TELEMEDICINE: Connecting More Patients With Medical Care
Our Commitments to You.

- Highest level of customer service and expert care
- Doctors will always be informed of the patient’s status & progress
- Quick results and happy patients

Don’t let pain or injury get in the way of your patients living their life to the fullest.
Refer now so your patients can FEEL BETTER.

Blue Valley Physical Therapy

Feel Better.
bluevalleypt.com

OVER 400 FIVE STAR GOOGLE REVIEWS
FROM THE EDITOR

03 TELEMEDICINE: NOT NEW ANY MORE?
By Michael O’Dell, MD, MSHA, FAAFP

FROM THE PRESIDENT

04 MANY WAYS TO GET INVOLVED IN KCMS ... JOIN US!
By Betty M. Drees, MD, FACP, FACE, KCMS
President 2020

EDITORIALLY SPEAKING

06 MEDICINE IN THE POST-TRUTH ERA
By Charles W. Van Wy, III, MD, Editor Emeritus, Kansas City Medicine

FEATUER

14 PRIMARY CARE EXAM ROOM: FULL CIRCLE? OR IS IT TIME TO GET RID OF THEM?
By David A. Voren, MD

COMMENTARY

08 MAINTENANCE OF CERTIFICATION PLACES HEAVY BURDEN ON PHYSICIANS
By Christine Park White, MD

10 EASY MOVES TO REDUCE YOUR RISK FOR HEART DISEASE
By Keith Jantz, MD

13 LET’S EXPAND MEDICAID AND SAVE MONEY
By Michael O’Dell, MD, MSHA, FAAFP

NEWS

05 CORONAVIRUS RESOURCE LINKS

11 NEW RESOURCES ADDED TO MISSOURI PRESCRIPTION DRUG MONITORING PROGRAM

12 MEDICAID EXPANSION UPDATE

29 MEDICAL STUDENTS AT NEW KCU CENTER WILL PRACTICE USING HIGH-TECH SIMULATION

TELEMEDICINE

19 TELEMEDICINE: CONNECTING MORE PATIENTS WITH MEDICAL CARE

20 KANSAS CITY-AREA HOSPITALS EXPAND TELEMEDICINE OFFERINGS

22 KU CENTER FOR TELEMEDICINE AND TELEHEALTH SPANS THREE DECADES OF PIONEERING INNOVATION
By Anne Christiansen-Bullers

26 USING TELEMEDICINE TO REACH UNDER-SERVED POPULATIONS IN URBAN AREAS
By Shelley J. Cooper, EdD

The immediacy and liveliness of the conversation reassured me that the human connection persists even with our current use of remote technology.

Telemedicine is not new: there should be little doubt it is effective and desirable patient care. As early as the 1980s, the pediatric cardiology department (especially Dr. Ken Goertz) at KU was using the technology to space out visits from patients in western Kansas. A hub installed at Hays, Kan., permitted patients good access to care for roughly two out of three visits. This setup saved a long trip to Kansas City, a blessing for many families.

During my Navy career, telemedicine saw use in providing expertise to afloat surgeons. Bethesda-based surgeons could assist the usually more junior physicians during difficult surgeries. A program with which I was involved while at the University of Texas Medical Branch studied remote telespsychiatry under a NASA grant. One of my favorite anecdotes from that work was watching a patient and psychiatrist interact remotely. Patients loved this manner of care, and I discovered why. At one point, the psychiatrist pushed a bit too far for patient comfort during the interview. The patient delighted in turning the camera, microphone, and thus the interview, off!

Impeding the use of telemedicine is the lack of a mechanism for funding. Our lack of a market economy in health care has deprived patients and physicians of the use of desirable technology. Third-party payors have shown little appetite for improving access to care. Thirty-plus years later, this seems to be slowly changing.

There is lemonade to be made out of every lemon and every crisis presents opportunity. Our newest epidemic threat, coronavirus, may well be just the push needed to steer us into using telemedicine intelligently. Why expose a waiting room or emergency room full of patients to an infectious illness? Patients wondering about their infectious status could often be advised using our telemedicine technology. “Containment Zones” could be limited to the patient’s home, as opposed to the mile-wide radius recently in place in New Rochelle, N.Y., or the more massive quarantines in place in Italy and China (as this issue of Kansas City Medicine goes to press).

What follows in this issue are stories of how many are succeeding in the use of telemedicine. It has been a long time coming. We also welcome in this issue the introduction of a regular column by our KCMS President Dr. Betty Drees. My colleague Dr. David Voran offers great insights into some innovative ideas for making the exam room more engaging and comfortable for patients … the ultimate outcome of which could even involve the revival of house calls through telemedicine! Enjoy the many accomplishments of your Kansas City area colleagues!

Michael O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at michael.o'dell@tmcmed.org.
My warmest regards to the Kansas City Medical Society (KCMS) members and friends at the start of 2020. I am deeply honored to serve as president of the Society this year, and greatly appreciate Dr. Mark Brady’s leadership as president in 2019. Under his guidance, the Society set priorities in advocacy for health care access, promotion of wellness and development of physician leadership.

The involvement of physicians in organized medicine is essential to the future of our profession. Change is occurring rapidly around us, and if we are not part of the decision-making, the decisions on how we practice will be made for us. The more of us who are involved in organized medicine, the more of an impact we will have on our future.

Since our local medical societies in Missouri and Kansas joined forces two years ago, our KCMS is thriving on many levels. This is due entirely to your involvement in our society and the partnerships we have built in the community. Here are some examples:

- Our KCMS Leadership Council brings together some 40 physician leaders representing hospitals, universities, private practices, state medical societies, medical students and residents. It was formed as an advisory group to enable KCMS to stay close to the concerns of medicine across the greater Kansas City area (Clay, Platte, Jackson, Cass counties in Missouri; Johnson and Wyandotte counties in Kansas). The discussions of the Leadership Council provide direction to the KCMS Board of Directors on strategic priorities, and the members provide a liaison back to physicians across the community. The Leadership Council meets quarterly, and for those on the Council, it is a good pathway into leadership with KCMS.

- The KCMS Foundation is our charitable arm for providing donated specialty care to the uninsured through Wy Jo Care and Metro Care. The Foundation Board this year is chaired by Dr. Stephen Salanski. Hundreds of physicians provide donated care; their generosity helps people access care who would otherwise not be able to get that care due to financial hardship. New physician volunteers are always welcome as the need never ends.

- Our members are actively involved with our partner state medical societies, the Kansas Medical Society (KMS) and the Missouri State Medical Association (MSMA). Dr. Mark Brady, immediate past president of KCMS, is president-elect of KMS and will be installed in September for a two-year term as president. Dr. Art Snow and Dr. Richard Warner from KCMS serve on the KMS Board of Trustees and for many years have represented us as delegates to the American Medical Association (AMA).

In Missouri, there are two MSMA councilors from our region (District 7): myself and Dr. Lancer Gates. We also have one vice-councilor, Dr. Michael O’Dell. Representing us as AMA delegates this year are Dr. Charles Van Way and alternate delegate Dr. O’Dell.

These state meetings are important because the decisions made a) help determine our state legislative agendas, b) set policies for the state associations, and c) submit resolutions to the AMA House of Delegates for consideration.

Just in 2019, medical students from Missouri initiated an MSMA resolution on providing for the health care needs of the children of incarcerated parents. After this was approved by MSMA, it was submitted to the AMA House of Delegates where it achieved passage.

To be part of this policymaking process, I invite you to attend the annual MSMA convention to be held April 3-5, 2020, in St. Louis. KCMS members are encouraged to volunteer to serve as delegates and help set policy at the state and national levels. Find out more at https://www.msma.org/annual-convention.html

- KCMS works with both KMS and MSMA on legislative advocacy. A priority for KCMS this year is increased health care access through Medicaid expansion. KCMS and the Foundation recently provided written testimony to the legislative hearings in Kansas on Medicaid expansion.

---

Many Ways to Get Involved in KCMS ... Join Us!
By Betty M. Drees, MD, FACP, FACE, KCMS President 2020

---

The more of us who are involved in organized medicine, the more of an impact we will have on our future.
• Our members represent KCMS on important issues related to medicine and public health in the community. Members of the KCMS Retired Physicians Organization give health education talks to community groups. Submitting articles for publication in this award-winning journal, Kansas City Medicine, is another rewarding avenue for engagement.

• Hundreds more of you attend and participate in various KCMS activities throughout the year such as social/advocacy events and the annual meeting. Considering the level to which our members are involved across these various programs, this is something of which we can be very proud. But we will only be stronger with even more engagement of our current and new members.

How can you get more involved? Learn more about our KCMS activities via your member email, through our website www.kcmdicine.org, by contacting me at drdrees@kcmedicine.org, or by contacting our membership and events director Emily Whalen at ewhalen@kcmedicine.org.

Betty M. Drees, MD, FACP, FACE, is dean emerita of the School of Medicine at the University of Missouri-Kansas City and president of the Graduate School of the Stowers Institute for Medical Research. She can be reached at bdrees@kcmdicine.org.

Stephen L. Reintjes, Sr., MD, Appointed CEO at North Kansas City Hospital

Stephen L. Reintjes, Sr., MD, has been appointed president and CEO of North Kansas City Hospital and its physician network subsidiary, Meritas Health. He will assume the CEO role in early April, succeeding Peggy Schmitt who is retiring.

A KCMS past president, Dr. Reintjes is a neurosurgeon and shares a practice with his son, Stephen L. Reintjes, Jr., MD. He has been a respected and engaged member of the North Kansas City Hospital medical staff for 30 years. Dr. Reintjes has held numerous executive leadership positions at the hospital, including director of spine surgery and medical staff president.

North Kansas City Hospital is a longtime KCMS partner and supporter of the KCMS Foundation charitable care programs, Wy Jo Care and Metro Care.

Dr. Reintjes is a graduate of Rockhurst High School, Georgetown University and the University of Kansas School of Medicine, earning his undergraduate and graduate degrees in philosophy and medicine. He completed his residency in neurosurgery at the KU School of Medicine.

He currently serves as a Board member for BioNexus KC and Midwest Transplant Network.

“I am honored to have been selected as North Kansas City Hospital’s next CEO,” Dr. Reintjes said. “We are an organization led by a purpose—to provide hope and healing to every life we touch. I will do my best to serve our patients and help our employees and physicians fulfill their passion to make a difference.”

Coronavirus Resources

FOR THE LATEST UPDATES ON THE NOVEL CORONAVIRUS (COVID-19), CHECK THESE LOCAL AND NATIONAL WEBSITES REGULARLY:

Centers for Disease Control and Prevention Information for Health Care Professionals

American Medical Association Physician Resources

Kansas Department of Health and Environment
www.kdheks.gov/coronavirus

Missouri Department of Health and Senior Services

Kansas City, Mo. Health Department
www.kcmo.gov/city-hall/departments/health/coronavirus

Johnson County Health Department
www.jocogov.org/dept/health-and-environment/resources/resouce-information
Medicine in the Post-Truth Era
By Charles W. Van Way, III, MD, Editor Emeritus, Kansas City Medicine

“Everyone is entitled to his own opinion, but not to his own facts.”
~ Daniel Patrick Moynihan

We have come to the Post-Truth Era. Yes, truth has become optional. An artistic conceit, if you will. In art, architecture and literature, Modernists were succeeded by Postmodernists. Now in public discourse, Truth has been succeeded by Post-Truth. To be precise, we are in a state of philosophical uncertainty concerning truth. Objective truth has been the standard for several hundred years. Now, subjective truth is viewed as equally or perhaps more valid. Facts have been replaced by narratives which are much more appealing than boring old objectivity. The quotation above from Daniel Patrick Moynihan seems almost quaint. Today, everyone has his or her own facts and will argue passionately that those facts are correct.

This is not entirely new. George Orwell, in his 1949 novel 1984, described the manipulation of truth to serve other purposes. His Animal Farm (1945) dealt with much the same issue. Further back, newspapers of the 18th and 19th centuries made little pretense of objectivity. The “pamphlet” wars of the 17th and 18th centuries were a major part of politics, with each side printing “facts” to support their point of view. Indeed, a pamphlet by Thomas Paine, Common Sense, strongly promoted the American Revolution.

When did this start? The expression “post-truth” was the Word of the Year of the Oxford Dictionary in 2016. According to the Oxford, the playwright Steve Tesich first used “post-truth era” in an essay in The Nation in 1992. In 2004, Ralph Keys published a book on the subject, The Post-Truth Era: Dishonesty and Deception in Contemporary Life. The book described it as the ascendency of emotional appeals and narratives over facts. Others have called this “post-reality” and “new reality.” The prototype is the public figure who “stays with the narrative” when answering questions, even unrelated questions. Politicians and journalists of all sides accuse their opponents of post-truth tactics and refuse to admit that they themselves are any different. Perhaps most disturbing, university education is incorporating narratives, rather than encouraging debate. Universities are becoming increasingly hostile to facts and opinions which contradict any one of several prevailing orthodoxies.

So, what about Medicine? We as physicians feel that we are inheritors of a long tradition of reliance on objective findings and scientific studies. And yet, we are still a part of our time and culture. For example, the legalization of “medical marijuana” is based almost entirely on emotion and narrative. Even the concept of “medical” use of marijuana is largely a narrative, since marijuana cannot be precisely dosed or prescribed. Some physicians support this movement. All of us are affected by it. The anti-vaccine movement is based on a cluster of emotional narratives, yet it affects our patients and ourselves as practitioners.

The increasing scope and variety of information available to the general public affects us in a number of ways. For one thing, it raises expectations. For another, it encourages us to be increasingly open with our patients. As individuals, they may be swayed by post-truth political appeals. But as patients, they still respect the objectivity of medical practice. Patients want to hear scientific evidence, not a good narrative. For now, at least.

The post-truth era impacts most strongly on us when we intersect with the political process, often in public health. As noted, marijuana legalization is a good example. What about the health care system itself? We will very likely see more legislative attempts to regulate the health care system over the coming years. Politicians really want to tinker with the system, usually in the service of ideology. Unhappily, their desires to change the system are inversely proportional to their knowledge and abilities. The highly emotional appeal of “Medicare for All” is a current example. We all remember the debate over the Affordable Care Act. Actually, we don’t need to remember it. It’s still going on.

That debate has little to do with objective data. It’s almost entirely based on emotion and narrative.

It can be hard to resist the appeals of emotional or narrative reasoning. To take yet another example, it is objectively clear that cigarette smoking is harmful. Therefore, efforts toward smoking cessation are good. Then, what about vaping? Is vaping sufficiently harmful that it should be condemned as leading children to lifelong nicotine addiction and lung disease? Should it be tolerated as a valid way of smoking cessation for adults? These are competing
narratives. Most of the vaping debate is based on narrative rather than data.

What about our internal discussions and debates? Importantly, what about medical education? I’m actually optimistic about this. As our politicians descend towards post-truth, we have managed to keep our heads above water. Narratives based on emotion generally don’t get very far. As just noted, they come in through public health policies and the political process. We still teach our students that evidence is all-important, and that data is central to all of our decision-making.

There are exceptions. Take obesity. Please. We are all familiar with the “obesity epidemic.” But we have defined obesity downward, to the point that “normal” weight may actually be harmful. In a 2016 paper, Kathleen Fleischer and her colleagues at the CDC reviewed some 80 papers on the effect of obesity on mortality. Their meta-analysis showed that the lowest risk of all-cause mortality was found in the group of patients who were classed as “overweight,” that is, BMI between 25 and 30. Patients with grade 1 obesity (BMI 30-35) actually had the same mortality risk as “normal” patients (BMI 18.5-25).

Have we changed our standards? Well, no. There was a brief flurry of editorials. The CDC website still has 18.5-25 as normal and 30-35 as obese, with the admonition that normal is best. Obesity is a real public health problem, but it shouldn’t be imperious to data.

To conclude: We live in a difficult time for objectivity. Data is easier to obtain than ever before. However, people have always been reluctant to accept facts which contradict their strongly held opinions. In our post-truth era, many people think that facts should be subordinated to narrative and emotional appeals. Medical science in general has maintained a focus on objectivity. But intersections between medicine and politics and between medicine and public health have been affected. Medical education is still intact. Yet, students coming into the system have been increasingly indoctrinated by an educational system which often regards facts as optional. It’s not clear just how far post-truth will carry us. It’s likely going to be a rough trip.
The United States is facing a crisis in health care. By the year 2020 there will be a shortfall of 46,000 to 91,000 physicians. Of this number, 12,500 to 31,000 will be primary care physicians. Kansas and Missouri are no different. Two-thirds of our counties are already medically underserved.

To limit this shortage, we should be looking at ways to retain the physicians we have. We should fix the issues that are pushing physicians to work less hours, or go into administrative jobs, or retire from medicine completely. I think most of us would agree these issues revolve around low value hoops we must jump through or comply with that take up what little time we have. These include electronic medical records, ICD-10, Physician Quality Reporting System, Meaningful Use, Value-Based Payment Modifier, MACRA, Maintenance of Certification, and fighting insurers for reimbursement or approval for a necessary patient test or medication.

Many of these time drags were created by bureaucrats to be sure physicians are practicing good medicine. But one was actually created by our fellow physicians. The American Board of Medical Specialties (ABMS) was created in 1933 by physicians and originally entrusted with administering board certification exams to new physicians after residency. About 80% of U.S. physicians are “Board Certified.” Only 12 states in the U.S. require a physician to be board certified to obtain a license to practice medicine.

For many years, once a physician was board certified, they were certified for life. They would continue to expand their knowledge through reading, meetings, interaction with colleagues and CME. Starting in the early 1990s, the ABMS started pushing the idea of Maintenance of Certification, arguing that physicians certified after 1990 should take a test every 10 years to reassure the public that they still knew their stuff.

Over the last 10 years, MOC has morphed into a multi-headed dragon. Now we take a test every five years. Often this test must be taken at a designated center over the course of a day. Physicians often drive hours to get to the center. They are “wanded” with a metal detector to be sure they aren’t hiding prohibited electronic devices. Sometimes their palms will be scanned with a palm vein recognition scanner to create a digital template of their veins. They may have to turn their pockets inside out before entering the testing room and roll up their sleeves to prove they aren’t hiding contraband.

At some point, the joy of caring for our patients is blotted out by the overwhelming load of non-medical things that some third party, non-physician, insurer or government worker decided was good for patients.

For many years, once a physician was board certified, they were certified for life. They would continue to expand their knowledge through reading, meetings, interaction with colleagues and CME. Starting in the early 1990s, the ABMS started pushing the idea of Maintenance of Certification, arguing that physicians certified after 1990 should take a test every 10 years to reassure the public that they still knew their stuff.

Over the last 10 years, MOC has morphed into a multi-headed dragon. Now we take a test every five years. Often this test must be taken at a designated center over the course of a day. Physicians often drive hours to get to the center. They are “wanded” with a metal detector to be sure they aren’t hiding prohibited electronic devices. Sometimes their palms will be scanned with a palm vein recognition scanner to create a digital template of their veins. They may have to turn their pockets inside out before entering the testing room and roll up their sleeves to prove they aren’t hiding contraband.

In addition to the written test with heavier security than that needed to board a plane, we must do multiple practice improvement modules, quality improvement modules and self-assessment activities to satisfy the Boards. An article from the *Annals of Internal Medicine* estimated that it would cost a general internist over $16,000 and 180 hours of time to maintain certification every time they had to recertify. That is $5.7 billion in costs and 32.7 million physician-hours spent on MOC over a five-year period for internists that participate in MOC. Could that time have been used to care for patients, or perhaps, GASP!, for the physician themselves through sleep, exercise, time with family, time doing something they love that brings them joy?

Even though MOC is touted as a voluntary program by the ABMS and its 24-member boards, it is anything but voluntary. With cunning lobbying of government, insurers, hospital associations, the Federation of State Medical Boards and our own specialty boards, the ABMS and its partners are quietly pushing their agenda to make MOC a requirement to practice medicine.
in the U.S. Many hospitals require MOC to be on staff. Many insurers require MOC for reimbursement for services provided to patients. ABMS and the Federation of State Medical Boards are pushing to establish MOC as a requirement for medical licensure in each state.

There are NO good studies that show MOC produces better outcomes for patients. It does, however, produce large sums of money for the Boards and the physicians that run the Boards. In 2012 the American Board of Pediatrics had total revenues over $27,500,000. The president of the American Board of Pediatrics, a pediatrician named James Stockman, III, MD, earned over $1,300,000 for a 50-hour work week. When my 11-year-old heard this statistic, she remarked, “Mama, you need to get a new job!” In 2012, the American Board of Internal Medicine took in $55,000,000 in revenues and their president, Christine Cassell, MD, received $950,000 for a 35-hour work week.

At some point, physicians will say “Enough!” At some point, they will retire, many before they would have liked to or planned to. At some point, the joy of caring for our patients is blotted out by the overwhelming load of non-medical things that some third party, non-physician, insurer or government worker decided was good for patients. There comes a point where even the caregivers, most of whom went to med school to help others, realize that if they keep going on the path before them, their health, their marriage, their children will suffer. When these physicians retire, patients suffer. For every physician who retires, approximately 2,300 patients lose their doctor.

What needs to be done? Some states have enacted laws that prevent hospitals, insurers, employers and state medical boards from requiring MOC for staff privileges, payment, employment and licensure. This is a good start. But until every state does it and everyone complies with it, physicians must continue to waste their time and money on an unproven product. In many states when physician groups worked with legislators to bring these bills to their state legislatures, they were defeated by the deep pockets of the ABMS that sent people and money to combat the bills. (Editor’s Note: Legislation prohibiting hospitals and insurance carriers from requiring MOC has been introduced in the 2020 Missouri Legislature session as SB 891 and SB 933.)

Currently there are four lawsuits that have been brought against different subspecialty Boards claiming fraud and other illegal actions by the Boards. I think this is currently our best hope for fighting the Boards. If the Boards can be found guilty of criminal activities in a state or federal court, that will be the onset of their demise. I encourage every physician to donate money to this cause. The group, Practicing Physicians of America, is spearheading the biggest lawsuit against the American Board of Internal Medicine. Please go to this website to start learning more and consider donating to the cause. https://practicingphysician.org/moc/#cta-1

Christine Park White, MD, is a pediatrician with Johnson County Pediatrics. She is a former KCMS board member and a KCMS “Rising Star Award” winner. She can be reached at christineparkwhite@outlook.com.

REFERENCES
Easy Moves to Reduce Your Risk for Heart Disease

By Keith Jantz, MD

We all hear about lowering the risk for heart attacks by controlling factors like hypertension, diabetes, high cholesterol and tobacco use. But other minor changes in one’s lifestyle can lower the risk for heart disease and add to one’s longevity.

Studies now reveal that a sedentary lifestyle, where no real physical exercise is performed on a daily basis, may increase the risk for heart disease almost as much as smoking a pack of cigarettes daily. People demonstrate great creativity in their excuses for not exercising, such as being too busy, not enough time in the day with work and kids, too tired after a long day at work, arthritis or other musculoskeletal ailments, inclement weather in winter, etc.

But the solution here is easier than most people realize. Several studies reveal that walking for 30 minutes nonstop on a daily basis reduces one’s risk for heart attack by 20% in their lifetime. This 20% is a huge number in the cardiac prevention scheme of things—more significant than the benefit provided by some prescriptions your doctor may recommend.

Added benefits here include the fact that it costs nothing to take a walk, and there are essentially no side effects to be concerned about like what may occur with medications. Plus, only 30 minutes of your day is required. Unlike the two-plus hours it takes for working out in a gym that requires changing clothes, driving there and back, and changing clothes again after a shower, a simple walking program from your front door only requires 30 minutes out of your busy day.

To reap the cardiac benefits of a walking program, several aspects of how you exercise are critical for the process to be effective:

• The walk must be nonstop and at a brisk pace, so no walking the dog or stopping to chat with neighbors.
• While 30 minutes daily is preferable, you should aim for a total of three and a half hours per week, making up any missed time for skipped walks or shorter walks by adding an extended walk later in the week. Sometimes busy weekdays prevent getting the full walk in, but that time can be made up with a longer walk on weekends.
• Wear good quality walking or jogging shoes. Walk indoors in a gym or mall when the sidewalks are icy, but don’t use inclement weather as an excuse that will reduce your total weekly walking time. Consider this idea for yourself and your patients.

It’s easy, safe, cheap, healthy, and it works! Happy walking!

Keith Jantz, MD, is chair of the Retired Physicians Organization of the Kansas City Medical Society and a member of the KCMS Wellness and Prevention Committee. He practiced for 32 years with Kansas City Internal Medicine and was president for six years. He served on the board of the American Heart Association Midwest Affiliate from 2010 to 2015. He can be reached at keith.jantz71414@gmail.com.
New Resources Added to Missouri Prescription Drug Monitoring Program

Two important enhancements have been announced for the Prescription Drug Monitoring Program (PDMP) that covers much of Missouri including Jackson, Clay and Cass counties. The program is operated by the St. Louis County Department of Public Health.

Prescribing Summaries will now be sent quarterly to providers in the Missouri jurisdictions covered by the PDMP. The Prescribing Summary breaks down the provider’s prescribing activity and compares it to one’s peers. Summaries are meant to help providers assess their own practice and will not be shared with employers or the public. Any physician, dentist, optometrist or podiatrist who practices in a participating PDMP jurisdiction and has written at least 15 prescriptions for controlled substances in the last quarter will receive a Prescribing Summary. Providers with PDMP accounts will receive their summary online within the PDMP; summaries will be mailed to providers without PDMP accounts.

Opioid Prescribing and Pain Management Toolbox is a new centralized opioid resource for providers who are prescribing opioids and/or treating patients with pain. The Toolbox contains information across six key areas of opioid management: 1) building a supportive patient-provider relationship, 2) screening and assessment, 3) safer prescribing, 4) harm reduction, 5) treatment across health care settings, and 6) training and educational opportunities. Each section highlights evidence-based practices and guidelines to help health care providers deliver compassionate, clinically appropriate pain management and opioid use disorder treatment. The Toolbox can be found at stlouisco.com/opioids.

The St. Louis County Prescription Drug Monitoring Program was launched in 2017 in the absence of a statewide prescription drug monitoring program. Currently, 75 city and county jurisdictions participate in the PDMP, representing 85% of the state population and 94% of health care providers. Besides St. Louis and Kansas City, other larger Missouri communities represented in the program include Cape Girardeau, Columbia, Jefferson City, Joplin, Springfield, and St. Joseph. Kansas already has a full statewide PDMP.

Missouri is the only state without a prescription drug monitoring program; legislation again has been introduced this year in both houses of the Missouri General Assembly.

To learn more about the PDMP, including the coverage map, visit stlouisco.com/PDMP.
The Kansas City Medical Society and the Kansas City Medical Society Foundation strongly urge the states of Missouri and Kansas to expand Medicaid to improve access to care for hundreds of thousands of uninsured individuals, bring millions of dollars of needed funding to our states, and strengthen our health care system. Here is a summary of the reasons to expand Medicaid:

**FOR OUR PATIENTS**
- **Access:** Provide access to needed health care for over 400,000 uninsured Kansans and Missourians.
- **Prevention:** Enable individuals to address conditions before they become more serious and require more extensive and expensive treatment. Reduce pressure on emergency departments as last resource for treatment.

**FOR OUR COMMUNITY**
- **New funds and jobs:** Bring Kansas and Missouri taxpayers’ money back from Washington to invest in local workers and local communities instead of sending it to other states.
- **Working families:** Prevent workers from missing time off from work by treating conditions sooner.
- **Rural health care:** Shore up the finances of rural hospitals and prevent further closures—11 Kansas rural hospitals and 10 Missouri rural hospitals have closed since 2010.

**LEGISLATIVE SITUATION - KANSAS**
A bipartisan compromise plan for Medicaid expansion was announced on January 9 by Gov. Laura Kelly and Senate Majority Leader Jim Denning. Hearings on the bill (SB 252) were held in late January in the Senate Health and Public Welfare Committee. However, the measure was voted down by the committee on Feb. 20; the proposal is stalled as part of a larger debate on legislation to present a constitutional amendment limiting abortion. If you live or practice in Kansas, you are advised to continue contacting your state senator where you live and/or practice to express your support.

**PETITION PROGRESS - MISSOURI**
Healthcare for Missouri, the organization promoting expansion in Missouri, announced in mid-February that it has collected 75% of the 172,000 signatures needed to place Medicaid expansion on the November 2020 ballot.

On February 11, three prominent Kansas City civic organizations announced their support Healthcare for Missouri’s Medicaid expansion ballot initiative: the Kansas City Chamber of Commerce, the Civic Council of Greater Kansas City and the United Way of Greater Kansas City.

**KCMS FOUNDATION RECEIVES ADVOCACY GRANT**
The Health Forward Foundation has awarded the Kansas City Medical Society Foundation a grant under its 2020 Policy and Civic Engagement program. The funding will be used during 2020 to conduct education and advocacy activities toward increasing health care access for uninsured people in Kansas and Missouri. We will be working to elevate the physician voice to advance health care access in both states.

**CONTINUED UPDATES**
For continued updates on the progress of expansion, and any calls for action, monitor the KCMS Facebook page and Twitter feed, as well as the KCMS website Medicaid expansion section at kcmedicine.org/foundation/medicaid-expansion. Also check out:
- **Alliance for a Healthy Kansas**
  www.expandkancare.com
- **Healthcare for Missouri**
  www.healthcareformissouri.org
Let’s Expand Medicaid and Save Money
By Michael O’Dell, MD, MSHA, FAAFP

Editor’s Note: The following is excerpted from a commentary by Dr. O’Dell in the February 6 Kansas City Star. A KCMS past president and editor of Kansas City Medicine, Dr. O’Dell is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City.

As a family care doctor, I’ve seen firsthand how hardworking Missourians can slip through the cracks of our health care system. In our state, more than half a million adults are uninsured, mostly because they have jobs that simply don’t offer coverage. Earning too little to afford to buy their own insurance, they’re caught in the limbo of this coverage gap.

Hundreds of thousands of Missourians face choices between lifesaving care for their loved ones and themselves or their economic survival.

I’ve seen this happen firsthand. In one case, I treated a 55-year-old truck driver who was beset by escalating diabetes. His condition worsened, and he subsequently lost his commercial driver’s license—a requirement for his job.

It was the start of a 10-year physical and financial spiral. Without that license, my patient lost his employer-provided insurance, so he was unable to afford his daily medicine. Though he had been an active, productive member of society, his condition steadily declined. It eventually led to dialysis, an amputation and frequent hospitalizations. He died at 65.

As it now stands, Medicaid is available only to children, pregnant women, those with disabilities and some seniors in Missouri. Expanding Medicaid to adults earning less than $18,000 a year—or about $30,000 for a family of three—would require the state to provide a 10% match. The federal program covers the remaining 90%.

While some politicians compare this to a tax increase, a look beyond the rhetoric suggests the exact opposite. Researchers at the Center for Health Economics and Policy at Washington University in St. Louis found that in a best-case scenario, Medicaid expansion could save Missouri as much as $39 million in its first year. By fiscal year 2026, the annual savings from Medicaid expansion in Missouri would top $1 billion, the researchers found, thanks to a shift that would essentially bring more of our federal tax dollars home from Washington.

All of us pay taxes, and we’d like to see those tax dollars put to good use, as they are in other states. Right now, Missouri is losing out. Our tax dollars are sitting in Washington, D.C. As a state, we can’t afford that kind of loss of revenue.

Medicaid expansion is also vital to protect health care for our state’s rural residents. Since 2014, 10 rural hospitals in Missouri have closed—most recently, Pinnacle Regional Hospital in Boonville in January. Its Overland Park owner also operates a hospital by the same name in Johnson County.

For years, our political leaders here have resisted the opportunity to expand Medicaid, even as 36 other states have moved to expand this safety net. That includes neighboring Arkansas, Illinois, Iowa, Kentucky and Nebraska. In Oklahoma, a 2020 Medicaid expansion ballot initiative is also on track.

A proposed statewide ballot initiative in November would give Missouri voters the opportunity to do what our elected officials in Jefferson City will not.

Healthcare for Missouri—the group of doctors, nurses, patients, hospitals, business owners and everyday Missourians behind the campaign—says it has already collected more than 75% of the 172,000 voter signatures required to put the measure on the 2020 general election ballot. I’m proud to be among those supporters, and I hope you’ll join me.
Primary Care Exam Room: Full Circle? Or Is it Time to Get Rid of Them?

THE SEARCH FOR AN EXAM ROOM DESIGN THAT IS MORE COMFORTABLE AND ENGAGING FOR PATIENTS

By David A. Voran, MD

Abstract. Physician exam rooms have varied considerably over time and country. Before the turn of the 20th century, physicians would see their patients most often in the patient’s home. Alternatively, patients would be welcomed in the physician’s home that might contain an exam table in addition to the usual desks, chairs, degrees and photos on the wall. These offices were often the front room or parlor of their homes. Over time the exam rooms were separated from the doctor’s office, morphed into small, sterile cubicles strictly devoted to short hands-on physical exams suited to high-volume, fee-for-service reimbursements predicated on face-to-face encounters and acute conditions. Recent value-based reimbursement systems incorporating patient satisfaction, coupled with advances in technology and physician burnout, all question the value of the traditional clinic exam rooms. This paper discusses and suggests alternative designs that may dramatically alter the look, feel and even the need for exam rooms in the near future.

EXAM ROOM HISTORY

Most medical care in the U.S. is provided in ambulatory, not inpatient settings, where an estimated 883.7 million visits take place in physicians’ offices. For long periods in the history of medicine, physicians met and examined patients in the patients’ own homes. Most of us are familiar with Dr. Arthur Hertzler’s The Horse and Buggy Doctor filled with anecdotes of long horse trips he made, often as long as a day, to treat a patient. House calls were the principal ways physicians practiced medicine. Doctors also devoted a parlor room in which to see patients, often furnished comfortably with pictures and mementos displayed in addition to the physician’s desk and reference material. Sometimes they also had an exam table with or without an adjacent waiting room. As infectious disease knowledge dictated, exam rooms totally separated from the doctor’s office became the norm. These separate exam rooms were much easier to clean and maintain.

The current sterile, cramped exam rooms are not inspiring in the least and do not lend themselves to the type of service needed to engage the patients.

There have always been problems with physician exam rooms. In the 1930s, patients complained about having to be examined in front of other patients. More recently, patients complain of being left in small exam rooms and being cramped in them when accompanied by family members or other care providers. Physicians themselves do not enjoy being in a windowless exam room all day and unconsciously try to minimize time spent. A contrast can be made by comparing medical office visits with those when meeting bankers, attorneys or financial accountants. Rarely, if ever, do those meetings occur in 10 x 11 rooms devoid of windows; nor are clients left alone for periods of time. Most often, the meetings are held in plushly furnished personal offices and/or conference rooms where a great deal of time is spent on education and joint decision making. Interestingly, much of the conversation attention is jointly directed to the customer’s financial results, opportunities and future goals prominently and interactively displayed on monitors so everyone can participate in the information.

THE CURRENT STATE

Over the last three decades the landscape is slowly changing along with a decline in independent, solo and small practices as hospitals and large multispecialty group practices acquired doctors’ offices. This opened the door for capital expenditures that were not
available for small clinics. This led to a whole industry where architectural design technology was applied to hospital-owned clinics. A lot of the impetus focused on increasing productivity and throughput in clinics, design, psychology and a host of other considerations.

The exam rooms have changed slightly as venues expanded to include retail locations such as pharmacies with CVS MinuteClinics and on-site clinics in larger companies. The types of rooms vary according to the purpose. Retail clinics are usually designed to minimize overhead and retail floor space. CVS MinuteClinic, for example, consists of single-room modules staffed by a nurse practitioner; patients self-check themselves in using a kiosk located outside the exam room entrance.

Despite these developments, most practices are not making fundamental changes to how clinicians see patients, and this has led to decreased satisfaction of the experience by both patients and physicians. It is a very rare patient or physician who will attest to really enjoying the time spent in "clinic." The argument could be made that one of the primary reasons is the very design of most clinical offices.

**EMERGING DESIGNS**

For a variety of reasons, hospitals have acquired physician practices and built new office towers either adjoining or adjacent to their facilities. Architectural design firms have followed this capital specializing in clinic office design. Research in clinic design demonstrated patients associate the quality of medicine based on stimuli such as the appearance of the entrance, lobby and patient rooms. Patients’ rating of quality correlated with the aesthetic appearance of the space. A premium was placed on modern, spacious and well-lit lobbies complete with coffee bars and other accoutrements.

Simultaneously, the reimbursement system is beginning a slow change from volume to value-based systems. In value-based reimbursement systems, the importance of seeing many patients in short encounters is diminished. The ability of a clinician to improve the metrics of a population becomes more important. A large number of these metrics do not require a face-to-face visit. Many of these metrics, especially the performance ones, require inspiring and engaging the patient to make significant lifestyle changes. The current sterile, cramped exam rooms are not inspiring in the least and do not lend themselves to the type of service needed to engage the patients. This effort requires more time and education rather than actual physical examination. Studies have shown patients feel more comfortable discussing their problems when they do not feel cramped. Newer designs allocate more space dedicated to consultation and education areas within exam rooms as practices transition to value-based reimbursement systems.

Sharing data with patients is an important patient engagement and educational part of helping patients (continued)

---

**Figure 1. Cerner’s Original Care Suite Design**
manage their health. Multiple studies have shown the optimum arrangement is where the patient, clinician and computer screen are arranged in a comfortable triangle that supports conversations in an inclusive fashion. This arrangement supports eye contact, communication and monitor-sharing opportunities.

This movement away from exam to consultation areas occurred in other venues, particularly on-site clinics in large corporations, because they need to offer much more than routine health care. I was very fortunate to be closely involved when Cerner Corporation designed their first on-site clinic in 2004. It was very interesting to watch Cliff Illig, one of Cerner’s founders, reject a number of traditional clinic designs offered by architects Gould, Evans, Goodman, but then finally accept a radical departure from the typical 10 x 10 exam room. In this design, each “exam room” consisted of a two-room suite called a Care Suite. This suite contained a comfortable living-room style consultation area contiguous with a spacious exam room, complete with its own bathroom/changing room with a privacy port for specimens. The physician’s office straddled two of these suites where they could conduct non-clinical business (See Figures 1 and 2). The consultation spaces were large enough to accompany families, and every participant could comfortably view the large monitors in the rooms while they engaged in conversations.

While this design is not optimal for high-volume clinics where emphasis is on cramming as many rooms in the smallest square footage as possible to support frequent, short physical exam-dominated encounters, it did meet the needs expressed by Cerner associates where comfort, privacy, convenience and time with clinicians were valued. Like other large corporations with on-site clinics, the clinic was located adjacent to the employee fitness center, on-site day care and Montessori school for associates’ children. This type of room is well suited for the type of visits that will be required as value-based reimbursements increase.

FUTURE THOUGHTS

The last decade has seen an explosion in health care technology available for consumers enabling them to conveniently obtain measurements and clinical tests that in previous decades were only available in clinic or hospital settings. In addition to the large array of point-of-care laboratory tests including genetic testing, consumers can now perform single-lead rhythm strips on their Apple Watches, 6-lead EKGs with a $149 device (Kardia) from AliveCor, which has been shown to be as effective as a 30-day event monitor. Self-measurement of blood pressure is now recognized as enhancing the care of those with hypertension while reducing costs. FitBit and Samsung are expanding the wearable technology to include non-invasive monitoring of oxygen saturation (FitBit) and glucose (Samsung). Under Armour offers Armour 39, a continuous heart rate monitor, and is developing clothing with a variety of workout and health-monitoring sensors woven into the clothing fabric. Toto, Japan’s largest toilet company, has long offered toilets that besides measuring urine volume, also monitor an ever-increasing number of urine biomarkers in addition to blood pressure, body fat and weight.

The last two decades have seen a large increase in direct-to-consumer telemedicine services such as Teledoc and HealthTap, offering nearly instantaneous telemedicine consults. The overwhelming majority of these are direct-pay, low-cost encounters with patients who often never see their consulting physician in person. There are even companies that specialize in coming to patients’ homes such as Heal, Doctors on Call and others.
hospitals are also offering these services, especially for Medicare beneficiaries. At the same time, Amazon has revolutionized the consumer experience by putting the entire consumer world at the customer’s fingertips with its fast delivery services. No longer do any of us need to go anywhere to get anything. Amazon is now moving into health care, first in its Haven Healthcare, a joint venture with JPMorgan and Berkshire Hathaway, led by Dr. Atul Gawande. Its recently released Amazon Care app, currently limited to its employees in Seattle, allows them to get convenient health care using their phones, but it may eventually wind up on a vast number of consumers. Amazon has opened up its Amazon Web Services to health care providers and health care vendors alike, investing in and forming partnerships with them, including Cerner Corporation, Beth Israel Deaconess Medical Center, UPMC and others. Its Alexa is now HIPAA compliant as of last year and is leveraging AI services on top of HealthTap’s large library of physician-provided clinical answers to patients’ questions. It has also purchased PillPack and is working with third-party payers to integrate their pharmacy services into health benefit plans starting with Blue Cross Blue Shield of Massachusetts.

This program, if successful, has the potential to completely disrupt primary health care as we know it in the same way Amazon, Uber, Lyft, Lime and other customer-centric services have not only disrupted existing consumer and transportation industries but are changing the psyche of each one of us.

Insurance companies are taking notice and are developing their own customer-centric services first by acquiring physician practices: Humana’s Partners in Primary Care, Walgreens’ acquisition of VillageMD and Blue Cross Blue Shield’s Spira Care.

It is conceivable that with the implementation of 5G telecommunications and further advancement in wearable technologies, physicians may be on the verge of coming around full circle and seeing many patients in their own homes instead of the office.

Even traditional clinics can now begin breaking free of the “jail cell” exam rooms and leverage these advancements by taking advantage of the annually increasing non-face-to-face CPT codes embedded in CMS’ physician fee schedule. These codes enable practices to profitably interact with their patients away from the offices. In addition to these virtual evaluation and management codes, the education and monitoring of patients who take their own measurements is reimbursable now by CMS for Medicare Beneficiaries, as are an increasing number of other non-face-to-face interactions by physicians.

All of these are going to force changes in how we think about physician offices and the exam room—the time of which may be short.

It is conceivable that with the implementation of 5G telecommunications and further advancements in wearable technologies, physicians may be on the verge of coming around full circle and seeing many patients in their own homes instead of the office. The only difference? They will not have to travel farther than their fingertips to diagnose and treat them. The physician can instantly appear on the patient’s home 4-8K wall TV and interact with them as if they were sitting next to each other. The patient’s wearables would be continuously transmitting more information to the clinician than could possibly be obtained with all of the instruments in current exam rooms. In this near-term future, what purpose is the exam room other than to increase the overhead of the practice? Could it be the exam rooms of the future will be in patients’ homes or in patients’ hands?

David A. Voran, MD, is an associate professor in the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine. He can be reached at david.voran@tmcmd.org.

Author Note: No grant funding. Author has employment history with Cerner Corporation (1997-2006), has been a collaborative physician for CVS MinuteClinics since 2006 and is an occasional HealthTap physician.

REFERENCES

3. Arthur E Hertzler, MD, The Horse and Buggy Doctor, University of Nebraska Press, 1938
Appointed Health Forward Foundation CEO

The Health Forward Foundation has appointed Qiana Thomason as president/CEO effective January 21. She succeeds Bridgett McCandless, MD, who retired.

Thomason joins Health Forward from Blue Cross and Blue Shield of Kansas City, where she most recently was vice president, community health and health equity. During that time, she spearheaded development of new care delivery and payment models in partnership with health care providers throughout Kansas City and has been a champion for the inclusion of health equity and the social determinants of health in corporate strategy. In this capacity, Thomason has appeared on panels at several KCMS events in recent years.

Prior to her tenure at Blue KC, Thomason spent eight years at Swope Health as the director of clinical operations, behavioral health and program manager of the multi-municipality Mental Health Court. She also served as deputy director and health and human services liaison for U.S. Senator Jean Carnahan.

A lifelong Kansas Citian, she currently serves on the City of Kansas City, Mo., Health Commission, is a board trustee for William Jewel College and is a board member of ArtsKC. She received her undergraduate degree from Florida A&M University and has a master of social work degree from the University of Kansas.

The Health Forward Foundation works to provide leadership, advocacy and resources to eliminate barriers and promote quality health for the uninsured and underserved in the Kansas City area. It was formed in 2003 following the purchase by HCA of Health Midwest, which owned a number of community hospitals around Kansas City. Health Forward has been a major supporter of the KCMS Foundation’s charitable care programs, Wy Jo Care and Metro Care ⚫️.
Telemedicine is emerging into the mainstream of health care. The American Hospital Association reports that 76% of U.S. hospitals now utilize telemedicine in some form.1

The use of telemedicine has expanded rapidly over the past decade. The number of claim lines for telemedicine grew by 1,202% from 2012 to 2017, and by 53% just from 2016 to 2017, according to FAIR Health.2 Yet telemedicine continues to represent just a small but growing portion of total medical claim lines, 0.11% in 2017.2

What services does telemedicine encompass? The American Telemedicine Association reports four basic uses:

- **Live videoconferencing** (synchronous)—the delivery of a live, interactive consultation between a physician and a patient. This will be supported by a physician or allied professional at the patient’s site.
- **Store and forward** (asynchronous)—the transmission of diagnostic images, vital signs and/or video clips along with patient data for later review that enables a primary care or allied health professional providing a consultation the ability to render a diagnosis.
- **Remote patient monitoring** (RPM)—including home telehealth, uses devices to remotely collect and send data to a home health agency or a remote facility for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound consumers.
- **Mobile health** (mHealth)—Consumer medical and health information includes the use of the internet and wireless devices for consumers to obtain specialized health information and online discussion groups to provide peer-to-peer support.1

Telemedicine is more appealing to millennials than older generations. A 2017 national survey by the Employee Benefit Research Institute found that 40% of millennials regard telemedicine as an extremely or very important option in their health benefits program, compared with 27% among Gen Xers and 19% among baby boomers.3

Kansas and Missouri have had statewide telemedicine programs since the 1990s, operated by the University of Kansas and the University of Missouri. As an adjunct to the telemedicine programs, the universities also use their networks for extensive professional education. Learn more about the current work of the KU Center for Telemedicine and Telehealth in the article on page 22.

Missouri and Kansas are among the 32 states and the District of Columbia that have parity laws requiring private insurers to cover telehealth the same as in-person services. Missouri’s parity law has been in existence since 2013 and was expanded in 2016. Kansas passed its parity law in 2018.

Telemedicine services have become an important part of the mix for several local Kansas City hospitals (next page). While telemedicine often has been thought of as primarily for rural areas, it also has tremendous advantages for reaching underserved populations in urban areas, who often lack access to health care due to transportation and other social determinants of health. One Kansas City entrepreneur is working to change that (page 26). ☞ (references cont’d on pg. 25)
Kansas City-Area Hospitals Expand Telemedicine Offerings

RANGE FROM VIDEO VISITS AT REGIONAL SITES TO APP FOR PATIENTS TO USE ANYWHERE

By Jim Braibish, Kansas City Medicine

Telemedicine is becoming more common at hospitals around Kansas City.

CHILDREN'S MERCY

As a specialty care provider serving a multi-state region, Children’s Mercy is an ideal candidate for telemedicine.

“Our primary use of telemedicine is to improve regional access to our highly sought after sub-specialists,” said Morgan Waller, MBA, BA Psych, BSN, RN, director of business and operations for telemedicine at Children’s Mercy.

Instead of traveling to Kansas City, patients have the option of seeing a Children’s Mercy doctor remotely from tele-specialty clinics in St. Joseph, Mo.; Joplin, Mo.; Wichita, Kan.; and Junction City, Kan. Patients simply request a telemedicine visit at the desired location when scheduling the appointment. Patients can see up to 30 different types of pediatric specialists.

“The tele-specialty clinics have trained BSN RN tele-facilitators who ensure that both the patient/family and provider have a quality experience,” Waller said. Besides assisting with the exam itself, the facilitator makes sure the audio and visual logistics of the videoconference are working. Exam rooms are equipped with a general exam camera plus a digital dermascope, otoscope, ophthalmoscopy and stethoscope.

“Due to the training of the tele-facilitators, the exceptional audio-visual technology and digital exam devices, our providers can deliver the same standard of care up to the highest level of patient encounter,” Waller said.

Telemedicine usage is booming, nearly doubling from 2,341 to 4,205 in the years ended June 30, 2018, and 2019. The program just began in 2012. Some 250 of the hospital’s physicians are trained and credentialed in telemedicine.

Other uses of telemedicine at Children’s Mercy include:
• Direct to Patient telemedicine platform for acute minor medical conditions available between 5 and 10 p.m. 365 days a year, giving families an alternative to urgent or emergency care
• Neonatologists available for consultation by several hospitals in the region when a preterm infant is born and needs stabilization before being transported to a neonatal intensive care unit
• As part of the hospital’s plan in the event of a local disaster, a mobile telemedicine unit that can bring any type of expert provider to the scene via telemedicine technology

Telemedicine today offers many benefits, Waller noted. These include "improved access to specialty care,"
Improved access to the right care at the right time in the right location, improved distribution of resources, and less unproductive time such as driving location-to-location. For patients and families, there are fewer burdens in travel and waiting time.

Looking ahead, she concluded, “I see the future of telemedicine as simply health care. It will be ubiquitous.”

HCA MIDWEST HEALTH
Through its network of Kansas City hospitals, led by Research Medical Center in telemedicine, HCA Midwest Health provides telemedicine services to more than 20 communities outside of the immediate metro area. Services range from neurology and stroke care, to psychiatry, to cardiology, and as of just last month, Maternal Fetal Medicine in outreach areas. More than 65 HCA Midwest Health providers performed more than 10,000 telemedicine encounters in 2019, according to Angie Lucchi, vice president of outreach and telehealth.

“This gives patients in these rural areas close-by access to medical specialists and allows them to remain and receive treatment in their local communities for longer,” she said. “Telemedicine also provides rural hospitals 24-hour access to specialized expertise, which improves the immediate care their patients get and helps keep costs lower for everyone by not having to transfer.”

HCA Midwest also offers a virtual visit where patients can consult with a health professional via video from their computer or mobile device. Patients must first register for an account on the MyHealthOne portal. The service is for routine conditions such as fever, flu, skin problems and more.

 Added Steven P. Marso, MD, chief medical officer and telemedicine cardiologist for HCA Midwest Health Cardiovascular Services, “Through the power of telemedicine, quick access to care is available no matter where a patient or physician is located. Telehealth has allowed us to provide more efficient and expedient care and connects specialists to the communities where they are needed most. The result has been improved outcomes and saved lives.”

SAINT LUKE’S HEALTH SYSTEM
Through its Saint Luke’s 24/7 mobile application, patients can access a physician directly from their smartphone or computer for non-emergency needs.

To use the service, the patient should first set up an account. Once an account is established, the patient can view provider profiles, schedule an appointment and complete the medical history profile. The patient can then be connected with a provider who can diagnose, recommend treatment and prescribe medicine in real time. Typical conditions treated include allergies, cough, diarrhea, fever, flu, insect bites and more.

~ Angie Lucchi, HCA Midwest Health
Not long after he became a faculty member at the University of Kansas Medical Center, Gary Doolittle, MD, jumped into the world of telemedicine.

It was the late 1990s, before the internet was commonly used, when “tele” referred to telephone and television and not much else. But KU Med needed a new oncologist for an existing program with Hays Medical Center, and Dr. Doolittle stepped forward.

“Telemedicine was really just beginning,” Dr. Doolittle said. “And frankly, Kansas was already way ahead of the curve when it came to harnessing the technology for patient care.”

Still, Dr. Doolittle insisted on flying out to Hays twice a month to see his patients face-to-face. To him, it seemed important to physically cross that 265 miles of distance between them.

“I was afraid that I wouldn’t be able to assess patients very well over the telemedicine equipment,” Dr. Doolittle said. “But it really didn’t take long to get very accustomed to using the technology, and honestly, within a couple of months, I was pretty confident that we could assess and practice good medicine—great oncology care—and still use the technology.”

Dr. Doolittle, professor of medicine, was an early clinician and proponent for the Center for Telemedicine & Telehealth at KU Medical Center (KUCTT), which has facilitated more than 100,000 clinical consultations and educational events since 1991.

KUCTT has leveraged its history as an early pioneer of telemedicine to become a recognized world leader in telehealth services and research. It maintains more than 100 sites throughout Kansas.

KUCTT has leveraged its history as an early pioneer of telemedicine to become a recognized world leader in telehealth services and research. It maintains more than 100 sites throughout Kansas.

Ryan Spaulding, PhD, is vice chancellor for the Institute for Community Engagement at KU Medical Center and former director for the KUCTT. He said a pediatrician from Hays, Kan., was the impetus for what would become KUCTT.

The pediatrician had read how soldiers fighting in the Gulf War were being treated from a distance using technology and wondered, “Why can’t we do that in Kansas?”

So, even before it was possible using the internet, the University of Kansas Medical Center connected with Hays Medical Center.

“We had to use really expensive, large telephone lines, which would conduct the video,” Spaulding said. On either end were large television sets and bulky video equipment, which were also expensive.

For those without much memory of the 20th century, it seems almost inconceivable that a camera and connection weren’t as ubiquitous as the modern-day cell phone. But telehealth needed infrastructure and funding in those days. It also needed success stories to show that such an investment would be worth it.

The first patients to benefit from KU Medical Center’s fledging program were babies with heart issues at Hays Medical Center.

“The pediatrician in Hays could get advice from the pediatric cardiologist here and decide whether a transfer was needed, or whether medications would treat the condition, or if some other intervention was needed,” Spaulding said. “After that, telemedicine slowly grew to other hospitals, to mental health facilities and to clinics.”
When KU Medical Center separated from The University of Kansas Health System 20+ years ago, the telemedicine services stayed with the university, though some of the physicians and psychologists also continue to practice in the health system.

“[It is] part of our mission to the state,” Spaulding said. “We think it’s important that these services reach those who need them. Reimbursement remains an issue, but it’s always been an issue for us to work through.”

### SERVICE TO SCHOOLS

In 1998, KUCTT expanded its reach to include students in the Kansas City, Kan., school district. The TeleKidcare program connected school nurses with the medical resources they needed to better assess and care for students who came into their offices.

“The point was not to take the place of the school nurse,” Spaulding said. “[It is] an adjunct or supplementary service for the things a school nurse may not be able to manage.”

As part of the program, nurses’ offices were supplied with otoscopes, stethoscopes and strep test kits. If a strep test came back positive and a prescription was needed, or if another condition necessitated a doctor, school nurses could use TeleKidcare to connect to a pediatrician.

Using the technology, the pediatrician could talk to both the student and the nurse to devise a treatment plan.

In the Kansas City, Kan., school district, where more than 80% of students are eligible for free or reduced-price lunches, TeleKidcare is a resource for the underserved. The program continues today, and it has since expanded to schools in rural Kansas, Spaulding said.

### SLOW TO CONNECT TO INTERNET

Surprising, perhaps, is the fact that KUCCT was slow to transition to an internet connection. In the 1990s, when the world wide web was still shiny with newness, KUCCT’s telemedicine and telehealth stayed away.

It was still the wild west, Spaulding said, in terms of safety of information. “There were concerns about security. We were really concerned about the video being intercepted or seen by somebody else who shouldn’t be seeing it,” Spaulding said. “There that was kind of a general concern, even among internet proponents at the time, that video could be intercepted.”

Keeping patient information secure was a challenge, but so was the bandwidth that video needed to travel through the internet. Video took so much data, and many hospitals and clinics didn’t have enough bandwidth to make it work.

“That really could be a barrier to having a good telemedicine visit. So those were kind of the downsides,” Spaulding said. “Those problems have been resolved, and security on the internet now is excellent, especially with encryption and other security measures. What it does is really open up where telemedicine can be done.”

### REACHING BEYOND BARRIERS

One longtime telemedicine site is at the Sedan City Hospital in Sedan, Kan., about 200 miles from KU Med’s campus. For more than a decade, KUCTT has cultivated a strong relationship with the critical access hospital in southeast Kansas.

Jolie Gerding started going to Sedan City Hospital in 2008 when her husband died unexpectedly.

Left alone with children to raise, she struggled. She began seeing a psychiatrist and a psychologist from The University of Kansas Health System via the KUCCT. When her psychiatrist retired, she let her family physician manage her medications (continued)
ON-SITE ASSISTANCE

Fredonia Regional Hospital (FRH) is about an hour’s drive from Sedan and 2-1/2 hours from Kansas City. Joy Williams, telemedicine senior coordinator for KUCTT, said the hospital began a telemedicine relationship with KU Med two years ago and has since become a very active site.

Brooke Romans, FRH chief nursing officer, and Amanda Bunyard, FRH telemedicine coordinator, lead patients to a small room, once a former office, with a flat-screen television and video camera both mounted on a wheeled stand.

Bunyard said telemedicine appointments are no more taxing than regular appointments.

Romans said, “Actually, it’s easier because the (health care) providers are readily available. We usually don’t have to wait for them at all,” whereas an in-person clinician might get held up by the patient load.

BEST OF BOTH WORLDS

Jan Chase, telemedicine coordinator for Sedan City Hospital, said she’s heard from patients how beneficial they consider the telemedicine appointments.

“She’s so many fearing we’ll lose that high-touch human connection, and my feeling is, if you are a practitioner who works hard to establish that connection in the clinic, you’ll establish a connection through technology.”

~ Gary Doolittle, MD

but continued sessions with her psychologist. She said she appreciated the quality and the continuity of care, which isn’t always possible in smaller communities.

“I think telemedicine is vital in a lot of ways, especially in rural communities,” Gerding said. “My psychologist is wonderful. I could not find a better-caliber person around here. I just couldn’t.”

Gerding appreciated that familiar relationship even more when, just a year ago, her son had his arm nearly cut off with a sword in a fight that took a horrible turn. Police on the scene had been sure her son would die, she said, and surgeons in Wichita spent hours reattaching muscles, arteries and veins.

“He has permanent nerve damage, and he needs more surgery,” Gerding said.

Following his mother’s example, her son signed up for some counseling sessions via telemedicine. He travels to Fredonia Regional Hospital to talk to a KU Medical Center counselor regarding post-traumatic stress and other mental health issues, his mother said.

Digital otoscope is used to transmit image of a patient’s eardrum (KU Medical Center).

~ Gary Doolittle, MD
KUMC PROJECT ECHO UNITES HEALTH COMMUNITY

The University of Kansas Medical Center uses technology to connect health care professionals to patients, but it also connects health care professionals with each other.

KUMC Project ECHO (Extension for Community Healthcare Outcomes) is part of an international telementoring program designed to share knowledge within the medical community.

Launched by Sanjeev Aurora, MD, in New Mexico in 2003, Project ECHO seeks to overcome health care disparities by moving the knowledge of researchers and specialists to the clinicians treating patients, no matter where they’re located. “Making geography irrelevant” is both the mission and motto of Project ECHO.

Project ECHO can also disseminate health information quickly, based on its network of connections to health care sites. In Kansas, four KU Med hubs—in Kansas City, Salina, Wichita and Dodge City—serve registered participants across the state.

In July 2019, the KU School of Nursing hosted its first KUMC Project ECHO series on the effect of stress on the mental health of pregnant women and mothers. More than 200 people, including physicians, nurses and social workers, registered for it.

“Nurses do a lot of work in the area of identifying stress and the impact it can have on health. This ECHO series was a way to share that with other providers,” said Cynthia Teel, PhD, RN, FAAN, associate dean of academic affairs at the KU School of Nursing.

Nearly 2,700 people have participated in 140 different KUMC tele-ECHO sessions since 2015. For additional information, contact projectecho@kumc.edu or visit http://www.kumc.edu/community-engagement/project-echo.html.

(Editor’s note: In Missouri, Project ECHO is operated by the University of Missouri Telehealth Network.)

FUTURE OF TELEMEDICINE AND TELEHEALTH

Looking ahead to telehealth’s future, Spaulding said health data—gathered from fitness trackers like FitBit or biodata monitors like Apple Watch—could be relayed directly to health care providers.

“Privacy is of course an issue, but I think we’ll see that happening,” he said.

Dr. Doolittle said he sees a day when patients connect to their doctors using the videochat function of their cell phones. “We’re living in an iPhone-FaceTime world,” he said. “I mean, anywhere you have a desktop computer, anywhere you have an iPad, you can connect. At this point, it’s really more about working out the logistics.”

Video appointments also cut down on drive time for patients and on the risk of infection from a waiting-room germ, too. For students currently in medical school, they’ve grown up with digital connection, Dr. Doolittle said, and they see digital communication as status quo, not value-added.

“Take a look at medical students in 2020. They grew up in this world. For them, it’s a natural form of communication,” Dr. Doolittle said.

The challenge, then, becomes how health care professionals maintain that personal connection despite the physical distance.

“I still think there’s this strong human factor that has to exist with health care, but technology allows us to maintain that,” Dr. Doolittle said. “There’s so many fearing we’ll lose that high-touch human connection, and my feeling is, if you are a practitioner who works hard to establish that connection in the clinic, you’ll establish a connection through technology.”

Anne Christiansen-Bullers is a writer and communications specialist with the University of Kansas Medical Center

TELEMEDICINE

(continued from page 19)

REFERENCES


Using Telemedicine to Reach Underserved Populations in Urban Areas

DIVERSITY TELEHEALTH ASSISTS COMMUNITY HEALTH CENTERS AND SCHOOLS IN LOW-INCOME AREAS AROUND KANSAS CITY IN DEVELOPING TELEMEDICINE AND TELEHEALTH CAPABILITIES

By Shelley J. Cooper, EdD

Should your ZIP code determine whether you live or die? Often this is the case with several ethnic groups in under-resourced areas of Kansas City. When access to health care is an issue, telemedicine can bridge the health care disparity gap. Telemedicine provides a needed service by connecting patients and health care providers who are separated by distance, time and accessibility.1

Access to health care isn’t limited just by distance. It is also related to social determinants of health, such as poverty, which affects the person’s ability to own reliable transportation, have gainful employment with health benefits, and the flexibility to take off work for medical appointments. As a result, many people in low-income areas can’t get to the doctor when they need to. Or they might need to take multiple buses and a couple of hours to attend a doctor’s appointment.

Therefore, the convenience of telemedicine allows people in urban areas to connect to health care providers without needing transportation or taking time from work or family commitments.

APPLICATION OF TELEMEDICINE IN URBAN AREAS

Telemedicine most often is assisting people in underserved areas through federally qualified health centers (FQHCs) and school-based programs.

Community Health Centers. Tele-psychiatry and behavioral health are the primary uses of telemedicine in FQHCs. Remote patient monitoring has been very effective at assisting with chronic disease management and medication adherence. However, multiple challenges have prevented the FQHCs from gaining more system-wide use of telemedicine. Beyond reimbursement rates and requirements, safety-net clinics face a myriad of other barriers. Infrastructure and broadband limitations, technology costs, billing issues, limited provider buy-in, patient population challenges, workflow issues, low provider workforce, and licensure all served as key telemedicine adoption barriers.1

Schools. School-based telemedicine is perfect for students because it allows them to have access to higher-level medical care without leaving the school, and/or parents having to take off work to transport their children to the doctor’s office. During my years as a classroom teacher in Kansas City, Mo. and Kansas City, Kan., many students missed valuable learning opportunities due to minor illnesses that could have been treated with a telemedicine visit.

The most common uses of telemedicine in schools have been behavioral health and asthma management.2,3 Currently, my company has been contracted to develop a school-based telehealth asthma...
management program for the Kansas City Public School District. Many of the services delivered face-to-face can be supported or replaced with telemedicine. Chronic disease management checkup and medication adherence visits can be accomplished with virtual sessions with health care providers. Teledentistry allows children to receive dental checkups from dental assistants or dental hygienists with the dentist reviewing the results and recommending treatment. Additional services might include speech and language therapy and occupational therapy.4

DIVERSITY TELEHEALTH

The goal of my company, Diversity Telehealth, is to bring health care to all communities—especially underserved populations—by collaborating with federally qualified health centers, schools and community organizations. I founded Diversity Telehealth in 2014 after completing my doctoral dissertation on telemedicine5 the same year. We strive to increase access to health care for underserved populations, improve continuity of care for patients in under-resourced communities, provide health care education by addressing the social determinants of health and help to close the health care disparity gap.

DIVERSITY TELEHEALTH ACTIVITIES

Here are some of the projects on which Diversity Telehealth is working or has worked:

SureShow Platform. This patent-pending platform allows clinics and FQHCs to replace no-show appointments with telemedicine visits. SureShow was created to allow people with chronic diseases to have a faster, more convenient and consistent way to connect with a physician. It creates revenue streams for health care facilities and provides continuity of care for patients who might need medical services sooner than their appointment allows. Patients with chronic diseases can download the SureShow app and place themselves on the list to receive telemedicine calls. This gives patients another option for a doctor visit sooner rather than wait for a face-to-face appointment. The Lok Incubator is our partner in creating the app for patients and clinics.

An inspiration for creating the SureShow app was the experience of my father. When my father died in his sleep with only a few days before his next scheduled appointment, I decided to create a way for people to see their doctor sooner via telemedicine. Irrational or not, I believe he’d had the opportunity to visit with his doctor via telemedicine or phone before his scheduled appointment, he would be alive today.

Swope Health Services. Diversity Telehealth provided consulting and research to this nine-site FQHC in conjunction with expansion of their telehealth initiatives.

CareSTL. Based in St. Louis, this four-site FQHC called on Diversity Telehealth to assess its telemedicine needs, train the staff and coordinate the implementation of telemedicine programming both to patients in their homes and through schools.

REESSI. We worked with Research, Evaluation & Social Solutions, Inc. on a pilot project to develop a psychosocial serious learning game for adolescents living in under-resourced families and communities.

Asthma Ready Communities. Diversity Telehealth is partnering with the University of Missouri School of Medicine-Asthma Ready Communities, along with the Black Healthcare Coalition and City Councilwoman Melissa Robinson, on its Teaming Up for Asthma Control initiative within the Kansas City, Mo., School District. This project is aligned with patient-centered education, care and population health for an underserved minority community in Kansas City. In addition, we are implementing the first school-based asthma telehealth pilot in Kansas City.

BlaqOut. This initiative is assisting HIV populations in gaining confidential and culturally competent access to virtual health care.

Doctor Por Telefono. Spanish-speaking patients who may find it difficult to leave work to see a doctor can access telemedicine services through Doctor Por Telefono. In conjunction with the Kansas City translation service Index Lingua, we have designed the Spanish website, www.doctorportelefono.com. Patients can (continued)
register for telemedicine services provided by Spanish-speaking doctors through an app on their phone or computer. We have worked with the Shawnee Mission School District’s Migrant Education Program to educate the community about this service and enable families to register for telehealth services.

PTBH at a Charter School. We completed an eight-week Pediatric Telebehavioral Health (PTBH) pilot program at Benjamin Banneker Charter Academy that allowed children in kindergarten through fourth grade to meet weekly with a behavioral health therapist using their laptops. We designed and coordinated the scheduling among the staff, students and provider. FreeState Health Care (Wichita, Kan.) provided in-kind software support and Humana donated a stipend for the provider.

CONCLUSION

As a member of an ethnic minority group, I am fully aware of the pronounced health care disparities between the races. African Americans are more likely to suffer from a multitude of comorbidities such as hypertension, diabetes, asthma, cancer, and stroke. In addition, the negative effects of disparities in education, income, incarceration and crime have an effect on lifestyle and longevity. For many people in low-income areas, the inability to get to the doctor keeps them from the much-needed medical care required to receive prescription refills, education and chronic disease management. Virtual health care, also known as telemedicine and telehealth, can bring the doctor to the patient and save lives.

Shelley J. Cooper, EdD, is president of Diversity Telehealth, providing telemedicine consulting services to community health centers, schools and others. She has given presentations on telemedicine to the national HIMSS conferences in 2017 and 2018 and to the American Telemedicine Association in 2015 and 2016. She can be reached at scooper@diversitytelehealth.com.

REFERENCES


Medical Students at New KCU Center Will Practice Using High-Tech Simulation

In addition to the VR and AR technology, the CMEI will house ICU simulation sites, medical robots, 22 standardized patient rooms, and a 70-bay lab for osteopathic manipulative medicine (OMM). No other medical school in the country has this extent of application-based technology under a single roof, KCU officials said.

Medical students will be able to experience real-world simulation of patient treatment through high-tech features at the new Center for Medical Education Innovation (CMEI) at Kansas City University opening in June.

This 54,000 square-foot, one-of-a-kind teaching facility will allow students to learn by doing through the use of virtual reality (VR) and augmented reality (AR) technology. As early as their first year at KCU, medical students can learn how to evaluate, diagnose and treat patients in repetition with real-world simulation.

At the new KCU center, students will experience 30-40 curriculum-based simulations by the time they reach third-year clinicals. Currently, students experience two non-specific simulations during each of their first two years. Giving students the opportunity to practice lowers the risk of medical errors and prevents patient harm.

In addition to the VR and AR technology, the CMEI will house ICU simulation sites, medical robots, 22 standardized patient rooms, and a 70-bay lab for osteopathic manipulative medicine (OMM). No other medical school in the country has this extent of application-based technology under a single roof, KCU officials said.

The facility also will be used to host CME training for rural communities and cultivate STEM interest in underserved and rural school children. “Imagine a scenario where a first-year student enters a virtual operating room surrounded in real-time by a student at KCU’s Joplin campus, a resident in Florida and a faculty member on a medical mission trip in Kenya. Students will experience hands-on VR and AR training that mirrors everyday clinical challenges faced by physicians. These tools enhance education retention, allow students to share experiences, increase the mastery of skills and push the boundaries of learning,” a KCU spokesperson said.

A grand opening is scheduled for June 9, 2020.
“This type of charity care is not only the right thing to do, it also helps reduce overutilization of health care resources. The professional staff of Wy Jo Care back us up completely, provide detailed prior medical records and arrange all of the necessary tests. I highly recommend participating in these charity care programs.”

The Kansas City Medical Society Foundation recognizes James S. Appelbaum, MD, FAAN, for serving as a volunteer physician with Wy Jo Care since its beginning in 2007. A board-certified neurologist, Dr. Appelbaum practices with Providence Medical Group. He is a graduate of the University of Kansas School of Medicine and completed his residency and fellowship in neurology at the University of Chicago Pritzker School of Medicine. He also is a member of the board of directors of the Kansas City Medical Society Foundation, under which Wy Jo Care operates.

Join the KCMS Foundation in our mission to provide care to the uninsured.

~ James S. Appelbaum, MD, FAAN
Providence Medical Group
Supporter, Wy Jo Care and Metro Care