Mercy Launces World’s First Virtual Care Center
City Again Serving as Gateway to a New Era

By LYNNE JETER

ST. LOUIS, MO — Last month, Mercy unveiled the world’s first Virtual Care Center in the heartland of America. Bishop Edward Rice of the St. Louis Archdiocese officially blessed the non-profit Catholic health system’s newest facility Oct. 6 in Chesterfield, Mo., a suburb located 15 miles west of St. Louis.

The new $54 million building on a 38-acre campus houses the nation’s largest single-hub electronic intensive care unit (ICU/Mercy SafeWatch), and also provides a center for telemedicine innovation and a testing ground for new healthcare products and services. More than 300 physicians, nurses, specialists, researchers and support staff at the four-story, 120,000-square-foot center are tapping into technology to deliver care to patients around the clock via audio, video and data connections to locations across Mercy and around the country through partnerships with other health care providers and large employers.

(Continued on Page 6)

Addressing Maintenance of Certification
13th Annual Hippocrates Lecture Focuses on Physician Certification and Regulation

By CHRISTOPHER CUSSAT

The 13th Annual Hippocrates Lecture was recently hosted by the St. Louis Metropolitan Medical Society (SLMMS) at Ces & Judy’s in Frontenac. The Hippocrates Lecture is an annual event funded by contributions to the St. Louis Society for Medical and Scientific Education by physicians in the Hippocrates Society, whose mission is “to reaffirm our dedication as physicians to the Hippocratic Oath.” The Hippocrates Society was founded by SLMMS members in the early 1990s at a time when the profession of medicine was beginning to face serious challenges because of the intrusion of corporate managed care and increased government regulation...
Modern Healthcare’s 2015 Healthcare Law Firms Survey
Polsinelli Named Best in the Country

By CHRISTOPHER CUSSAT

Modern Healthcare’s 2015 Healthcare Law Firms Survey recently named national law firm, Polsinelli, at the top of its list. This top ranking acknowledges that Polsinelli has built the largest Health Care Practice in the nation. Modern Healthcare’s rankings are based on a blended score of healthcare lawyers employed in 2014 and American Health Lawyers Association (AH LA) memberships.

“This recognition from Modern Healthcare underscores the strength of our national Health Care Practice and commitment to serving clients in this dynamic and complex industry,” said Polsinelli Chairman, Russ Welsh.

Polsinelli represents a wide variety of healthcare clients including hospital and health systems, infusion therapy providers, health care technology companies, home health and hospice agencies and senior and long-term care facilities. Health Care attorneys provide a wide variety of services for clients, including mergers and acquisitions, regulatory issues, compliance issues, HIPAA and confidentiality compliance counseling, reimbursement, payor disputes, Medicare and Medicaid fraud allegations, medical staff and credentialing, risk management, public policy and real estate matters, 340B compliance and more.

One of the firm’s first healthcare attorneys, Randy Gerber, is Polsinelli’s St. Louis managing director. He illustrated the firm’s impressive growth by comparing its present size to its beginnings. “We were five lawyers primarily doing physician and hospital work. The expertise today is ten-fold and the number of lawyers is night and day – it is the difference between a small boutique firm and a large national firm.”

Today, Polsinelli has 15 healthcare attorneys in St. Louis alone and currently 190 lawyers and other professionals make up the practice in large cities all across the country including: Atlanta, Chicago, Denver, Dallas, Kansas City, St. Louis, and Washington DC.

According to Matthew J. Murer, chair of Polsinelli’s healthcare practice in Chicago, the top three issues that clients are bringing to the firm are transactions, compliance and reimbursement, which he explained are all being driven by the Affordable Care Act. “The new reimbursement landscape is driving consolidation among providers as they look to build scale that will drive efficiency – this is driving a flood of acquisitions and affiliations.” He added that reimbursement has always been one of the most complex areas for healthcare providers and that the Affordable Care Act has only made it more complex. “Finally in regards to compliance, the federal government has ramped up its enforcement efforts from large scale audits to massive investigations into potential fraud, so every move made by a healthcare provider is subject to unprecedented scrutiny today.”

U.S. News & World Report also recently named Polsinelli the “Law Firm of the Year in Health Care” in its 2015 Best Law Firms report. The designation was based on Polsinelli’s overall performance in healthcare, incorporating both client feedback and peer review, and reflective of the firm’s growing talent pool, complete range of health care legal services, and geographic footprint across 18 cities.

But according to Polsinelli’s Jane Arnold, vice chair of its Health Care Practice in St. Louis, all of these rankings and recognitions are much more than just positive press. “For us, being number one is not a magazine ranking, but being top of mind with our clients and having them be really pleased with our work.” She added that it is all about providing expertise, insight, and delivering exceptional service that clients cannot get anywhere else. “That’s the real goal.”

Polsinelli is now in its sixth year as one of the fastest-growing law firms in the U.S., opening two new offices this year in Raleigh and Nashville (cities with a focus in the health care industry). The Health Care Practice has grown from two regional practices which merged in 2009 into a coast to coast national practice attracting sophisticated laterals across the country. The American Lawyer recently featured Polsinelli’s Health Care Practice as one that focuses on concentrating its attorneys in competitive markets with high demands for health care work.

This noticeable and continual growth was even part of Gerber’s initial interest in joining the firm nearly 15 years ago. “I can tell you there was always a plan to grow the group – that’s one of the reasons I came to Polsinelli. They sold me on the firm’s commitment to healthcare and they delivered.”

Murer related Polsinelli’s expansion to the overall growth evident in the healthcare industry. “The number of physicians and physician practices that have been acquired by large health systems is simply staggering – the entire landscape has changed.” He added that the doctors and the health systems are still working out how their evolving relationship will work and Polsinelli is at the center of that discussion. “As I mentioned, growth is being driven by the desire to have scale, and providers are hopeful that scale will lead to efficiency and to negotiating power with various payors. There is also a hope that scale will help ensure better patient outcomes, especially now that Medicare is focused on adjusting payments based upon outcomes.”

To determine the law firm rankings, Modern Healthcare utilized a survey methodology based on a blended score, including the sum of 50 percent weighting from data collected in the survey (number of health care lawyers) and 50 percent weighting of American Health Lawyers Association (AH LA) membership from each firm, provided by the AHLA as of April 30, 2015. The AHLA also recently released its own national rankings, placing Polsinelli second among national law firms for the second consecutive year.

“We will continue to attract quality attorneys who want to grow their practices—that includes layers of all levels,” Gerber concluded. “I’m very proud of what we have built. It shows the talent of the firm, and we will continue to work very hard to maintain the quality of service we provide our clients.”

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Physician Spotlight

For Bariatric Surgeon, Patient Access to Procedures Remains Chief Concern

As Field Has Matured, Broader Understanding, Fewer Complications Among Benefits

By LUCY SCHULTZE

It started as an operation, then it became a disease. Now it’s an entire field of medicine.

That’s how J. Stephen Scott, MD, sums up the dramatic evolution of bariatric surgery since he first added it to his general surgery practice 20 years ago. Over time, bariatric surgery has become the focus of his practice and has matured in its technique, safety and acceptance by the medical community.

“When we first began, bariatric surgery was viewed almost as a cosmetic procedure,” said Scott, medical director for metabolic disease at the Des Peres Hospital Bariatric and Surgical Institute.

The biggest change is that, today, we understand the consequences of obesity, he said. “Back then, we knew that if you were really overweight, that’s an unhealthy thing. But we didn’t really understand the implications.

Now we understand the cost of obesity, both from a medical point of view and an economic point of view. People understand bariatric surgery as a medically necessary intervention.”

The other most significant change: The way complication rates have come down tenfold over the past two decades.

“It’s just amazing,” Scott said.

“Weight-loss surgery today is a very safe procedure, and the introduction of robotic surgery is improving it even more. I’m excited to see how the technology evolves in the years to come.”

Scott’s entry into the field of bariatric surgery came through a relationship with a San Diego physician group, which came to him for early training in laparoscopic surgery. That group had begun performing bariatric surgery, and Scott and his partner learned from them in return.

Scott’s practice began offering weight-loss surgery in the St. Louis area. That non-surgical option places a saline-filled balloon temporarily inside the patient’s stomach to curb appetite and accelerate weight loss.

As the procedures have evolved, so, too, has the team which supports patients before and after surgery.

“When I first started, I had my receptionist and my administrative assistant and the surgeons,” he said. “Now we have a complete team, with two full-time dieticians, a psychologist and exercise staff. We have a multidisciplinary approach, which improves everything for the patient and also allows me to focus on the surgical aspects.”

The latter has been a positive side benefit for Scott.

“What happens in the operating room is still the most enjoyable part of what I do,” he said.

Still, he said, his focus on bariatric surgery has meant the opportunity to develop relationships with his patients.

“For most general surgeons, you see a patient once before surgery and maybe once or twice after,” he said. “Once you fix somebody’s hernia or take their gall-bladder out, that’s it. But with bariatric surgery, we tell people: ‘You’re our patient for the rest of your life.’ We have annual visits and follow them up closely. It really is a long-term relationship you develop with patients, and you get to see the effects of your work over a long period of time.”

Among those effects: The fact that when a familiar patient comes back to the office for an annual visit, he or she may look like a complete stranger.

“I saw a patient today I didn’t recognize at all,” Scott said. “He’d lost 176 pounds and weighs 180 now. He’s just a completely different guy.

“Once you get off the couch, that’s it. But with bariatric surgery is improving it even more. I’m excited to see how the technology evolves in the years to come.”

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“I saw a patient today I didn’t recognize at all,” Scott said. “He’d lost 176 pounds and weighs 180 now. He’s just a completely different guy.

“His gotten off a lot of his medications and is exercising for an hour and a half three times a week — something he could never have done before. For my staff and me, having the opportunity to change somebody’s life like that is very rewarding.”

Improving access to such a life-changing procedure is among Scott’s efforts as the current president of the Missouri chapter of the American Society of Metabolic and Bariatric Surgery.

“Our goal is to be advocates for the patients,” he said. “We still have patients who don’t have access to this treatment, which is very difficult. You have patients come to you, and you know you have something to offer that would really help them — make their diabetes and sleep apnea and high blood pressure go away. And yet the insurance company says it’s not medically necessary.

“That’s why the biggest focus of our group is to educate other doctors, insurance companies, businesses and the public in general about the disease of morbid obesity. This disease costs everybody a lot of money, and treating it is a very smart thing to do from an economic and medical point of view.”

Raised in a small town between Kansas City and Springfield, Scott attended the University of Missouri for his undergraduate degree and for medical school. He went on to complete an internship and residency in general surgery at Mount Sinai Medical Center in Miami and began private practice in 1991. He joined Des Peres Hospital in 2012.

Outside of work, Scott and his wife, Donna, a nurse, enjoy traveling to follow their children’s endeavors. Son Michael is currently pursuing a master’s degree in Australia, while daughter Mandy and son Nathan are undergraduates at the University of Iowa and Ball State University, respectively.

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Missouri Non-Profit Offers Free Legal Assistance for Low-Income Residents’ Healthcare Needs

By CHRISTOPHER CUSSAT

For so many families struggling to afford basic healthcare, the thought of acquiring sound legal assistance is an even more daunting prospect and seemingly unattainable luxury. But for over five decades, lower-income Missourians have had a strong legal voice and friend in Legal Services of Eastern Missouri (LSEM). This long-standing, independent, non-profit advocate provides free, high-quality, civil legal assistance and equal access to justice for residents of 21 counties in eastern Missouri who are in economic need, as well as the elderly.

To fulfill this mission, LSEM offers free legal advice, advocacy, and representation to the socially and economically vulnerable. Its services are designed to help remove the legal barriers that often prevent low-income families from overcoming poverty and violence, maintaining or obtaining independence, and achieving self-sufficiency.

LSEM has dedicated a significant part of its mission to providing legal aid healthcare services and programs to the low-income community. Several of these programs have just been developed over the past few years and they have already been a tremendous help to people who are often in dire need of assistance.

“We have a long history of helping clients with public benefits matters, including necessary income support, nutritional assistance, and access to healthcare through Medicaid,” noted Joel Ferber, director of advocacy for LSEM. “We help our clients secure the coverage and services they need to receive medically necessary medications and healthcare services, which of course, improves their health.”

The five programs related to healthcare that LSEM has focused on in recent years include: the Advocates for Family Health Program; the Legal Advocacy for Adults with Mental Illness Program; the Marketplace Assistance Program; the Medical-Legal Program; and the Public Benefits Program.

“The Advocates for Family Health Program assists children, families and pregnant women who are eligible for and enrolled in Missouri's family Medicaid programs or MO HealthNet managed care plans (MO HealthNet for Kids, MO HealthNet for Families, and MO HealthNet for Pregnant Women). Through this program, LSEM assists client-families having problems in obtaining or maintaining their MO HealthNet coverage, as well as other issues like denial of services, finding providers, changing plans, payment-processing problems, and coverage suspension.

“LSEM founded the Advocates for Family Health Program to assist children and families in navigating the Medicaid HMO system after Missouri transitioned to a managed care model in 1995,” explained Ferber. “We help our clients secure medically necessary therapies, durable medical equipment, dental care, mental health treatment and other services from the Medicaid HMOs. He adds that LSEM also assists children and families with Medicaid and CHIP enrollment issues to make sure they access the coverage they need.

Because those who receive proper treatment and services for mental illness still may sometimes experience obstacles in their recovery, LSEM’s newest offering, the Legal Advocacy for Adults with Mental Illness (LAAMI) Program, partners with agencies that provide services to adult residents of St. Louis City with mental illness. LAAMI works to identify civil legal issues that can potentially hinder their clients’ healing progress and provides free legal representation.

According to Ferber, this medical/legal partnership will assist clients and improve their mental health by addressing the social determinants of overall health—lack of housing, domestic violence, lack of income, etc. “In other words, LAAMI helps to remove what gets in the way of good health by removing the legal barriers associated with mental illness, and providing these clients with an array of civil legal needs.”

LSEM’s Marketplace Assistance Program (MAP) helps individuals and families navigate the Missouri Health Insurance Marketplace (Marketplace). MAP advises clients in determining their eligibility, in applying for, and re-enrolling in low-cost or no-cost Marketplace health insurance, as well as assisting those without coverage to apply for penalty exemptions. In addition, MAP works with school districts and other community organizations to find individuals and families who need help accessing Marketplace insurance.

Ferber adds that in addition to assisting its low-income clients when navigating this federally facilitated marketplace, MAP also helps them receive premium tax credits when enrolling in a health plan. “We help children in these same families enroll in Medicaid or CHIP as well.”

The Medical-Legal Program (MLP), offered by LSEM is a groundbreaking concept for healthcare that helps patients navigate complex government and community systems. The MLP implements its approach to improve the health of the most vulnerable people in society. It gives direct legal services, training for healthcare professionals, and partners with healthcare providers on systemic issues affecting patient health in St. Louis and eastern Missouri. This program utilizes LSEM advocates with specialized expertise, volunteer attorneys, as well as students and faculty from the St. Louis University School of Law to assist healthcare providers and their patients with a wide variety of legal issues. The MLP is currently on-site at Grace Hill Health Centers.

LSEM’s Public Benefits Program helps clients resolve problems with programs administered by the Missouri Department of Social Services, including: Blind Pension/Supplemental Aid to Blind, Childcare, Food Stamps, MO HealthNet for the Aged, Blind and Disabled (Medicaid), Qualified Medicare Beneficiary, Specified Low Income-Medicaid Beneficiary, Medicaid-Waiver Home and Community Based Services Programs and Temporary Assistance for Needy Families. For example, the program offers legal representation when clients are denied Medicaid, issues with certain Medicare benefits, and food stamp denial or termination.

“The Public Benefits Program is instrumental in helping aged, blind and disabled individuals establish their disability for the purpose of obtaining Medicaid coverage, and it assists them in obtaining Medicaid services when they are eligible,” explains Ferber. “We also help individuals with disabilities obtain the personal care and/or home and community-based waiver services that enable them to remain in their own homes, rather than more costly nursing homes and other institutions.”

LSEM continues its dedication to the philosophy that legal representation can significantly improve a client’s ability to recover from a wide array of potential healthcare issues.

Joel Ferber, Director of Advocacy

Missouri Non-Profit Offers Free Legal Assistance for Low-Income Residents’ Healthcare Needs

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This article is Part 1 of a four-part series designed to showcase the extraordinary healthcare capabilities of St. Louis and the region. Often overlooked and taken for granted, St. Louis healthcare leaders are working tirelessly to provide the highest quality care to patients. In this series, we hope you never take St. Louis healthcare leadership role for granted again.

Growing up in Mt. Vernon, Ill., I learned that if you got sick, you went to a local physician or hospital, but if you got very ill you needed to go to St. Louis for top healthcare. That truth still exists today, but the St. Louis capability for providing top quality care and leading edge medicine has grown to national and global dimensions. I personally experienced the importance of that capability in a profound manner. One morning in March of this year, I awoke with numbness in my face. I immediately made an appointment with my primary care physician. Because of a previous medical issue, he ordered a scan of my brain to rule out a stroke. It was negative, and I was referred to my dentist for possible dental involvement. After a root canal and additional testing, I was referred to Frederick Gustave, DDS, an oral surgeon in Carbondale, Ill. He performed two extractions and a biopsy. The result was squamous cell carcinoma of the mandible.

Gustave immediately referred me to Bruce Haughey, MD, an ENT surgeon and professor at Washington University and Siteman Cancer Center who specializes in my condition. His first advice was to choose Dr. Ryan Jackson, his team that saved my life and gave me a chance to see my grandchildren mature and graduate college. The skill, capability, expertise and technology Haughey and his team of doctors brought to the operating room is second to none.

I can never thank Haughey and his team enough for what they have done for my family and me. There are many similar specialized teams of physicians in St. Louis that provide incredible leading edge healthcare for the people of St. Louis, the Midwest region, and beyond.

Details of the preparation and the technical aspect of the surgery itself underline the capability that exists in our area. Now, meet the incredible team that saved my life, led by Bruce Haughey, MD, (ENT surgeon), Wade Thorstad, MD, (radiation oncologist), and Loren Michel, MD, (medical oncologist).

Medical Details: Comments by Bruce Haughey, MD

Mr. Henry was afflicted with a T4 (AJCC Stage IVa) mandibular alveolar ridge primary tumor, probably induced by long standing compromise of his dental health. The widely accepted, overall strategy for management of oral cavity malignancy is surgical resection, reconstruction and postoperative adjuvant therapy, as indicated by intraoperative evaluation and the pathologist’s findings from the surgical specimen.

When the patient arrived on referral to the Head and Neck service in the Department of Otolaryngology at Washington University, his presenting cranial neuropathy, and the positive biopsy for squamous carcinoma raised concern for extensive neurotropic spread, in a centrifugal pattern, away from the center of his primary tumor towards the skull base, possibly with intracranial extension. With our radiologist’s expertise using “nerve protocol” MRI, we were able to track spread along fifth cranial nerve branches to, but fortunately not through, the skull base, thus rendering the tumor resectable to a negative margin, despite its presence in the infratemporal fossa. Another positive feature going in to surgery was the absence of clinical or radiological evidence of cervical node metastasis. Presence of node metastases would have been a significant prognostic indicator for an oral cavity primary, as opposed to the now more common human papilloma virus-driven tonsil / base of tongue squamous carcinoma, in which quite extensive nodal metastasis is often seen, but without the negative prognostic implications.

Surgical planning incorporated performance of the mucosal incisions and peri-mandibular dissection trans-orally with final “pull-through” of the major resection specimen into the neck where an elective neck dissection (i.e. preservation of the sternomastoid muscle, eleventh nerve and internal jugular vein). Final pathology reported no metastatic disease in the regional lymph nodes. The patient was ambulating on crutches at five days and walking without assistance at two weeks, by which time he had resumed a soft/medium oral diet.

Due to the extensive bone and soft tissue/nerve involvement, selective use of adjuvant radiation (66Gy) targeted to the primary resection bed was discussed with and decided upon by Dr. Wade Thorstad, Associate Professor of Radiology and director of Head and Neck Radiology at Washington University. Absence of positive margins and/or neck nodal disease with extra capsular extension guided Dr. Loren Michel, Associate Professor of Medicine and Mr. Henry’s medical oncologist, to not recommend adjuvant chemotherapy.

This patient’s future course, after resolution of his radiation reactions, will include dental rehabilitation with the maxillofacial prosthodontics service at Barnes Hospital and possibly the insertion of osseointegrated implants into the fibula graft by the patient’s oral surgeon, by Frederick Gustave, DDS.

We are thus able to anticipate for Mr. Henry a close to normal diet, near normal speech, physically acceptable cosmesis, normal ambulation and a return to his vocation. Standard oncologic follow up will require full head and neck examinations in the clinic and periodic CT scans.
Mercy Launches World’s First Virtual Care Center, continued from page 1

“...This is a huge and impactful step forward for telehealth and I appreciate that Mercy leadership had the vision and determination to demonstrate to their community and the world how telehealth is one powerful and effective solution to the issue of diminished access to healthcare that many citizens in America and across the globe are experiencing,” said Rena Brewer, CEO of Global Partnership for Telehealth Inc., and director of the Southeastern Telehealth Resource Center.

Randall Moore, MD, MBA, Mercy Virtual president, spoke with Medical News exclusively about establishing the Virtual Care Center and the positive impact it’s already making on practices, clinics and hospitals across the United States.

How did the idea of Mercy creating a Virtual Care Center originate?

It was an evolutionary process. We launched our first virtual program – Mercy SafeWatch, our electronic ICU – in 2006, and we’ve experienced great success. As the team continued to build programs and saw the importance of virtual care becoming a transformational pathway for our health system, a light bulb went on. It made sense to create a Virtual Care Center that worked like a hospital to bring together teams, resources and infrastructure to care for patients in a much more coordinated manner and to offer a care continuum that extends 24/7/365. We needed a facility for this conduit of care, just as we’d need one for a particular service like cancer care.

How did the concept evolve into the world’s first-of-its-kind telehealth center?

The Virtual Care Center evolves from the culture and charism of Mercy. The Sisters of Mercy who founded our health system were famously known as ‘the walking sisters.’ That goes back 187 years, when nuns were mostly cloistered and did good deeds from their convent for people in need. The walking sisters, who were quite independent, didn’t want to wait for people to find them. Instead, they searched for people in need and addressed those needs on the spot. They were an anomaly for their time.

When you think about hospitals in general, we wait for people to come to us, and we give them exceptional care. The idea permeating our culture was to seek those needing medical care by taking virtual care teams from our clinics and hospitals and proactively identifying their healthcare needs, intervening with them earlier and more completely. It translates to a lower cost, high impact option to keep a person from deteriorating.

At the board level and leadership level, (Mercy president and CEO) Lynn Britton and (Mercy CFO) Shannah Sock were the primary drivers of this project. Understanding the Virtual Care Center is 100 percent consistent with our organizational mission – and also a model for us to progressively replace our hospital-based care with care when and where people need it. If we do this well, we’ll be able to realign our contracts to be rewarded for keeping people well.

How have you made the Virtual Care Center a sustainable business model while also dealing with the complexities of regulations, interstate commerce, and the like?

First, it’s important to know we didn’t go into the Virtual Care Center thinking that a fee-for-service equivalent would make it a sustainable business model. We weren’t expecting, though, we’d have welcomed it, very much direct reimbursement as has panned out. In Missouri, our parity laws have helped.

We’re broadening it to enable us to move our teams and our patient-centricity from our facilities, which are somewhat limiting, to virtual care anytime, anywhere. If we did that with something like performance-based, population health contracts, we could intervene earlier and more effectively, and then it would pay for itself.

For example, here’s how it works in today’s environment in the hospital vs. the floor. In the hospital, the ICU is paid a lump sum for a patient with a given condition and it’s a fixed amount of money. The ICU is more expensive, and the patient usually doesn’t have as good an outcome. One result of our Mercy SafeWatch program shows the actual vs. predicted mortality for the last few quarters in our Joplin (MO) hospital has been running around 50 to 53 percent.

In other words, 43 to 50 percent of the patients who ‘should’ve’ died didn’t. That statistic doesn’t help much with finances, right? It should help us with market differentiation; by having Mercy SafeWatch in place, we can do a better job taking care of people. But here’s another example: Looking at the risk-predicted length of stay, both in the hospital and the ICU, our length of stay is running 20 to 30 percent less than predicted in the ICU, and 30 to 35 percent less than predicted on the whole hospitalization. If we can get a sick person well faster, that’s less time for the patient in the ICU. Looking at it financially, the direct variable ICU costs us about $900 a day. If it costs us $650 a day to use Mercy SafeWatch, then we’re getting 100 percent return on our investment of virtual care without being paid directly for it.

But the most important aspect is that a third of the ICU patients predicted to die aren’t dying. That’s just the tip of the iceberg, and it implies that patients accessing the Virtual Care Center are doing better. We expect to deliver more efficient, effective, and higher impact care as we integrate virtual into bedside and clinic care.

What’s Mercy’s longer-term goal for the Virtual Care Center?

One of our key growth areas for our mission is to create the Virtual Care Center as a conduit of care anywhere, anywhere can access. We’ve been on a 10-year, several hundred million dollar journey to get where we are. We’ve learned many positive things, and we continue to learn from missteps.

We’re proposing that instead of selling our services, or having an entity trying to replicate the same services without us being able to provide much support, we’d like to build a national consortium of interdependent partners. We’d continue packaging our offerings and building our infrastructure with our partners’ support. They could buy into our entity, we could capitalize it together and replicate what we’ve learned with a fraction of time and money, and also do it in an interdependent way so we could then go to GM, Boeing, or United Healthcare to offer it to people they’re covering throughout the 50 states.
Mercy’s Virtual Care Center Tailored to Improve Physicians’ Quality of Life

By LYNNE JETER

ST. LOUIS, MO — Inter

nist Randall Moore, MD, MBA, recalls countless nights of sleep inter-

rupted by on-call requests.

Moore, now president of

Mercy Virtual, is doing his part

to make sure more doctors enjoy their private lives when they clock

clock out of their practice, clinic or hos-

pital.

“Instead of getting a 2 a.m.
call to come in, they can sleep,”
said Moore, who helped open the

world’s first-of-its-kind Virtual Care Care Center last month near St.

Louis, Mo. “It’ll enable them to be

more productive, have less chance of burn-

out, and improve their quality of life while

we enable better, more responsive care for

their patients.”

When Mercy’s electronic intensive
care unit (ICU), also known as Mercy Safe-

Watch, was established in 2006, Mercy had

one “full” intensivist group in one site. Now,

Mercy has intensivist groups at multiple

sites, said Moore.

“One reason why, aside from our over-

arching mission of care, is to improve the

quality of life for our doctors,” explained

Moore. “For example, if a doctor goes into

a community with no virtual care and he’s

the only intensivist, he’s on call all the time. It’s tough and doctors burn out. With

the virtual team, the doctor can go home and

have a life. We do that increasingly across

the board, not just Mercy SafeWatch. Using

a nurse-on-call feature, which is housed insid-

e the Virtual Care Center, 70 percent of

the calls our doctors were getting a couple

of years ago are now handled without them

being bothered.”

Moore said Mercy will take another

step to making it easier for doctors by bring-

ing more physicians into the Virtual Care

Center.

“Hopefully, we’ll approach

100 percent of the calls at night no

longer going to our doctors,” he

said. “By not taking calls at night,

doctors can be more productive.”

Physicians have shared con-

cerns about Virtual Care Center operations and how it will impact

their practices, Moore shared.

“The Virtual Care Center

isn’t a call center,” he empha-

sized. “It should be progressively

integrated into the doctor’s prac-

tice. We’ve designed it specifically

the way the doctor would want it done. You might say it’s somewhat of a mass customization … sup-

porting our doctors and other healthcare professionals via the Virtual Care Center.”

In one-on-one conversations with doc-

tors, Moore is often asked how the Virtual Care Center “can be better than what I can

do?” Bolder ones ask: “Is it a threat to my

practice?”

“The Virtual Care Center is another

resource for a doctor or hospital to have in

the care of their patient when they don’t

have the time, resources or infrastructure
to do it on their own,” he said. “It’s very
complementary to what they do.”

One telehealth success story involves

Mercy’s early warning system for sepsis. To identify patients at risk for sepsis and alert

doctors to these risks for early intervention, Mercy’s Early Warning & Identification System (EWIS) monitors multiple patient variables in real-time.

“We look at building programs as ways to partner with doctors to create a seam-

less integration for the patient,” explained

Moore. “We look at how we can improve the value of that entity – practice, clinic or hospital – in the local marketplace so they can show first and foremost, they can del-

eriver better care with documented outcomes for the patients they serve. Secondly, we show how they’ll be financially and operationally rewarded instead of having their revenue adversely affected. I’ve had doctors say, ‘I don’t know how to sustain my prac-
tice if that happens.’ Instead, we’re helping them build a financially sustainable and professionally more rewarding offering in the community.”

Moore recalled a primary care physi-

ician sharing his experience after working with the Virtual Care Center. “He told me that after 35 years of the practice of medi-
cine (without telehealth),” said Moore, “it was the most rewarding time of his profes-

sional life. That’s what we strive for, to allow doctors to get back to the basics of practice–

medicine.”

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Washington University Medical Center
Deep in Campus Renewal Projects

By CHRISTOPHER CUSSAT

BJC HealthCare Washington University Medical Center (WUMC) campus renewal projects are focused on patient comfort and readiness of hospital facilities for the looming demands of healthcare.

Kathy Bretsch, communications consultant for these renewal projects, said WUMC is replacing outdated facilities that can no longer keep up with the contemporary demands of medical care. “We also have some opportunities for growth, where the population in general is requiring more healthcare services.” She added that all new construction will have private rooms, which are important for patient comfort and healing.

“We are very excited to participate in these projects that will stimulate the St. Louis economy and keep our city on the map for excellent building architecture as well as quality healthcare,” said Todd Staley, general manager of IWR Building Systems (IWR) selected to be the exterior enclosure contractor and design assist partner for two of the projects. A specialty contractor focusing on building enclosure systems, IWR teamed with Alliance Glazing Technologies (Alliance) to offer a total enclosure package for both Barnes-Jewish Hospital North and St. Louis Children’s Hospital.

“Our group possesses the size, stability, talent and experience to add a significant amount of value to this project, and we are determined to deliver a high-quality final product.”

The new enclosure provided by IWR will include a complete, “unitized” approach to dry the building at an accelerated rate. A mixture of stainless steel, aluminum, concrete, stone and metal panels will be engineered and installed in the exterior of the buildings. According to Dan Shields, director of sales at Alliance, this project has several advanced features and products that separate it from other façade projects. “One item in particular is the UHPC (Ultra High Performance Concrete) that has been integrated onto our ‘unitized’ curtain wall units.”

Keith Myers, executive vice president of MHS Legacy Group (the parent company of IWR), said that this curtain wall system is a completely unique design engineered specifically for the requirements of BJC. “Also, the UHPC stone products going on the walls above the fifth floor are actually a relatively new product called Takhl. It is a product that ages like natural stone and actually gets stronger with multiple weather cycles–these towers are being constructed to last!” Shields also noted that in addition to the design and engineering focus, this distinctive feature adds a level of complexity to fabrication, shipping, handling and erecting due to the increased weight and geometry applied to a standard unit.

Myers further explained the process of creating “unitized” walls, which are formed into large sections and then hoisted into place, thus covering a large amount of square footage without the lengthy onsite construction time and congestion. “While this method is not always less expensive, it is often the best way to build in an urban environment. When these ‘unitized’ sections are lifted into place, composite crews made of several different crafts will be working side by side.”

This allows each craft person to focus on what their respective trade does very well. “In other words, our craft people will focus on their strengths and are not asked to work within their weaknesses–the end result will be a better built and safer project,” added Myers.

IWR has formed multi-craft composite construction crews to provide the best possible solution for the installation of each part of the enclosure. In fact, the enclosure being provided by IWR is not an “off the shelf” type of wall system. “The curtainwall is a custom design, tailored specifically to meet the stringent requirements of both towers in terms of UV, thermal insulation and air/water infiltration,” said Myers.

The project is phased over the next several years and the schedule of the current phase shows occupancy in mid-2017. Phase 2 will more than likely cover the same durations and go through 2020. Shields noted that budgeting required its own significant amount of thoughtful planning as well. “There was a challenge of an aggressive budget–so the entire team spent several thought-provoking months in a design-assist format identifying any opportunities with the design and associated costs to achieve the desired look without compromising quality, schedule and performance.”

Bretsch noted that the entirety of the project is focused on the patient and family experience, to promote healing and comfort in the absolute safest environment. “From private rooms with accommodations for family members, to rooftop gardens and views to Forest Park, to the design of parking, streetscape and even the outdoor dining, the patient was at the forefront,” Myers agreed, adding, “The specifications for the enclosure are some of the most stringent I have personally ever seen–such a sound structure and patient comfort seem to be paramount.” In fact, the project team brought former and current patients and their families, from both Barnes-Jewish and St. Louis Children’s hospitals, into the design process very early on to learn about their needs and concerns. “As design proceeded, we went back to them time and time again so we’d get it right,” Bretsch concluded.

For construction updates visit http://www.bjconstruction.org/.
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From Medicine to the Business World
Helping Women Achieve Success in Business

By LINDA F. JARRETT

Growing up in Illinois, Mary Jo Gorman, MD, knew that she was destined for a career in medicine. She did not know, however, that her desire to help people would translate into helping women start their own companies, and that she would become a driving force in entrepreneurship.

After graduating from Southern Illinois University School of Medicine, she received her MBA from the Olinn School of Business at Washington University in St. Louis, and her BA in chemistry and biology from Saint Louis University. Gorman obtained board certifications in Critical Care Medicine and Internal Medicine.

Her first job was working at St. Louis University Hospital in the intensive care unit. “It felt like we organized the way we did the care, we could improve the outcome for the patient and the facility, so I started a medical practice group,” Gorman said.

So was born her first business, Critical Care Services, which she started in 1992. She formed her second business, Inpatient Care Group, in 1997, and sold that company to IPC Hospitals in 1999.

“In 2002, I decided I would stop seeing patients and focus full time on the business aspect,” she said.

“When I made that transition, I was working to continue to build the hospitalist practice nationwide, then in 2006 I started Advanced ICU Care where I became the CEO and chairman,” she said.

Having practiced as both hospitalist and intensivist, Gorman saw what needed to be done to streamline patient care.

Throughout her career, she had mentored and advised women on various facets of their career.

She saw this need in younger women, and in 2006, she joined the board of Mar- ian Middle School which helps break the cycle of poverty of urban young women.

In 2013, American Express OPEN released studies on women’s entrepreneur- ship and its impact on the economy. Missouri ranked 41st in terms of growth and economic clout of women’s businesses from 1992 to 2013.

After reading this study and being shocked at the results, a group of St. Louis community leaders came together and created the Women Entrepreneurs to add- dress the entrepreneur gender gap in the St. Louis region.

Gorman realized this was where she should be.

“From a personal progression from work that I had done in the past, in terms of taking all the experience I had in building and running businesses and combining that with my preference in trying to advance women in their business careers,” she said.

Proper Women Entrepreneur Group is divided into two sections. One, the Prosper Institute, a non-profit organization focused on training and mentoring women in the entrepreneurial community and those women with early ideas.

“We have ways that they can engage with us through advice and classes we give,” Gorman said. “We also have a program called Mastermind where women can come and work on their business in a peer group.”

The other section is the Prosper Capital Group where Gorman is the lead managing partner.

“We actually invest cash in the company,” she said. “And we put them through a special intensive three month accelerator program to help them grow their business.”

“We start a lot of businesses, so starting businesses is not the problem,” she said.

“The problem that women have is with the choices they’ve made, and they tend not to grow very big businesses.”

According to the research, one of the reasons is that women do not see other people who have grown their businesses.

“They don’t create the right network of people to figure out how to get the resources they need to do that,” Gorman said. “They don’t attract as much investment, because sometimes they’re not even asking, so by creating an environment through both parts of Prosper Women Entrepreneurs to challenge women to think bigger, get funding, and really grow something big, that’s where we can make a difference.”

Starting a business can be a daunting venture for anyone, and while many women have good ideas, putting them into play, getting their business started, and keeping it going, means they have to keep a lot of balls in the air.

“One of the challenges supported by research is that sometimes women discount our program,” Gorman said. “They may think their business is too big, too small, or not the right industry.

“Our research shows that women won’t often raise their hands to participate in these things, so part of our message is that everybody should raise their hands, and be thinking about how to advance their business,” Gorman said.

Creating a “women only” environment, she said, reduces some of the reasons they do not participate because of feeling intimidated or unwelcome in a mostly male setting.

Prosper Capital helps women entre- preneurs in one of the biggest steps in starting a business — getting money.

“All businesses need capital as some point,” Gorman said. “Depending on the type of business they have, there are different sources of capital, and we help them understand and identify that.”

Prosper Capital has identified investors in St. Louis who have pledged money to invest in these companies, and 70 percent are women.

“We are excited about that, because if we get more women participating, we’ll get more women involved in the whole market place,” Gorman said. “We then help them identify our other funding sources, and help them understand how to speak the language of those sources to be successful in those environments.”

“We invest in up to 12 companies a year,” Gorman said. “Statistically, only three or four will actually be successful.”

She defines “success” as being purch- ased by a bigger company.

“Typically that will happen six to eight years after they have been invested in,” she said. “After that, they may go along for a while, but you either grow or die.”

Seeing businesses go through the trials of starting, then becoming successful is what drives Gorman.

“I’m part of the investment group of the companies that are successful and I participate in the financial success of the group,” she said, “I feel like I’ve learned a lot in my career and if I can help somebody else advance their business and avoid mistakes that other people or I have made then that’s extremely satisfying.”

In 2009, Modern Healthcare named Gorman as one of the top 25 Women in Health Care Medicine for her contributions to the field of hospital medi-

Clayton, Missouri ranked 41st in the National Women’s Entrepreneurship program. In 2011 she was named one of the ten national Ernst & Young Entrepreneurial Winning Women, and served as one of the national judges for the 2012 award.

Some of the businesses in the accelerator that have been started are Smart Monitor, a device that that checks when epileptic patients are having a seizure and notifies their support system.

Another is EDIS Solutions, a software platform for drug companies to identify and analyze investments in terms of medications.

Sanus E0 is a mobile platform that allows patients to engage with a facility or with their doctor, and better manage chronic diseases, such as diabetes.

Bookalokal, a global social dining community that helps people connect through food & beverage experiences around the world. Our guests are travelers, locals, and people settling into a new city.

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Addressing Maintenance of Certification, continued from page 1

into the doctor-patient relationship.

Michael J. Stadnyk, MD, 2015 President of SLMMS, delivered the welcome and served as master of ceremonies for the event. Approximately 80 area physicians and their guests were present to hear the discussion which focused on the Maintenance of Certification (MOC) program that has been overseeing physician certification and regulation since 2000.

MOC was initiated by the American Board of Medical Specialties (ABMS) and its 24 member boards as a program of continuous professional development.

The program affords its “diplomates” the opportunity to publicly demonstrate their commitment to lifelong learning and improvement in their chosen field of practice. By documenting that physician specialists certified by the ABMS boards are maintaining their necessary and required skills and knowledge, the process ensures that diplomates are providing quality patient care in their specialties. Perhaps most importantly, MOC represents an opportunity for physicians to take a leadership position in the national movement to improve health care quality and patient safety, through performance assessments founded on objective clinical standards and measurable outcomes.

Paul Kempen, MD, PhD, delivered this year’s Hippocrates Lecture entitled, “Certification, Regulation and the Organized Physician Resolve: Past, Present and Future.” An anesthesiologist from Weirton, W. Va., Kempen is an active physician advocate and national presenter on the topics of MOC, as well as the related, maintenance of licensure (MOL) system. Part of his professional expertise is helping physician groups understand the available choices and opportunities necessary to preserve physician autonomy.

For the past five years, Kempen has been a leader in investigating and illuminating the ABMS MOC as well as the Federation of State Medical Boards (FSMB) MOL programs. “Regulatory capture” is the economic term he has applied when referring to the use of laws and policies to induce compliance with what he deems regulatory capture is occurring within the practice of medicine, as “special interests co-opt policymakers or political bodies, regulatory agencies in particular, to further their own needs. These agencies have declared themselves as the sole official agents of verification of physician abilities.”

Although MOC has been coined the “gold standard” of specialty board certification by the ABMS, Kempen dissented when summarizing the growing national opposition to MOC, as 17 state medical associations and numerous national specialty societies have voiced the following concerns regarding the process:
- The majority of available data indicates MOC has no impact on patient outcomes,
- The majority of physicians believe the medical knowledge modules and re-certifying exams are onerous and a poor use of their time,
- MOC is costly for physicians, takes valuable time away from their practice, and has become a money-making enterprise for a select few.

Somewhat contradicting this position, the ABMS believes that diplomates demonstrate a commitment to excellence by becoming certified, and MOC helps them build upon their experience by incorporating its six core physician competencies into an evaluation process by which practicing doctors can document their ongoing commitment to excellent patient care.

In his remarks, Kempen continued to argue that the MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment. He further added that MOC activities and measurement should be relevant to the clinical practice, and the process should not be cost-prohibitive or present barriers to patient care.

Past president of SLMMS and a longtime leader of the Hippocrates Society, Arthur Gale, MD, initially introduced Kempen to the audience and credited him with helping to “strip away the curtain and leading medical boards to take action” in response to physician concerns regarding MOC.

Kempen closed the 13th Annual Hippocrates Lecture with a call to action for physicians, urging them to “take a stand, remove the extortion, and support the movement toward lifelong certification.”
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