-perpetuating."

With St. Anthony's changes, the National Board of Physicians and Surgeons (NBPAS) is recognized in the bylaws as an organization providing certification. Under the terms of NBPAS, initial certification by ABIM/ABMS is required.

"If more hospitals act through their organized medical staff to stop MOC and recertification as currently structured," said Dr. McMahon, "the chokehold ABIM/ABMS exerts will be lessened, and a deliberate dialogue between organized medicine and the certifying boards will lead to meaningful change in the certification and recertification processes." —

Ravi Johar, MD, Installed as MSMA President

Ravi S. Johar, MD, SLMMS past president and current Nominations chair, was installed as president of the Missouri State Medical Association at the association's annual convention in St. Louis March 18-20.

Dr. Johar is a board certified obstetrician-gynecologist with Mercy Women's Health Care. He is a Fellow of the American College of Obstetricians and Gynecologists, and is the vice-chair elect for the Missouri Section of the American College of OB-GYN.

In his installation remarks, he reminded physicians to focus on what makes them want to practice medicine.

"We have the unique ability to heal," he said. "Think about the first time you got a call because someone wanted to know what you thought they should do to take care of themselves. The first time you delivered a baby. Or the first time you took out somebody's tumor. You took out something that could've killed them, and you saved them. First time you make a diagnosis that has perplexed people for ... forever. And they're better. ... You just did something special. You healed someone."



Dr. Johar was joined at the installation by members of his family, from left, daughter Katelyn, parents Jogindar and Manjit Johar, Dr. Johar, wife Kay, son Alex and daughter Megan. Also in attendance were his brothers, Jassi Johar, MD, of Colorado Springs, Colo., and Vinny Johar from New York, N.Y. (Photo copyright Missouri State Medical Association).

Among several areas of emphasis Dr. Johar noted for his year as president are hearing physician concerns about the Medicare and CHIP Reauthorization Act (MACRA) and working to stem the opioid abuse crisis. —

Thirteen Physicians Complete 2016 PLI Curriculum

Congratulations to 13 physicians from across Missouri who completed the second annual Physician Leadership Institute, a five-session educational program sponsored by Anders Health Care Services, Healthcare Management Alternatives, Inc., and SLMMS. This year's program met for five Saturdays between early February and late April, emphasizing the business aspects of medical practice and the development of leadership skills.

Physicians participated in interactive sessions focused on foundations of health care, finance and revenue, practice management, risk and compliance, and leadership. Five alumni from the inaugural program joined the class for the final session. A total of 38 Missouri physicians have completed the program over the first two years, and planning has begun for a third annual institute in 2017. —



Graduates (pictured left to right) included Drs. Lisa Thomas, Bridget Early, Munier El-Beck, Susan Meidl, Ernest Graypel, Pearl Serota (SLMMS), Roderick Bartlett, Toniya Singh (SLMMS), I.J. Singh (SLMMS), Ravi Johar (SLMMS), Brian Bergfeld, and Jeffry Evans. Not pictured is Dr. Michele Woodley (SLMMS).



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St. Louis-Area Telemedicine Expands With Local, National Scope

Connects specialists with rural patients; offers remote monitoring

By Jim Braibish, St. Louis Metropolitan Medicine

Telemedicine promises to play an increasingly important role in health care as it uses advanced technology to link patients with physicians and offer 24/7 monitoring. Locally, hospitals are expanding their use of telemedicine. St. Louis also is the home to two large telemedicine centers serving hospitals and patients nationwide.

What is Telemedicine/Telehealth?

Telemedicine—also called telehealth—is defined as “the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status,” according to the American Telemedicine Association (ATA). Telemedicine can be carried out in a variety of ways, including two-way video, email, smart phones, wireless tools and other forms of telecommunications technology. The ATA estimates there are some 200 telemedicine networks in the United States providing connectivity to over 3,000 sites; over 1.25 million online patient consults are projected this year.

The goal of telemedicine is to bring the best level of care to the patient. Hospital systems can connect the top specialists from an urban center with patients at hospitals in outlying areas. Remote monitoring of patients for chronic conditions helps to detect changes in condition before they become emergencies requiring hospitalization. Hospitals can make more efficient use of their staff resources by utilizing telemedicine centers to help staff ICUs. For primary care, patients can consult directly with a physician online via such companies such as American Well, Doctor on Demand or TelaDoc.

Currently, Missouri is one of 29 states that have parity laws requiring that telemedicine services be compensated at the same rate as in-person consultations. In addition, Missouri just passed legislation giving statutory authorization for the use of telehealth and clarifying its use within the MO HealthNet program. Medicare coverage of telemedicine remains limited. *For more information on the national scope of telemedicine, see the President’s Page by Samer Cabbabe, MD, FACS, on page 4, and “The Four Pillars” article on page 14.*

Local Hospital Use

Among the local hospital systems, Mercy has been a national

leader in telemedicine, launching into the field in 2006 with its Mercy SafeWatch teleICU program. Its new Virtual Care Center that opened in October in Chesterfield is the largest single-hub telemedicine center in the country, with capacity for nearly 300 physicians, nurses and other staff. The center serves patients of both Mercy and other health systems around the nation. This year, Mercy Virtual has signed partnership agreements with University of North Carolina Health Care and Penn State Health Partners. Both involve Mercy monitoring their ICU patients, along with plans for expanding telemedicine services to patients of both medical centers. *For more information on Mercy Virtual, see article on page 12.*

At SSM Health, telemedicine has been in use since 2007 and today brings specialized pediatric and maternal fetal medicine care to benefit patients at eight SSM Health and affiliated hospitals in Missouri and southern Illinois, including SSM Health Good Samaritan Hospital – Mt. Vernon. The pediatric telemedicine emergency department (TeleED) program at SSM Health Cardinal Glennon Children’s Hospital enables its pediatric emergency room physicians to provide real-time remote evaluation and consultation with patients and their families at other hospitals. With TeleNICU, the tiniest patients are able to receive expert consultative services by connecting rural hospital nurseries to the neonatology experts at SSM Health Cardinal Glennon.

Maternal fetal medicine telehealth services are delivered from SSM Health St. Mary’s Hospital – St. Louis. The program allows mothers-to-be who are experiencing high-risk pregnancies, to access the experts with SSM Health St. Mary’s and SLUCare.



Kathy Kuhlenbeck

“Health care systems are being asked today to take a greater part in managing the health of populations, keeping costs as low as possible, and providing greater access to care in both rural and urban settings,” said Kathy Kuhlenbeck, SSM Health system vice president of strategic business development in St. Louis. “By staying abreast of advances in medical technology, telemedicine at SSM Health has become an increasingly important component in meeting those needs.”

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Mercy Virtual: Health Care That Reaches a World Beyond

By Thomas H. Hale, MD, PhD

When the Sisters of Mercy were first established more than 180 years ago, they were not content to remain cloistered. They became known as the “walking sisters” and ventured into the streets of Dublin and nearby communities to serve where the need was most obvious.

In much the same way, Mercy Virtual today is using telehealth innovations to reach beyond the walls of its hospitals and physician offices. We are connecting patients and providers, regardless of the distance between them. This includes monitoring and caring for patients in both hospitals and in their homes.

The Mercy Virtual team is using a combination of people and technology to make health care continuous, convenient and complete and at the same time addressing the challenges facing an overburdened system.



Gavin Helton, MD, medical director of Mercy Virtual Ambulatory, discusses home monitoring patients with a member of his team.



Dr. Thomas H. Hale

Thomas H. Hale, MD, PhD is executive medical director of Mercy Virtual. Prior to being named to his current position with Mercy Virtual 2009, Dr. Hale maintained a patient practice for 23 years and was president of Mercy Medical Group (now known as Mercy Clinic) for 15 years. Dr. Hale served as the physician leader for Mercy's implementation of a fully integrated electronic health record system covering more than 30 hospitals and 700 ambulatory sites. In 2011, he earned a Master's in medical informatics from Northwestern University. He can be reached at 314-628-3561, thomas.hale@mercy.net.

Life-Saving Support for Hospitals

Mercy began its telehealth journey in 2006 with the creation of Mercy SafeWatch, a teleICU program. By watching over patients with an extra set of expert eyes—provided 24/7 by both clinicians and technology—Mercy is on pace to eliminate ICU complications, such as ventilator-associated pneumonia and central line blood stream infections, and reduce ICU length of stay and mortality rates by up to 40 percent compared to national averages.

Today, we operate the world's largest single-hub electronic intensive care unit serving both Mercy patients and those of other health care organizations. From Mercy's Virtual Care Center in Chesterfield, experienced critical care physicians and nurses monitor more than 470 ICU beds in five states.

This same teleICU monitoring technology, coupled with a sophisticated early warning system, is helping identify, triage and manage hospital patients most susceptible to sepsis. In doing so, we have been able to reduce the mortality rate for severe sepsis by 68% and for those who have progressed to septic shock by 44%.

For stroke victims, Mercy's telestroke program uses two-way video to connect stroke patients with a neurologist the moment they arrive at one of our emergency departments. Currently, we provide 24/7 telestroke care at 33 hospitals both small and large.

Once a telestroke connection is initiated, the neurologist can talk with the patient and see scans to determine if the patient should receive the clot-busting drug tPA. As result of the program, Mercy is able to administer tPA to three times more patients than the national average.

Keeping Patients Healthy and at Home

Mercy is currently piloting a program through our hospital in Washington, Mo., targeting the sickest chronically ill patients. It is estimated that the sickest five percent of the population accounts for nearly 50 percent of the health care spend, often through recurring emergency room visits and preventable hospital readmissions.

Patients in this program are sent home with an iPad and wirelessly connected biometric devices to monitor blood pressure, weight, blood sugar and other vital signs. This allows the Mercy Virtual team to continuously monitor patients with COPD, heart failure and diabetes, for example, and quickly respond before symptoms escalate.



The Mercy Virtual team is using a combination of people and technology to make health care continuous, convenient and complete and at the same time addressing the challenges facing an overburdened system.

(left) A nurse in the Mercy SafeWatch teleICU program monitors patients.

(right) Matthew Boland, MD, Mercy SafeWatch critical care physician, keeping an extra set of eyes on ICU patients.



Using the iPad, Mercy Virtual team members can have secure video conversations with patients, similar to using FaceTime or Skype. Patients also use the iPad and triage software to respond to questions about their health and symptoms.

The results are very encouraging, helping people remain at home, improve the quality of care and reduce readmissions—all while reducing costs. One example is a heart failure patient who lives in a rural area more than 100 miles from the Mercy hospital in Washington. Over the span of several months, he had to be transported numerous times to the hospital by helicopter when his symptoms flared out of control. Now, using these home monitoring tools, he has not been back to the hospital for more than five months.

Helping More Than Patients

While there are obvious benefits for patients, a telehealth model also offers significant benefits for providers. Our home monitoring programs give primary care physicians and specialists peace of mind knowing that their patients are being carefully monitored and cared for once they leave the hospital or office—care that is documented and easily at hand when they next see the patient.

Telehealth is also one answer to the growing shortage of physicians, particularly in rural areas where it can be challenging to recruit an experienced specialist. Through telehealth, Mercy provides specialty care where it is currently unavailable and provides needed support to the limited number of specialists serving smaller communities. This allows local providers to maintain balance in their lives, increasing both satisfaction and retention.

But good health care is still about people serving people. Telehealth is not a replacement for the relationship patients have with their physicians or their care teams. Telehealth

is a tool that supports the effectiveness of the caregiver and extends the accessibility of the physician so patients can receive the right care at the right time in the right place. This usually means patients remain in their communities with their families.

Mercy Virtual Care Center and Beyond

Mercy has cemented its commitment to telehealth by building the world's first Virtual Care Center in west St. Louis County. This four-story, 120,000-square-foot center accommodates nearly 300 physicians, nurses, specialists, researchers and support staff. Care is delivered 24/7 via audio, video and data connections to locations across Mercy, as well as outside the Mercy system through partnerships with large employers and other health care providers.

In addition to enabling care to more than three million patients over the next five years, the Mercy Virtual Care Center serves as a hub for advancing telehealth through research and training.

As we rapidly move to accountable care and contracted care models, telehealth will be a key component to help meet the “triple aim” of improving the patient experience, improving the overall health of our population and reducing the per capita cost of health care. We have learned that our caregivers and technology teams can work together to identify care needs earlier, allowing us to deliver simpler, less costly and higher impact care.

With a clear focus on getting health care right, Mercy is exploring partnerships with other health systems to bring the promise and potential of telehealth into their systems. In doing so, we envision a national, interdependent network of virtual care centers—organizations that will significantly improve access to high value care and be a bridge for the transformation of our national health system. ◀

Telemedicine Services Through the Four Pillars of Health Care Value

Reimbursement, regulatory, competitive and technology trends reviewed

By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA and Todd A. Zigrang, MBA, MHA, FACHE, ASA

As health-care reimbursement shifts from volume to value-based care, partially as a result of the Patient Protection and Affordable Care Act (ACA),¹ health-care practitioners are increasingly utilizing telemedicine to improve the value of care provided to patients. Although utilization of this technology has been low historically, practitioners' use of telemedicine services has grown considerably in recent years as the technology has become more readily available and affordable to providers.² Regulatory bodies, such as the Centers for Medicare and Medicaid Services (CMS), are progressively recognizing the utility of telemedicine services due to the cost savings realized.³ These savings may motivate other providers to begin using these services, especially if the goal of patient-centered, quality-based care can be simultaneously achieved. Despite these trends, widespread adoption and utilization of telemedicine services has yet to occur, most notably due to limited reimbursement and regulatory hurdles.⁴

Examining the telemedicine industry through the Four Pillars of health-care valuation⁵—*reimbursement, regulatory, competition and technology*—can provide insight into the future utilization of telemedicine services.

Reimbursement Environment

The complexity of the current telemedicine financial landscape



Robert James Cimasi

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Todd A. Zigrang

Todd A. Zigrang, MBA, MHA, FACHE, ASA, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices and other health-care enterprises. Their website is <https://www.healthcapital.com>.

is complicated by reimbursement structures that vary widely among the states.⁶ In the context of commercial payors, 32 states and the District of Columbia have passed some form of parity law requiring commercial insurers to cover telemedicine services if the same service would be eligible for reimbursement when provided in person.⁷ Notwithstanding these state laws, and that commercial insurance companies currently reimburse providers for a wide variety of telemedicine services, there is still no widely accepted standard for reimbursement of telemedicine services from private payors.⁸

Public payor reimbursement may significantly influence the future reimbursement environment for telemedicine services. Currently, 47 states, including Missouri, mandate that their Medicaid programs provide reimbursement to providers for health-care services furnished via live video, compared to 44 states in 2014.⁹ Additionally, CMS continues to expand the list of reimbursable telemedicine services each year; from 2015 to 2016, CMS increased the number of reimbursable telemedicine services from 75 to 81.¹⁰ The growth of Medicaid reimbursement for telemedicine services is correlated with the increased utilization of Medicare telemedicine benefits. A January 2016 study published in *Telemedicine and e-Health* noted that, in Illinois during the year 2012, Medicaid utilization grew by 173%, after the state expanded Medicaid coverage in 2011, and, in Michigan, Medicare utilization grew by 78% in 2013 after the state's commercial payor telemedicine parity law went into effect in 2012. In contrast, states surrounding Illinois and Michigan, which passed no significant telemedicine policy, demonstrated varied annual Medicare telemedicine utilization growth, with no discernible pattern.¹¹

Regulatory Environment

The regulatory environment for telemedicine services is fairly restrictive, particularly in regard to the licensure of physicians and other allied health professionals. Currently, only nine states extend some form of conditional or telemedicine licensure to out-of-state providers,¹² down 10% since July 2014.¹³ This legislative trend mirrors the position of the Federation of State Medical Boards (FSMB), which, in 2014, issued a policy requiring physicians utilizing telemedicine services to be licensed in the same state in which the patient resides.¹⁴ This

policy may restrict the pool of telemedicine supplies available to a patient to only those providers located in the same state as them.¹⁵

Recent legislative efforts may erode rigid medical licensure requirements in the future. For example, the Interstate Medical Licensure Compact, enacted in 12 states, creates a pathway to expedite the licensing of qualified physicians who wish to practice in multiple states.¹⁶ In an attempt to allow Medicare beneficiaries to receive telemedicine services across states, Congress introduced the Tele-Med Act of 2015.¹⁷ Although the Tele-Med Act remains in committee, the bill demonstrates legislative interest in creating greater access to telemedicine services. This legislative interest is also present on the state level; in 2015, more than 200 telemedicine bills were introduced in state legislatures to allow for greater access to telemedicine services.¹⁸ While a large interest in improved access to telemedicine services exists (as evidenced by the introduction of laws on both the state and national level), the future impact of the regulatory environment on the rise of telemedicine remains uncertain, due to regulatory barriers, e.g., state licensing requirements.

Competitive Environment

Telemedicine services allow consumers the ability to access health care at distant locations, which may increase the number of competing health-care suppliers in a given area. However,

increased access to health-care services through telemedicine platforms may also ameliorate the shortage of physicians in medically underserved areas.¹⁹ Providers in rural areas utilize telemedicine services to treat patients in underserved areas, in part, through partnerships with urban and suburban providers.² Such partnerships may increase the supply of providers in underserved areas to levels sufficient for adequate access to care for patients living in these areas. In addition to concerns about the supply of providers, demand for telemedicine services may affect the overall prevalence of telemedicine services. In particular, the elderly population is driving the demand for telemedicine services. A study published in the *American Journal of Public Health* noted that 20% of the survey's elderly respondents indicated that transportation difficulty was an impediment to their ability to access health care.²⁰ Telemedicine services, such as remote monitoring, may help to alleviate such concerns. Additionally, as the "baby boomer" generation ages, the prevalence of chronic conditions, such as hypertension, diabetes and obesity, may rise, potentially leading to increased utilization for telemedicine services related to chronic disease management.²¹

Technological Environment

The technological environment for telemedicine services is a significant variable in future utilization trends related to telemedicine services. Evidence suggests that telemedicine

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St. Louis-Area Telemedicine ➤ *continued from page 10*

Patients have warmed to the technology, Kuhlenbeck said. “One of our rural hospitals has even named its telemedicine equipment ‘Super Man,’ and clothes it with a cape to enhance the ‘coolness’ of the technology for pediatric patients. Patients and their parents soon forget that the physicians with whom they’re interacting are located a long distance away.”

Missouri Telehealth Network

A statewide pioneer is the Missouri Telehealth Network. Started in 1994 as one of the nation’s first public-private telehealth partnerships, Missouri Telehealth Network connects physicians from the University of Missouri School of Medicine with patients in rural areas. Missouri Telehealth Network provides care in more than 40 different specialties and subspecialties to approximately 200 telehealth sites in 62 Missouri counties. Partners include federally qualified health care centers, community mental health facilities, rural health clinics, hospitals, health systems and nursing homes.



Rachel Mutrux

“The benefits of telehealth include increased access and reduced transportation costs for patients and providers,” said Rachel Mutrux, Missouri Telehealth director. “Without the use of telehealth, community mental health centers would have a difficult time connecting providers to patients. Telehealth also helps local economic development by allowing auxiliary health services—such as pharmacy, labs and X-rays—to stay local.”

Examining Telemedicine ➤ *continued from page 15*

technology can be more cost effective than traditional medicine, by allowing physicians to monitor their patients without patients leaving their home, or physicians leaving their office.²² Further, for diagnostic care and preventative medicine, telemedicine services often cost less than in-person care, while maintaining similar levels of clinical effectiveness.²³ As the technology continues to develop, the cost savings associated with providing telemedicine services may become even more important in the shift from volume-based to value-based reimbursement models, which emphasize cost-effective care, particularly in light of a growing, aging and more diverse population. However, many providers have expressed reservations regarding the technological benefits of telemedicine services. Reported barriers to the use of telemedicine by users and non-users of telemedicine services include, among others: 1) a lack of training; and, 2) the high cost of equipment to provide many telemedicine services.² Notably, *non-users* generally consider each of these barriers to be a much larger problem than users do.²

Private Telemedicine Center

A private company in St. Louis also provides telemedicine services on a contract basis with hospitals across the country. Advanced ICU, founded in 2005, now serves over 65 hospitals with ICU monitoring. Its staff of over 140 clinicians works from centers in St. Louis and seven other locations around the country.



Andrea Clegg

Andrea Clegg, CFO of Advanced ICU, said, “Telehealth is a solution to many of the issues facing health care, including increased demand, decreasing supply of specialists and the move to value-based payment. It enables the delivery of clinical expertise where it is needed, offering the best clinical experts to any location. For hospitals, it enables clinical staffing efficiencies, particularly in the ICU.”

Telemedicine Resources

- American Telemedicine Association
www.americantelemed.org
- Missouri Telehealth Network
medicine.missouri.edu/telehealth
- Mercy Virtual
www.mercyvirtual.net
- Advanced ICU
www.advancedicucare.com

Conclusion

The global utilization of telemedicine services is expected to increase 14.3% per year through 2020, reaching a value of \$36.2 billion.²⁴ The framework of the *Four Pillars*—*reimbursement, regulatory, competition* and *technology*—can help providers, investors and policymakers examine the continued evolution of this pivotal industry and its impact on the future of health-care delivery. As technology improves and consumer demand for accessible care grows, providers may be driven to increasingly utilize telemedicine services. However, utilization growth for telemedicine services may be limited by: 1) increased scrutiny in the regulatory environment, particularly through state licensure regulations; and, 2) uncertainty in the reimbursement environment, in which providers face haphazard reimbursement schemes among the states, as well as, among both public and private payors. ◀

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Telemedicine – The Future Is Now

By Becky York, MBA, President-Elect, MGMA of Greater St. Louis



You may have heard health-care experts say, “Telemedicine is the future of health care.” However, telemedicine is not the future—it is the now. Technology has become a huge component of every aspect of our lives. Smartphones and tablets are used for just about everything, from monitoring your bank account to ordering your take-out, so it would only make sense that health care become part of this technological advancement. In fact, technology has been actively changing the way consumers receive health care for years. Many of the large hospitals and other health-care systems recognize the cost and care advantages of remote patient monitoring, virtual doctor visits, disease management, and providing the latest mobile apps available for chronic disease management. Adopting the latest innovations in telemedicine in your practice can provide numerous benefits including: helping to lower health-care costs, improve practice efficiency, thus increasing revenue, providing better access to services for your patients, and overall achieving healthier patients.

Telemedicine reduces unnecessary non-urgent visits and eliminates transportation expenses for regular checkups. Remote analysis and monitoring services and electronic data storage significantly reduce health-care service costs, saving money for you, your patients and insurance companies. In



Becky York

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addition to these general cost savings, telehealth can help boost doctors’ revenue by turning on-call hours into billable time, attracting new patients, reducing no-shows, and even reducing overhead for physicians who decide to switch to a flexible work-from-home model for part of the week.

Increased patient engagement can also help facilitate patients to take a more proactive role in their health care. Increased patient engagement through telemedicine can help them maintain appointments, be compliant with their physician’s recommended health plan and overall encourage their patients’ healthy lifestyle choices. Additionally, virtual visits reassure patients that their doctors are available and involved in their care, making it much easier for them to reach out with questions, report early warning signs and schedule follow-up appointments.

While telemedicine does sound exciting, it’s not without its obstacles. It still poses both technical and practical problems for health-care providers. Restructuring staff responsibilities and purchasing equipment takes time and costs money. Training is crucial to building an effective telemedicine program. Physicians, managers and other medical practice staff need to be trained on the new systems to ensure a solid return on investment.

Furthermore, easier access to physicians may lead to patient overuse, a problem that could overwhelm the already inundated health-care system. Lastly, many patients and physicians alike still prefer a “personal touch” and thus, may prefer the old-fashioned face-to-face check-ups.

Regardless of these hurdles, it’s clear that telemedicine is here to stay and bound to only become more popular. It’s just the natural evolution of health. ➔

Examining Telemedicine ➔ continued from page 16

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Understanding the Process for Medical Claims Review

How does an insurer like Anthem make decisions about what to cover and what not to cover?

By Jay Moore, MD, Anthem Blue Cross and Blue Shield

As the senior clinical officer for a major commercial health insurance company in Missouri, I get many questions about the process for medical procedure reviews and appeals. How does a company like Anthem make decisions about what to cover and what not to cover? How can a physician on the phone who has never met your patient justify a decision to deny coverage for what you believe to be necessary medical care? And above all, how does a treating physician navigate the complicated world of health insurance decisions, denials and appeals?

Employers Seek Care at Appropriate Cost

First, it's necessary to understand some of the reasons for this process. In 2014, the Kaiser Family Foundation reported that roughly half of all Americans receive health insurance coverage through an employer.¹ Employer-based group coverage accounted for 49% of coverage, with Medicare and Medicaid coming in at 32% combined, and non-group coverage accounting for 6% of coverage. This means that employers are, by far, the largest purchaser of health care in terms of number of lives covered. At the same time, an Institute of Medicine report in 2012 revealed that 30% of all medical spending was wasteful.² With 17.5% of Gross Domestic Product now going to fund health care,³ employers have asked insurers to work with them to help employees access care at an appropriate cost, and that waste is minimized.

Anthem, Inc. owns health insurance companies, including Anthem Blue Cross and Blue Shield in Missouri, that provide coverage to more than 20 million Americans. In 14 states, an Anthem company is the Blue Cross and/or Blue Shield (BCBS) licensed insurer, but Anthem members also have access to non-Anthem Blue Cross and Blue Shield providers across the country. When an Anthem Missouri member travels outside of our service area, that member has access to physicians who

are contracted through the local BCBS insurer. Claims are priced by the local plan and sent to Anthem in Missouri whose benefits and medical policies govern coverage. When a member who is insured by another BCBS plan is cared for in Missouri, the process is reversed. Anthem in Missouri's contracts govern rates of payment to providers, but the home plan's benefits and medical policies dictate rules of coverage. Therefore, the information I am sharing with you applies only to individuals who have insurance through Anthem in Missouri or another plan owned by Anthem, Inc., not to all BCBS members.

Developing Medical Policies and Clinical Guidelines

New products and technologies frequently become available, and physicians naturally wish to provide those services to members. Our Medical Policy process starts with an analysis of data to determine current or projected future trends in utilization for new services or technologies. If a new service or technology is on the horizon, or utilization trends up, our physician leaders study available evidence to determine if there are particular patients for whom the service or technology would be appropriate. In many cases, this is the first step toward creation of a Medical Policy.

Our Medical Policies and Clinical Guidelines are reviewed by a board of physicians. Approximately half of these physicians are Anthem employees, and the other half are not employed by any insurance company, but are considered experts in their various fields. The committee is supported by a staff of physicians and researchers who review the available evidence as is available for the service being studied. Four times per year, the committee meets to review the evidence pertaining to policies under consideration. At the same time, new evidence related to policies already in effect is presented as well. Each policy or guideline is examined on a regular basis—at least once every year, if not more often.

For each service or technology being considered, the evidence comes from a variety of sources. Primary literature is of course consulted, along with position statements and guidance from specialty societies and other authoritative organizations. No one source is definitive, as sources frequently disagree. The committee examines the evidence without regard to cost impact. In the end, the policy is meant to reflect and determine evidence-based rules for coverage.



Dr. Jay Moore

Jay Moore, MD, is the senior clinical officer for Anthem Blue Cross and Blue Shield in Missouri. Jay has been with Anthem since 2014. He is a board-certified internal medicine physician, and trained at the University of Missouri.

He can be reached at 314-923-4083 or jay.moore@anthem.com.

Reviewing Claims

Once a policy is in place, cases related to the governed service will be reviewed against policy. When a new claim comes in that involves a medical policy, a “claim edit” stops the claim from automatically being paid. Generally, a review is conducted by a nurse familiar with the service. Many claims are certified at that point, as the nurse is able to generate an approval. If the nurse feels the requested service does not meet guidelines, he or she forwards it to a physician reviewer.

Our physician reviewers are based locally in Missouri. These reviewers come from a variety of medical disciplines, but all are trained in each of the policies and guidelines. The reviewer has access to any medical records or other supporting documentation that goes along with the requested service. If the service does not meet guidelines, the physician denies the request. Only a physician may deny a requested service.

If a denial is generated, a letter is issued to the member and to the ordering physician. Federal and state laws require that our denials must be written at no greater than a sixth grade level. This means that some of the denials are written using language that differs from what physicians are used to seeing on clinical matters. When a denial is issued, a provider may request a peer-to-peer discussion and speak with a physician reviewer. This conversation can help explain why the service was not covered, and what could be done to mitigate any problem. In many cases, the required information was not initially available to the physician reviewer, and a quick conversation with an ordering physician can clear up any confusion.

Levels of Appeal

In some cases, a peer-to-peer request does not result in an approval, or is never requested. Members and physicians have appeal rights, meaning they can ask for the service to be reviewed again. On appeal, the review is sent out to a specialty-matched reviewer. At this point, an orthopedic

surgeon would review an orthopedic case; an oncologist would review a chemotherapy case; and so on. The appeal reviewer is still bound by Anthem’s Medical Policy or Clinical Guideline.

If a denial is still issued, members may request a second appeal (providers must appeal on behalf of the member). The second appeal is examined by a committee made of Anthem employees, external parties and physicians.

If the denial is upheld by committee, there is still a final level of review. Any denial from a second level appeal is automatically sent out to two external physician reviewers that do not work for Anthem. These two reviewers are asked for an independent review—a review based on their own judgment, not based on Anthem Medical Policy. In all cases if both reviewers overturn the denial and in most cases even if only one overturns the denial, the denial is reversed and the service is covered.

This process means that if a member exhausts all appeals rights, the case may have been examined by one nurse, one specialty-matched physician, a committee (which includes a physician), and two specialty-matched external physicians. Working through all of these appeals takes time and is costly. However, all of these steps can help promote members getting appropriate care, not care which is wasteful or not evidence-based.

Our process is fair, evidence-based and rigorous. Members and employers save millions of dollars annually and enhance quality of care provided by avoiding care which is not evidence-based or is unnecessary for a given member. —

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READ ANTHEM MEDICAL POLICIES AND CLINICAL GUIDELINES ONLINE

— Go to www.slmms.org for the link, or search “Anthem Medical Policies” in your search engine

WU Physicians Recommend Prescribing Fewer Opioids After Surgery

Two Washington University School of Medicine physicians recommend that surgeons consider cutting back on the number of take-home opioid pills prescribed to patients after surgery. In a commentary published in the April issue of the journal *Anesthesiology*, anesthesiologist Evan D. Kharasch, MD, PhD, and surgeon L. Michael Brunt, MD, suggest new approaches for administering and prescribing pain medications to surgery

patients. Their recommendations coincide with newly released guidelines from the Centers for Disease Control and Prevention. Besides prescribing fewer pain pills, the authors also suggest encouraging pharmacies to take back unused opioids, and re-evaluate how pain-killing drugs are used not just after surgery but during operations. See the SLMMS website and Facebook page for links. —

Advancing Quality Care

Midwest Health Initiative program helps clinicians and patients access new reporting tools

By Louise Probst, St. Louis Area Business Health Coalition

St. Louisans will soon have the ability to see how often patients across the region are receiving care in line with national best practices. This October, the Midwest Health Initiative (MHI) will launch ChooseWell, a public website showing comparative quality information by practice location.

MHI is St. Louis' regional health improvement collaborative. It brings together physicians, employers, hospital leaders, unions, health plan leaders and patient representatives to work collaboratively to improve the health of our region and the quality and affordability of its health care. To help inform the community, MHI aggregates commercial claims information across the region's major health plans. MHI is also a Medicare Qualified Entity and will soon integrate Medicare data into its data set.

"Midwest Health Initiative houses a robust and growing community data asset that informs MHI's work," said Jan Vest, CEO of Signature Medical Group and board member of Midwest Health Initiative. "This opportunity for collaboration is invaluable to our community as we work together to advance improvements in care delivery and outcomes."

After two years of sharing data with licensees including health care provider organizations and the St. Louis Area Business Health Coalition, MHI through ChooseWell will provide limited quality information to the public and to primary care clinicians at no charge. ChooseWell draws from data representing over 1.4 million unique lives offering results from merged payers' claims data with local and national benchmarks.

There also is a companion site for health-care providers. Starting in July, CareWell will allow clinicians private access to results on how often patients under their care received care consistent with nationally standardized quality measures. This unique access will allow clinicians to understand and trend results while identifying and evaluating opportunities for quality improvement.

Physicians and health systems interested in more detailed information about patient populations, practice patterns and resource use already have the opportunity to purchase customized reports from MHI based on their individual needs. MHI's councils and board are dedicated to providing tools for better decision-making and better outcomes. They believe it's imperative to provide detailed information to clinicians first through CareWell prior to sharing information with consumers via ChooseWell in October.

"The Midwest Health Initiative's data asset is powerful," says Bryan Burns, DO, SLMMS member, internal medicine physician at St. Anthony's Primary Care Consultants. "Physicians are searching for new ways to understand the quality and cost of health care. Important insights can be concluded because it integrates data from across the patient care process."

In addition to showing measures of care quality in the primary care office, ChooseWell will provide information on key hospital performance measures such as health care-associated infection rates and patient satisfaction scores. This data initially will be supplied by the Centers for Medicare and Medicaid Services and The Leapfrog Group, a Washington, D.C.-based nonprofit watchdog organization.

It is important to clearly define health care quality in a simple manner for consumers. By explaining quality measures and sharing steps patients should take to achieve their best health, ChooseWell will empower patients while supporting evidenced-based treatment recommendations.

More information about these programs and the Midwest Health Initiative is available at www.midwesthealthinitiative.com.

If you have questions about MHI's work, contact Louise Probst, executive director at lprobst@stlbhc.org or 314-721-7800. If you are interested in learning how to access CareWell, the web portal for clinicians, contact Sarah Kennedy at skennedy@midwesthealthinitiative.org or by phone at 314-721-8715. ➡



Louise Probst

Louise Probst is executive director of the St. Louis Area Business Health Coalition. She can be reached at 314-721-7800 or lprobst@stlbhc.org.



MIDWEST HEALTH INITIATIVE

Improving Health Care Through Shared Knowledge and Understanding

Mission: To provide a forum where trusted information and shared responsibility are used to improve health and the quality and affordability of health care.

Vision: A community that consistently leads the nation in health, care quality and affordability.

Our Values:

1. Our community's interest comes first.
2. Progress cannot be achieved without active engagement and collaboration.
3. Transparency is the foundation of accountability.
4. Learning from others is the basis of all advancement.
5. Resources are limited. Midwest Health Initiative strives to avoid waste and duplication of work.

Midwest Health Initiative is a certified Medicare Qualified Entity (QE) and is preparing to add Medicare claims to its dataset.

MHI's Three Web-based Information Tools

CareWell Allows Clinicians:

- Secure and personalized access to aggregated claims across multiple insurers.
- Insight into how often patients received care consistent with evidence-based measures as documented by claims information.
- Information on 28 quality measures at the practice and individual primary physician level.

ChooseWell Allows Consumers:

- Access to hospital quality information from Hospital Compare.
- Aggregate information on physician quality measures by practice site.
- Educational information on quality measures for patients.

LiveWellSTL serves as a public resource for:

- Information on healthy education activities and events across the region.



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SLMMS, MSMA Alliances Honored at State Meeting

By Gill Waltman, SLMMS Alliance

Alliance members from around the state gathered March 18-20 for the MSMA Alliance annual meeting in St. Louis, hosted by the SLMMS Alliance and held concurrent with the MSMA convention.

MSMA Alliance President Sue Ann Greco presided over the general assembly sessions and the awards luncheon. Speakers included AMA Alliance President Julie Newman, and Southern Medical Association Alliance President Barbara Blanton. Also addressing the Alliance were AMA President Steve Stack, MD, from Lexington, Ky.; AMA Board of Trustees member David Barbe, MD, from Mountain Grove, Mo.; and MSMA 2015-2016 President John Stanley, MD, from Kansas City. Informational speakers were SLMMS Alliance member Carrie Hruza, OD, on eye health, and nationally known consultant Carol Weisman on board and membership development.



2016-2017 MSMA Alliance officers, from left: Barbara Hover (installing officer), Marsha Conant (president-elect), Diana Corzine (Health), Gail Holand (Legislation), Carol Jean DeFeo (Foundations), Donna Corrado (Membership), Gill Waltman (Recording Secretary). Not shown: Jana Wolfe (President) and Debora Snyder (Treasurer.)

The slate of 2016-2017 officers was installed, led by President Jana Wolfe from Greene County. SLMMS Alliance members serving on the new state board include Gill Waltman, recording secretary; Sue Ann Greco, immediate past president; Sandra Murdock, MMPAC; and Millie Bever and Angela Zylka, medical student and resident spouse liaisons. —



Displaying their Southern Medical Association Alliance awards are, from left: Shirley Collison, Marsha Conant, SMA Alliance president Barbara Blanton, Angela Zylka, Kathy Weigand, Sue Ann Greco and Millie Bever.

The SLMMS Alliance received recognition for generating the most contributions to the MSM and AMA Foundations. In addition, the Southern Medical Association Alliance honored the MSMA Alliance with first place awards in the SMA Alliance Doctors Day and Medical Heritage categories.

A successful fundraiser with a Wild, Wild West theme was organized by Foundation chair Stacy Peters. Many attendees wore creative western attire and enjoyed a western-style dinner. Using a “Jail and Bail” theme, many physicians volunteered to be “arrested” earlier in the day and had to pay bail by 7:00 p.m. or they would be sent to the “jail” during dinner. There also was a silent auction.

MEMBERSHIP DRIVE

Renewing, returning and new physician spouses are invited to submit their annual dues for regular membership by **July 31** to be included in the new directory. Medical student spouse or resident spouse members may join for a reduced fee and are often sponsored by regular members. For more information, contact Angela Zylka at angela.zylka@gmail.com.

Upcoming Event

August 2016 – CAbi Fashion Show

See CAbi fall/winter fashions at this fundraiser for Alliance members and guests. Angela Zylka will host the events at the home of CAbi associate Carrie Kreutz. To accommodate busy schedules, there will be two showings, Thursday, Aug 25, starting at 6:00 p.m., and Saturday Aug. 27, starting at 2:00 p.m. For more information, contact Angela Zylka at angela.zylka@gmail.com.

Newton B. White, MD



Newton B. White, MD, board certified orthopedic surgeon and past SLMMS president, died April 9, 2016, at the age of 88.

Born in Chicago, Dr. White completed his undergraduate studies between 1947 and 1953 at Miami University in Oxford, Ohio, the University of Chicago School of Divinity and the University of Illinois-Chicago. He earned his medical degree in 1957 from the University of Cincinnati. He completed his internship at Cook County Hospital, then did a surgical residency in Mason City, Ia., and orthopedic surgery residencies at Washington University School of Medicine.

Dr. White served in the U.S. Marine Corps from 1946-1947, and in the U.S. Navy ROTC while in college from 1947-1949.

While in private practice, he also was an instructor in clinical orthopedic surgery at Saint Louis University School of Medicine. He was on staff at St. Anthony's Medical Center, SSM Health Cardinal Glennon Children's Hospital and the former St. Joseph's Hospital in Kirkwood.

Dr. White joined the St. Louis Metropolitan Medical Society in 1963 as a Junior member. He served as SLMMS president in 1991, and was a member of the SLMMS Council for many years. He also served on the Missouri State Medical Association Council. He became an SLMMS Life Member in 1999.

SLMMS extends its condolences to his wife, Mary Ann; his children, Rebecca Simpson, Newton White, Stephen White, Katherine Stenson; eight grandchildren; and two great-grandchildren. —

Anwar A. Shah, MD



Anwar A. Shah, MD, an ophthalmologist specializing in retina surgery, died April 21, 2016, at the age of 91.

Born in Mergui, Burma, Dr. Shah received his undergraduate degree from University College in Rangoon, Burma, and his medical degree from the King Edward Medical College in Lahore, Pakistan. He completed a fellowship in glaucoma at Washington University School of Medicine followed by three years of residency at Saint Louis University School of Medicine. He then completed a fellowship at the Massachusetts Eye and Ear Infirmary.

As director of retina service at Saint Louis University School of Medicine, he trained ophthalmologists in diseases and surgery of the retina and macula as well as laser surgery. He also was founder and medical director of the former St. Louis Eye Hospital and later opened the Midwest Eye Institute and

Midwest Surgery Center in South County. He funded the Anwar Shah, MD, Endowed Chair in Ophthalmology at Saint Louis University in 2009.

Dr. Shah joined the St. Louis Metropolitan Medical Society in 1959 as a Junior member, and became a Life Member in 1996.

SLMMS extends its condolences to his former wife, Joan Shah; his children, Joan Spencer-Ruper, Richard Shah and Andy Austin. —

Subodh K. (S.K.) Mehra, MD

Subodh K. (S.K.) Mehra, MD, a board-certified internist with a specialty in cardiovascular disease, died May 4, 2016, at the age of 65.

Born in New Dehli, India, Dr. Mehra received his medical degree from the All India Institute of Medical Sciences in New Dehli. He completed his internship and residency at John H. Stroger, Jr. Hospital of Cook County, Ill.

He practiced with Southside Comprehensive Medical Group, and was on staff at St. Anthony's Medical Center, SSM Health St. Clare Hospital, and St. Alexius Hospital. Dr. Mehra joined the St. Louis Metropolitan Medical Society in 2006.

SLMMS extends its condolences to his wife, Anu Mehra; his children, Shaila and Anjali, and his two grandchildren. —

NEWSMAKERS

MD News



Dr. Nirav Patel

Nirav Patel, MD, (SLMMS member), has been named chief medical officer of SSM Health Saint Louis University Hospital. A specialist in infectious disease and critical care medicine, Dr. Patel joined the hospital in February 2013 and became interim CMO in July 2014. He is assistant professor of internal medicine at Saint Louis University.

- **Timothy J. Eberlein, MD, (SLMMS member)**, director of Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine, has been elected chairman of the National Comprehensive Cancer Network (NCCN) board of directors.
- **David Mutch, MD, (SLMMS member)**, has been named co-chair of the National Cancer Institute Gynecologic Cancer Steering Committee. He is the Ira C. and Judith Gall Professor of Obstetrics and Gynecology at Washington University School of Medicine.

Medical Student Teams Present Technology Projects

Students from the medical schools at Washington University and Saint Louis University showed their innovative medical technology projects at their annual Demo Days.

The Washington University program, IDEA Labs, featured 20 teams from St. Louis, plus teams from the University of Pennsylvania, the University of Minnesota, and Harvard/MIT, as well as 10 alumni teams. Keynote speaker was Robert Langer, professor of biomechanical engineering from MIT. Some 400 people attended the April 25 event.

Also in conjunction with Demo Day, the American Medical Association announced a partnership with IDEA Labs to help spread the concept to more institutions and clinicians.

Saint Louis University MEDLaunch students held their Demo Day on April 27 at the university's School of Law building in downtown St. Louis. Five projects were presented. About 250 guests attended, including university president Dr. Fred Pestello, along with other officials from the medical school and the university. Keynote speaker was Bud Albers, former chief technology officer at Disney and current CEO of Recursive Labs in St. Louis.

Contributions from the St. Louis Society for Medical and Scientific Education (SLSMSE), the charitable arm of SLMMMS, supported both events. ➡



Medical students from Washington University, left, and Saint Louis University show their innovative projects. For more photos of Demo Days, see the SLMMMS Facebook page, saint.louis.metropolitan.medical.society

Examining Telemedicine ➡ continued from page 17

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SLMMS 50-Year Physicians Recognized by MSMA

Eleven SLMMS members were among the 31 physicians honored by the Missouri State Medical Association for achieving 50 years of membership. Recognized with 50-year pins at the annual convention March 18-20 were SLMMS members Parviz M. Behbahani, MD; David M. Berwald, MD; Louis P. Dehner, MD; Harry C. Eggleston, MD; Wilfrido C. Feliciano, MD; Gordon M. Goldman, MD; Michael A. Kass, MD; Lester T. Reese, MD; Glenn M. Sherrod, DO; Charles H. Sincox, MD; and Bruce J. Walz, MD. Congratulations from SLMMS for achieving this distinction! —

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