POPULATION HEALTH
How physicians benefit from data-driven care

HEALTHCARE PRICING
Special interests keep doctors, patients in the dark

VACCINES
6 tips for getting paid
The work of primary care has changed. What was once mostly minor acute care with patients only going to their doctor when they were sick with one problem has become much more complex. Today, primary care physicians are expected to provide comprehensive preventive services, manage a variety of chronic diseases and provide counseling for patients suffering from stress at home or at work. On top of that, the coding and documentation of patient visits now takes up half the time in a busy physician’s schedule.

The problem is that nobody changed the schedule! Primary care doctors are still expected to do their work in brief visits and care for the same large panel of patients as yesteryear. No wonder the burnout rate among primary care physicians is approaching 50 percent, according to various studies, and U.S. medical students are avoiding primary care specialties.

The fable of the boiling frog is widely known. The premise is that if you put a frog into boiling water it will jump out. If you put a frog in water and you slowly turn up the heat it will just sit there and boil.

Most primary care physicians today are boiling frogs. Some commit suicide, many retire early, and brave ones go into new models such as direct primary care.

Primary care is vitally important to any rational healthcare system. Primary care physicians manage 75 to 85 percent or more of the reasons patients see a doctor. When primary care is used, populations are healthier and have lower overall healthcare costs.

For that, in the United State, primary care physicians receive about 8 percent of the healthcare insurance premium dollar. (All together, physicians receive nearly 16 percent of the healthcare dollar.) Primary care has been in great trouble for some time and needs to change.

There must be a national effort to rethink how we practice primary care. Quality primary care takes time with patients to do the complex work, even with teams providing the effort, and the panel sizes per physician need to match the work required. There are new models of primary care emerging such as concierge medicine, direct primary care, and franchise models such as Iora Health. These all provide insights into what works well.

It is time for a revolution throughout primary care, voicing the words of Howard Beale in the 1976 film “Network”: “I’m mad as hell and I’m not going to take it anymore!”

The healthcare system would grind to a halt if primary care physicians stopped and demanded proper working conditions, with appropriate payment from health plans and health systems. Let’s do that before we boil away.

Joseph E. Scherger, MD, MPH, is vice president for primary care and Marie E. Pinizzotto, MD, Chair of Academic Affairs at Eisenhower Medical Center in Rancho Mirage, Calif. He is also a member of the Medical Economics editorial advisory board.

Why special interests fight against healthcare price transparency PAGE 52
Family physicians who dislike the high-stakes maintenance of certification test they have to take every 10 years are being offered a new option that will be piloted in 2019.

The alternative test will deliver 25 online questions each quarter to those who prefer this new option, according to the American Board of Family Medicine (ABFM). Not only will diplomates be able to take the test at a time and place of their choosing, they will also be able to use clinical references to answer the questions, just like they would in practice.

“This approach is more aligned with the ongoing changes in medicine and draws upon adult learning principles, combined with modern technology, to promote learning, retention and transfer of information,” Jerry Kruse, MD, chair of the ABFM board of directors, said in a release. “Over time, we will be able to assess the core clinical knowledge of board-certified family physicians and recognize the vast majority who work to keep up to date to take care of their patients.”

According to the ABFM, a combination of physician experience with the testing platform, feedback from diplomates, an independent survey, and information gleaned from the experience of other specialty boards contributed to the design of the new online, longitudinal assessment. The original 10-year test is still available as an option.

The American Association of Family Physicians (AAFP) is pleased with the changes. “We at AAFP have been encouraging the ABFM to implement some alternatives to the traditional high-stakes exam,” says Clif Knight, MD, FAAPA, senior vice president of education for AAFP. “We see this as a positive step forward.”

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First Take
Primary care needs a revolution
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MedicalEconomics.com
Like Dr. Sean McNeeley (“What’s behind the growth of urgent care clinics?” September 10, 2018), I first dipped my toes into the urgent care waters for some extra income in April 2016. I had been in full time family practice for nearly 23 years at that point. I was tired of working harder and harder, seeing more and more patients, and making less money. I was also constantly inundated with paperwork like physical forms, FMLA and other disability forms, prior authorizations, DME requests, and the like.

My experience in urgent care was remarkably different. I spent my shifts treating patients, and that was it. No insurance hassles.

Eventually, I transitioned from per diem work to part-time and ultimately to full-time at urgent care, leaving my family practice for good in September 2017.

A year later, I couldn’t be happier with my decision. I’m earning the most I’ve ever made and have the least stress and aggravation I’ve ever had since going into practice 25 years ago. My only regret is that I didn’t do it sooner.

Steven Gitler, DO
CHERRY HILL, N.J.
Physicians have one of the worst gender pay gaps

*$500 billion.* That's how much women lose out on each year because they are paid less than men, according to a new report. And the pay disparity among physicians is one of the worst. The report by the American Association of University Women (AAUW), found that female physicians are collectively paid $19.5 billion less than their male counterparts. The only profession with worse performance was financial managers, and the difference is relatively minor, at $19.6 billion.

“It’s unacceptable. There is no gender differentiation when it comes to quality, skills and talent.”
—Kim Churches, CEO, AAUW

The physician gender pay gap

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Source: 2018 Medical Economics Physician Report

How physician organizations have responded

Physician advocacy groups, including the AMA and the American College of Physicians (ACP), have pledged to take on the gender pay gap.

In an interview earlier this year with *Medical Economics*, ACP President Ana Maria Lopez, MD, said that pay equality is "critically important."

"Sometimes we have this [thought process] that if women get paid more, somebody is going to have to be paid less," Lopez said. "It's not that sort of thing. You raise the level for women; you raise the level for everyone."

The pay gap, by the numbers

80¢ What a woman makes, on average, for every dollar a man makes

State with the largest pay gap: Louisiana
State with the smallest pay gap: California

Source: AAUW
The dangers of trusting your employees too much

Preventing and addressing dishonesty in the workplace continues to challenge my physician practice clients. Recently, a physician client suffered an extreme example of how workplace dishonesty can cause harm. Her scary story is, unfortunately, familiar to many physicians.

The situation began with a visit from a payer’s fraud department. The investigators reviewed patient charts with my client, the practice owner, and hinted at fraudulent billing and other improprieties. She could not understand the investigators’ claims and did not recognize the patient names at issue.

She began by looking for the patient names in the system. We immediately realized the charts were modified, deleted or nonexistent. When the individual who handles IT for the practice was contacted for help—let’s call him “Bart”—he became nervous and uneasy. Bart was fired when it became clear he had played some role in the issue at hand.

Bart alone handled the practice’s administration, provider billing, bill paying, check deposits, vendor contracts, payroll and other key activities.

My client brought in an IT and forensic specialist to address the issues Bart created, as he was also the only one at the practice with passwords, system access and any knowledge of the IT setup. We are still trying to locate missing records and determine the exact activities Bart engaged in.

After reviewing payroll records, it appeared that Bart established fake vendors to which payroll funneled thousands of dollars biweekly. My client had not detected the payments since all payroll and other financial activities had been left in Bart’s hands.

We also determined that Bart had obtained credit cards in the practice’s name and racked up bills for friends and family—all paid at the practice’s expense. We have yet to fully determine the extent of his activities. The police, FBI and the payer all are involved in trying to sort this situation out.

Controlling conduct like this should be a red flag for practice owners.

Tips to protect your practice from employee fraud

- Complete a background check on everyone who is hired. Bart had a criminal history, which could easily have been detected.
- Never assign one employee complete oversight of any particular function in the practice. Make sure there is more than one person assigned to every task and regular oversight and/or audit for any employee with significant financial, IT, or billing responsibilities.
- Always have access to passwords and bank accounts, and be trained in other major practice responsibilities.
- Conduct regular financial audits. This could mean reviewing the income and expenses with your accountant monthly or some other approach. The important thing is that business owners take responsibility for their business.
- Look for red flags. In this case, Bart did not let anyone else touch his computer or handle billing. He got anyone who he did not “like” fired. He was the only one allowed to open mail, handle checks, or pay vendors. He always took his laptop home with him.

Ericka L. Adler, JD, has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@ubm.com
As both public and private payers focus more on value-based care, population health management has become more common as providers take a more proactive approach to caring for patients.

And while definitions vary, experts agree that population health management is about going beyond the walls of the practice to improve patient health, with the ultimate goals of better quality scores for providers and fewer long-term issues for patients, especially those with chronic conditions.

“Population health is about no longer just treating the patients who walked in the door to see you today,” says Christina Taylor, MD, an internist and chief quality officer at The Iowa Clinic in Des Moines, Iowa, where she also serves as director of the population health, quality analytics and care management team. “Whether the patients choose to come to you for care or visit other primary care providers, you are responsible for their healthcare and outcomes.”

This requires an approach to managing patients that many primary care physicians are not used to, as well as investments in technology and personnel that smaller practices may struggle with, but solutions are available.

Data analysis and social determinants become as important as mammograms and diabetic eye exams as value-based care drives demand for more population health analyses to manage costs.

“For folks on the frontlines, population health is an explicit recognition that delivery of care is only 20 percent of the story,” says David Nash, MD, MBA, an internist and dean of the Jefferson College of Population Health. He adds that linking physician income to performance measures at the population level is leaving doctors little choice other than to implement it.

Nash predicts that small practices eventually will be forced to incorporate population health, either because of the elimination of exemptions in the Merit-based Incentive Payment System (MIPS) or the demands of commercial insurers who also...
want to pay for healthy outcomes and not just patient volume.

“If CMS doesn’t get you, Aetna and Anthem will,” he says.

While payers see the cost benefits to population health, providers have seen it make a difference in the health of their patients. Anuradha Phadke, MD, an internist and director of population health at Stanford Health Care, says Stanford’s efforts have improved patient care and freed up doctor time to focus on the most serious cases.

“For instance, we’ve been able to identify which patients are poorly controlled diabetics and connect them to resources who reach out and help them bring it under control,” says Phadke. “It makes it easier for us to get the desired action by the patient without the clinician spending their time.”

Taylor says outreach to remind patients of annual physicals, vaccines, and cancer screenings are all examples of how patients benefit. “It’s all about a stronger emphasis on preventative medicine and making sure these appointments happen,” says Taylor. “You have to view it as your responsibility to shepherd patients to make sure they get checkups and preventive care.”

Some doctors have seen population health management in a negative light, because it requires an emphasis on healthier behaviors. These physicians view that as being beyond their influence.

“As physicians, we can tell people to move more and eat less, but we can’t force them to be healthy,” says Taylor. “That may all be true, but it is still our responsibility to try, and if we continue to try, we will reach some.”

Preventative care and value-based care are closely linked, because without a solid commit-
ment to prevention, most patient problems will only get worse—and more expensive, says Taylor. As a result, she says, population health management will continue to be an integral part of moving the healthcare industry in a value-based direction.

“It’s key to keeping costs down,” she says. “If you do it right, there is less duplication in tests and less waste. You are keeping track of and coordinating a person’s healthcare.”

HOW SMALL PRACTICES CAN GET STARTED
Experts say the challenges facing a small practice looking to implement population health management are difficult, but not impossible, to overcome.

One of the first challenges is identifying patients with chronic conditions that might benefit from outreach efforts, and the place to start is with the EHR.

Taylor suggests seeing what tools are available within the EHR that can help identify specific groups of patients with chronic diseases, such as diabetes, and then develop a plan to better manage those patients. “It should be team-based care,” she says, adding that much of the work is nonclinical and doesn’t require a doctor’s time.

“Have a nurse take a look twice a year or quarterly, to see who has been in for an appointment and how they are doing. If they haven’t been in to the office in six months, you need to get them in.” This level of commitment does not require advanced analytics or expensive software tools to implement, she adds.

Phadke says to start small and build gradually. For example, is the practice doing a better job of getting all diabetic patients into the office for regular exams? Are patients with high blood pressure getting regular screenings? Are all patients up to date on their vaccinations? Find out who needs what and contact patients to get them into the office, she says.

“Population health can be intimidating at first, but if you start with a smaller scope and a small set of measures, that will make it easier,” Phadke says.

Another entryway to population health management is to consider becoming a patient-centered medical home (PCMH), says Jay Bhatt, DO, MPH, an internist and chief medical officer of the American Hospital Association and president of the Health Research & Educational Trust.

“If you don’t want to go through the whole process to becoming a PCMH, a small practice could still work toward it, allowing them to experiment with managing a population effectively. It’s a great way to build competency.”

WHY JOINING A LARGER GROUP MAY BE NECESSARY
While population health management can be achieved to some degree by a small practice, if payers start to require physicians to accept some downside risk in their contracts, it may require more resources than the practice can afford.

“For those with risk-based contracts, you have to have a lot more resources and there is a lot of infrastructure that goes into it,” says Taylor. “You have to be able to analyze claims, there are expensive pieces of software you need and you have to pay analysts to turn the data into meaningful information.”

Once patients with chronic conditions are identified, it requires staff time to act on it. “It might require hiring a [nursing assistant] or additional clerical staff, and if you are doing high-risk patient management, hopefully you are doing some health coaching. But that requires a health coach or nurse,” says Taylor.

Larger organizations, like the Stanford clinics where Phadke works, have sophisticated software tools that help identify which patients need extra care as well as message the patients.

“It allows us to do a lot more with fewer personnel,” she says. “But for a small practice, the upfront cost is something they would have to consider.”

Nash doesn’t envision a long-term future for small practices that aren’t affiliated with a larger group, because he sees healthcare marching inexorably toward favoring groups and health systems that can afford high-tech tools and additional staff.
“For private payers, population health could determine whether they will contract with you, if you are underperforming on quality measures.”

—ANURADHA PHADKE, MD, INTERNIST AND DIRECTOR OF POPULATION HEALTH, STANFORD HEALTH CARE

“That may not be the answer they want, but it will be incredibly hard for practices with one or two doctors to compete in the new world.”

**SUCCEED WHILE STAYING INDEPENDENT**

There may be ways for a practice to get the tools and support it needs for population health management that don’t require a complete sacrifice of independence.

Bhatt says to check with local hospitals to see if they have any affiliate programs that share resources and data with local physicians. “Getting into a clinically integrated network can be very helpful for small practices,” he says. “They do not have to give up their independence, but generate economies of scale and get the resources they need.”

“Shared resources are definitely a good idea,” says Phadke, adding that Stanford enables sharing through its United Healthcare Alliance, a group of clinics affiliated with the university to get the tools they need to provide better care.

Joining an Accountable Care Organization may also be an option for practices. “They can share best practices and be able to share the administrative burden of doing things like claims analysis,” says Taylor.

Phadke says the stakes involved in population health management are too high to ignore. “CMS (via MIPS) added a financial reward or penalty for your Medicare patients,” she says. “For private payers, population health could determine whether they will contract with you, if you are underperforming on quality measures.”

Experts agree that physicians are going to need much more data on their patients to prove they are providing value, and that the demand for this data is only going to increase. It might also provide some surprises when first examined in detail.

“By measuring how you are doing on your performance and benchmarking that to your peers, it can shed light on different opportunities,” says Phadke. “Most physicians think they are performing better than they are, but if they look at population health management as an opportunity to improve, it really does help patient care.”

Regardless of what approach a practice takes to population health management, Nash says there really is no avoiding it. “You can run, but you can’t hide from it,” he says. “We are heading toward the total accountability for the outcome of care, and with no outcomes, there will be no income for doctors, and that is a sea change.”
Help your patients understand both of their LARC location options

LARC = long-acting reversible contraceptive

NEXPLANON is indicated for use by women to prevent pregnancy.

SELECTED SAFETY INFORMATION

Who is not appropriate for NEXPLANON

- NEXPLANON should not be used in women who have known or suspected pregnancy; current or past history of thrombosis or thromboembolic disorders; liver tumors, benign or malignant, or active liver disease; undiagnosed abnormal genital bleeding; known or suspected breast cancer, personal history of breast cancer, or other progestin-sensitive cancer, now or in the past; and/or allergic reaction to any of the components of NEXPLANON.

WARNINGS and PRECAUTIONS

Complications of insertion and removal

- NEXPLANON should be inserted subdermally and be palpable after insertion. Palpate immediately after insertion to ensure proper placement. Undetected failure to insert the implant may lead to unintended pregnancy. Failure to remove the implant may result in continued effects of etonogestrel, such as compromised fertility, ectopic pregnancy, or persistence or occurrence of a drug-related adverse event.

- Insertion and removal-related complications may include pain, paresthesias, bleeding, hematoma, scarring, or infection. If NEXPLANON is inserted too deeply (intramuscular or in the fascia), neural or vascular injury may occur. Implant removal may be difficult or impossible if the implant is not inserted correctly, inserted too deeply, not palpable, encased in fibrous tissue, or has migrated. If at any time the implant cannot be palpated, it should be localized and removal is recommended.

- There have been postmarketing reports of implants located within the vessels of the arm and the pulmonary artery, which may be related to deep insertions or intravascular insertion. Endovascular or surgical procedures may be needed for removal.

NEXPLANON and pregnancy

- Be alert to the possibility of an ectopic pregnancy in women using NEXPLANON who become pregnant or complain of lower abdominal pain.

- Rule out pregnancy before inserting NEXPLANON.

Educate her about the risk of serious vascular events

- The use of combination hormonal contraceptives increases the risk of vascular events, including arterial events [stroke and myocardial infarction (MI)] or deep venous thrombotic events (venous thromboembolism, deep venous thrombosis (DVT), retinal vein thrombosis, and pulmonary embolism). Women with risk factors known to increase the risk of these events should be carefully assessed. Postmarketing reports in women using the nonradiopaque etonogestrel implant have included pulmonary emboli (some fatal), DVT, MI, and stroke. NEXPLANON should be removed if thrombosis occurs.
NEXPLANON is the only non-uterine LARC option

- Provides Up to 3 years of pregnancy prevention*
- >99% effective†
- Reversible if her plans change

Placed subdermally in the inner upper arm just under the skin

*NEXPLANON must be removed by the end of the third year and may be replaced by another NEXPLANON at the time of removal, if continued contraceptive protection is desired.
†Less than 1 pregnancy per 100 women who used NEXPLANON for 1 year.

SELECTED SAFETY INFORMATION (continued)

- Due to the risk of thromboembolism associated with pregnancy and immediately following delivery, NEXPLANON should not be used prior to 21 days postpartum.
- Women with a history of thromboembolic disorders should be made aware of the possibility of a recurrence. Consider removing the NEXPLANON implant in case of long-term immobilization due to surgery or illness.

Counsel her about changes in bleeding patterns

- Women are likely to have changes in their menstrual bleeding pattern with NEXPLANON, including changes in frequency, intensity, or duration. Abnormal bleeding should be evaluated as needed to exclude pathologic conditions or pregnancy. In clinical studies of the non-radiopaque etonogestrel implant, changes in bleeding pattern were the most common reason reported for stopping treatment (11.1%). Counsel women regarding potential changes they may experience.

Be aware of other serious complications, adverse reactions, and drug interactions

- Remove NEXPLANON if jaundice occurs.
- Remove NEXPLANON if blood pressure rises significantly and becomes uncontrolled.
- Prediabetic and diabetic women using NEXPLANON should be carefully monitored.
- Carefully observe women with a history of depressed mood. Consider removing NEXPLANON in patients who become significantly depressed.
- The most common adverse reactions (≥10%) reported in clinical trials were headache (24.9%), vaginitis (14.5%), weight increase (13.7%), acne (13.5%), breast pain (12.8%), abdominal pain (10.9%), and pharyngitis (10.5%).
- Drugs or herbal products that induce enzymes, including CYP3A4, may decrease the effectiveness of NEXPLANON or increase breakthrough bleeding.
- The efficacy of NEXPLANON in women weighing more than 130% of their ideal body weight has not been studied. Serum concentrations of etonogestrel are inversely related to body weight and decrease with time after implant insertion. Therefore, NEXPLANON may be less effective in overweight women.
- Counsel women to contact their health care provider immediately if, at any time, they are unable to palpate the implant.
- NEXPLANON does not protect against HIV or other STDs.

Please read the adjacent Brief Summary of the Prescribing Information

**INDICATION AND USAGE**

Women should be informed that this product does not protect against HIV infection (the virus that causes AIDS) or other sexually transmitted diseases.

**WARNINGS AND PRECAUTIONS**

- **1. Complications of Insertion and Removal**
  - NEXPLANON should be inserted subdermally so that it is palpable after insertion, and this should be confirmed by palpation immediately after insertion. Failure to insert NEXPLANON properly may go undetected until it is removed immediately after insertion. Undetected failure to insert the implant may lead to an unintended pregnancy. Complications related to insertion and removal procedures, such as pain, paresthesia, bleeding, hematoma, scarring or infection, may occur.
  - If NEXPLANON is inserted too deeply (intramuscular or intravelar), neural or vascular injury may occur. To reduce the risk of neural or vascular injury, NEXPLANON should be inserted at the inner side of the non-dominant upper arm about 8-10 cm (3-4 inches) above the medial epicondyle of the humerus. NEXPLANON should be inserted subdermally just under the skin avoiding the subcutaneous tissues. An implanted inserted more deeply than subdermally (deeply implantation) may not be palpable and therefore the localization and/or removal can be difficult or impossible (see Dosage, Administration and Warnings and Precautions).

- **2. Changes in Menstrual Bleeding Patterns**

After starting NEXPLANON, women are likely to have a change from their normal menstrual bleeding pattern. These may include changes in bleeding frequency (absent, less frequent or continuous, intensity reduced or increased) or duration. In clinical trials of the non-radiopaque etonogestrel implant (IMPLANON), bleeding patterns ranged from amenorrhea (11 in 5 women) to frequent and/or prolonged bleeding (1 in 5 women). The bleeding pattern experienced during the first three months of NEXPLANON use is broadly predictive of the future bleeding pattern for many women. Women should be counseled regarding the bleeding changes they may experience so that they know what to expect. Abnormal bleeding should be evaluated as needed to exclude pathologic conditions or pregnancy. In clinical studies of the non-radiopaque etonogestrel implant, reports of changes in bleeding pattern were the most common reason for stopping treatment (31%). Irregular bleeding (10.8%) was the single most common reason women stopped treatment, while amenorrhea (0.3%) was cited less frequently. In these studies, women had an average of 17.7 days of bleeding or spotting, or spotting every 90 days (based on 3,315 intervals of 90 days reported by 760 patients). The percentages of patients having 0, 1-7, 8-21, or >21 days of spotting or bleeding over a 90-day interval while using the non-radiopaque etonogestrel implant are shown in Table 1.

**Bleeding Patterns Definitions %**

- Infrequent Less than three bleeding and/or spotting episodes in 90 days (excluding amenorrhea) 33.6
- Amenorrhea No bleeding and/or spotting in 90 days 22.2
- Prolonged Any bleeding and/or spotting episode lasting more than 14 days in 90 days 17.7
- Frequent More than 5 bleeding and/or spotting episodes in 90 days 6.7

Based on 3,315 recording periods of 90 days duration in 780 women, excluding the first 90 days after the implant insertion.

- **3. Ectopic Pregnancies**

As with all progestin-only contraceptive products, be alert to the possibility of an ectopic pregnancy among women using NEXPLANON. Greater risk of ectopic pregnancy may be increased in women with a history of pelvic inflammatory disease and in women with infection at the time of insertion. In case of undiagnosed, persistent, or recurrent abnormal vaginal bleeding, appropriate measures should be conducted to rule out malignancy.

- **4. Thrombotic and Other Vascular Events**

The use of combination hormonal contraceptives (progestin plus estrogen) increases the risk of vascular events, including arterial events (coronary artery disease, stroke) and venous thrombotic events (venous thromboembolism, deep venous thrombosis, retinal venous thrombosis, and pulmonary embolism). NEXPLANON is a progestin-only contraceptive. It is unknown whether this increased risk is applicable to etonogestrel alone. It is recommended, however, that women be informed of the increased risk of venous and arterial thromboembolism, and pulmonary embolism. Use of NEXPLANON is associated with an increased risk of deep vein thrombosis, myocardial infarction, and strokes, in women using etonogestrel implants. NEXPLANON should be removed in the event of a thrombosis.

- **5. Ovarian Cysts**

If follicular development occurs, atresia of the follicle is sometimes delayed, and the follicle may continue to grow beyond the size it would attain in a normal cycle. Generally, these enlarged follicles disappear spontaneously. On rare occasion, surgery may be required.

- **6. Carcinoma of the Breast and Reproductive Organs**

Women who currently have or have had breast cancer should not use hormonal contraception because breast cancer may be hormonally sensitive (see Contraindications). Some studies suggest that the use of progestin-only methods like NEXPLANON may increase the risk of developing breast cancer; however, other studies have not confirmed such findings. Some studies suggest that the use of combination hormonal contraceptives is associated with an increase in the risk of cervical cancer or intraepithelial neoplasia. However, there is controversy about the extent to which these findings are due to differences in sexual behavior and other factors. Women with a family history of breast cancer or who develop breast nodules should be carefully monitored.

- **7. Liver Disease**

Disturbances of liver function may necessitate the discontinuation of hormonal contraceptive use until markers of liver function return to normal. Removal NEXPLANON if jaundice develops. Hepatic adenomas are associated with combination hormonal contraceptives use. An estimate of the attributable risk is 0.3 cases per 100,000 for combination hormonal contraceptives users. It is unknown whether this risk is similar to progestin-only methods like NEXPLANON. The progestin in NEXPLANON may be poorly metabolized with liver involvement. Use of NEXPLANON in women with active liver disease or liver cancer is contraindicated (see Contraindications).

- **8. Weight Gain**

Men and women can gain weight with any method of birth control. In clinical trials of the non-radiopaque etonogestrel implant (IMPLANON), reported weight gain as the reason for having the non-radiopaque etonogestrel implant removed. Women with a history of hypertension-related diseases or renal disease should be discouraged from using hormonal contraception. For women with well-controlled hypertension, use of NEXPLANON can be considered. Women with hypertension using NEXPLANON should be closely monitored. If sustained hypertension develops during the use of NEXPLANON, or if a significant increase in blood pressure does not respond adequately to antihypertensive therapy, NEXPLANON should be removed.

- **9. Galbladder Disease**

Studies suggest a small increased relative risk of developing gallbladder disease among combination hormonal contraceptive users. It is not known whether a similar risk exists with progestin-only methods like NEXPLANON.

- **10. Carbohydrate and Lipid Metabolic Effects**

Use of NEXPLANON may induce mild insulin resistance and small changes in glucose concentrations of unknown clinical significance. Careful monitor prediabetic and diabetic women using NEXPLANON. Women who are being treated for hyperlipidemia should be followed closely if they elect to use NEXPLANON. Some patients may elevate LDL levels and may render the control of hyperlipidemia more difficult.

- **11. Depressed Mood**

Women with a history of depressed mood should be carefully observed. Consideration should be given to removing NEXPLANON in patients who become significantly depressed.

- **12. Return to Ovulation**

In clinical trials with the non-radiopaque etonogestrel implant (IMPLANON), the etonogestrel levels in blood decreased below undetectable levels by one week after removal of the implant. In addition, pregnancies were observed to occur as early as 7 to 14 days after removal. Therefore, a woman should re-start contraception immediately after removal of the implant if continued contraceptive protection is desired.

**Table 2: Bleeding Patterns Using the Non-Radiopaque Etonogestrel Implant (IMPLANON)**

<table>
<thead>
<tr>
<th>Total Days of Spotted or Bleeding</th>
<th>Treatment Days 91-180 (N = 740)</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Days</td>
<td>17%</td>
<td>24%</td>
</tr>
<tr>
<td>1-7 Days</td>
<td>15%</td>
<td>22%</td>
</tr>
<tr>
<td>8-21 Days</td>
<td>30%</td>
<td>37%</td>
</tr>
<tr>
<td>&gt;21 Days</td>
<td>35%</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Table 1: Percentages of Patients With 0, 1-7, 8-21, or >21 Days of Spotted or Bleeding Over 90-Day Interval While Using the Non-Radiopaque Etonogestrel Implant (IMPLANON)**

<table>
<thead>
<tr>
<th>Days</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>19%</td>
</tr>
<tr>
<td>1-7</td>
<td>24%</td>
</tr>
<tr>
<td>8-21</td>
<td>30%</td>
</tr>
<tr>
<td>&gt;21</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Table 2: Bleeding Patterns Using the Non-Radiopaque Etonogestrel Implant (IMPLANON)**

<table>
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<tr>
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<tbody>
<tr>
<td>0</td>
<td>19%</td>
</tr>
<tr>
<td>1-7</td>
<td>24%</td>
</tr>
<tr>
<td>8-21</td>
<td>30%</td>
</tr>
<tr>
<td>&gt;21</td>
<td>37%</td>
</tr>
</tbody>
</table>
14. Fluid Retention
Hormonal contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients whose conditions which might be aggravated by fluid retention. It is unknown if NEXPLANON causes fluid retention.

15. Contact Lenses
Contact lens wearers who develop visual changes or lens tolerance should be assessed by an ophthalmologist.

16. In Situ Broken or Bent Implant
There have been reports of broken or bent implants while in the patient’s arm. Based on in vitro data, when an implant is broken or bent, the release rate of etonogestrel may be slightly increased. When an implant is removed, it is important to remove it in its entirety (see Dosage and Administration).

17. Monitoring
A woman who is using NEXPLANON should have a yearly visit with her healthcare provider for a blood pressure check and for other indicated health care.

18. Drug-Laboratory Test Interactions
Severe hormone-binding globulin concentrations may be decreased for the first six months after NEXPLANON insertion followed by gradual recovery. Thyroxine concentrations may initially be slightly decreased followed by gradual recovery to baseline.

ADVERSE REACTIONS
In clinical trials involving 942 women who were evaluated for safety, change in menstrual bleeding patterns (irregular menses) was the most common adverse reaction causing discontinuation of use of the non-rodapico etonogestrel implant (IMPLANON® [etonogestrel implant]) (11.1% of women).

Adverse reactions that resulted in a rate of discontinuation of ≥1% are shown in Table 3.

Table 3: Adverse Reactions Leading to Discontinuation of Treatment in 1% or More of Subjects in Clinical Trials of the Non-rodapico Etonogestrel Implant (IMPLANON)

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>All Studies N = 942</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding irregularities*</td>
<td>11.1%</td>
</tr>
<tr>
<td>Emotional Lability†</td>
<td>2.3%</td>
</tr>
<tr>
<td>Weight increaseS</td>
<td>2.3%</td>
</tr>
<tr>
<td>Headache</td>
<td>1.6%</td>
</tr>
<tr>
<td>Acne</td>
<td>1.3%</td>
</tr>
<tr>
<td>Depression†</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

*Includes “frequent,” “heavy,” “prolonged,” “spotting,” and other patterns of bleeding irregularity.
†Among US subjects (N=330), 6.1% experienced emotional lability that led to discontinuation.
‡Among US subjects (N=330), 2.4% experienced depression that led to discontinuation.

Other adverse reactions that were reported by at least 5% of subjects in the non-rodapico etonogestrel implant clinical trials are listed in Table 4.

Table 4: Common Adverse Reactions Reported by ≥5% of Subjects in Clinical Trials With the Non-rodapico Etonogestrel Implant (IMPLANON)

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>All Studies N = 942</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>24.9%</td>
</tr>
<tr>
<td>Vaginitis</td>
<td>14.3%</td>
</tr>
<tr>
<td>Weight increase</td>
<td>13.7%</td>
</tr>
<tr>
<td>Acne</td>
<td>13.5%</td>
</tr>
<tr>
<td>Breast pain</td>
<td>12.8%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>10.9%</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>10.5%</td>
</tr>
<tr>
<td>Leukorrhea</td>
<td>9.6%</td>
</tr>
<tr>
<td>influenza-like symptoms</td>
<td>7.6%</td>
</tr>
<tr>
<td>Siziness</td>
<td>7.2%</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>7.2%</td>
</tr>
<tr>
<td>Back pain</td>
<td>6.8%</td>
</tr>
<tr>
<td>Emotional lability</td>
<td>6.5%</td>
</tr>
<tr>
<td>Nausea</td>
<td>6.4%</td>
</tr>
<tr>
<td>Pain</td>
<td>5.6%</td>
</tr>
<tr>
<td>Nervousness</td>
<td>5.6%</td>
</tr>
<tr>
<td>Depression</td>
<td>5.5%</td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

In a clinical trial of NEXPLANON, in which investigators were asked to examine the implant site after insertion, implant site reactions were reported in 8.6% of women. Erythema was the most frequent implant site complication, reported during and/or shortly after insertion, occurring in 3.3% of subjects. Additionally, hematoma (3.0%), bruising (2.0%), pain (1.0%), and swelling (0.7%) were reported.

Effects of Other Drugs on Hormonal Contraceptives
Substances decreasing the plasma concentrations of hormonal contraceptives (HCs) and potentially diminishing the efficacy of HCs: Drugs or herbal products that induce certain enzymes, including cytochrome P450 3A4 (CYP3A4), may decrease the plasma concentrations of HCs and potentially diminish the effectiveness of HCs or increase breakthrough bleeding. Some drugs or herbal products that may decrease the effectiveness of HCs include rifampin, phenobarbital, phenytoin, barbiturates, carbamazepine, bosentan, felbamate, griseofulvin, ocarbamazepine, rifampicin, topiramate, rifabutin, rufinamide, and products containing St. John’s wort. Interactions between HCs and other drugs may lead to breakthrough bleeding and/or contraceptive failure. Counsel women who are using NEXPLANON that they should avoid taking other non-rodapico contraceptive methods during this time.

Substances increasing the plasma concentrations of HCs: Co-administration of certain HCs and strong or moderate CYP3A4 inhibitors such as ritonavir, voriconazole, fluconazole, grapefruit juice, and ketoconazole may increase the plasma concentrations of progestins, including etonogestrel.

Human Immunodeficiency Virus (HIV)/Hepatitis C Virus (HCV) Protease inhibitors and non-nucleoside reverse transcriptase inhibitors: Significant changes (increase or decrease) in the plasma concentrations of progestin have been noted in cases of co-administration with HIV protease inhibitors (decrease [e.g., nevirapin, ritonavir, darunavir/ritonavir, fosamprenavir/ritonavir, lopinavir/ ritonavir, and tipranavir/ritonavir]) or increase [e.g., indinavir and atazanavir/ritonavir]/HCV protease inhibitors (decrease [e.g., buprenorphine/tert butyl alcohol] or with non-nucleoside reverse transcriptase inhibitors (decrease [e.g., nevirapine, efavirenz]) or increase [e.g., etravirine]. These changes may be clinically relevant in some cases. Consult the prescribing information of anti-viral and anti-retroviral concomitant medications to identify potential interactions.

Effects of Hormonal Contraceptives on Other Drugs
Hormonal contraceptives may affect the metabolism of other drugs. Consequently, plasma concentrations may either increase (for example, cyclosporine) or decrease (for example, lamotrigine).

Consult the labeling of all concurrently-used drugs to obtain further information about interactions with hormonal contraceptives or the potential for enzyme alterations.

USE IN SPECIFIC POPULATIONS
1. Pregnancy
Risk Summary
NEXPLANON is contraindicated during pregnancy because there is no need for pregnancy prevention in a woman who is already pregnant (see Contraindications). Epidemiologic studies and meta-analyses have not shown an increased risk of genital or non-genital birth defects (including cardiac anomalies and limb-reduction defects) following maternal exposure to low dose CHCs prior to conception or during early pregnancy. No adverse development outcomes were observed in pregnant rats and rabbits with the administration of etonogestrel during organogenesis at doses of 315 or 781 times the anticipated human dose (60 μg/day). NEXPLANON should be removed if maintaining a pregnancy.

2. Nursing Mothers
Lactation
Risk Summary
Small amounts of contraceptive steroids and/or metabolites, including etonogestrel are present in human milk. No significant adverse effects have been observed in the production or quality of breast milk, or on the physical and psychomotor development of breastfed infants. Hormonal contraceptives, including etonogestrel, can reduce milk production in breastfeeding mothers. This is less likely to occur if the breastfeeding has been established; however, it can occur at any time in some women. When possible, advise the nursing mother about both hormonal and non-hormonal contraceptive options, as steroids may not be the initial choice for these patients. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for NEXPLANON and any potential adverse effects on the breastfeeding child from NEXPLANON or from the underlying maternal condition.

3. Pediatric Use
Safety and efficacy of NEXPLANON have been established in women of reproductive age. Safety and efficacy of NEXPLANON appear to be similar for postpubertal adolescents. However, no clinical studies have been conducted in women less than 18 years of age. Use of this product before menarche is not indicated.

4. Geriatric Use
Risk Summary
This product has not been studied in women over 65 years of age and is not indicated in this population.

5. Hepatic Impairment
No studies were conducted to evaluate the effect of hepatic disease on the disposition of NEXPLANON. The use of NEXPLANON in women with active liver disease is contraindicated (see Contraindications).

6. Overweight Women
Effectiveness of the etonogestrel implant in women who weighed more than 130% of their ideal body weight has not been defined because such women were not studied in clinical trials. Serum concentrations of etonogestrel are inversely related to body weight. A 10% decrease in body weight is associated with a decrease in weight with implant insertion. It is therefore possible that NEXPLANON may be less effective in overweight women, especially in the presence of other factors that decrease serum etonogestrel concentrations such as concomitant use of hepatic enzyme inducers.

OVERDOSE
Overdose may result if more than one implant is inserted. In case of suspected overdose, the implant should be removed.

NONCLINICAL TOXICOLOGY
In a 24-month carcinogenicity study in rats with subdermal implants releasing 10 and 20 mcg etonogestrel per day (equal to approximately 1.8-3.6 times the systemic steady state exposure in women using NEXPLANON), no drug-related carcinogenic potential was observed. Etonogestrel was not genotoxic in the in vitro Ames/Salmonella reverse mutation assay, the chromosomal aberration assay in Chinese hamster ovary cells or in the in vivo mouse micronucleus test. Fertility in rats returned after withdrawal from treatment.

PATIENT COUNSELING INFORMATION See FDA-Approved Patient Labeling.

• Counsel women about the insertion of NEXPLANON implant. Provide the woman with a copy of the Patient Labeling and ensure that she understands the information in the Patient Labeling before insertion and removal. A USER CARD and consent form are included in the packaging. Have the woman complete a copy and retain it in your records. The USER CARD should be filled out and given to the woman after insertion of the NEXPLANON implant so that she will have a record of the location of the implant in the upper arm and when it should be removed.

• Counsel women to contact their healthcare provider immediately if, at any time, they are unable to palpate the implant.

• Counsel women that NEXPLANON does not protect against HIV or other STDs.

• Counsel women that the use of NEXPLANON may be associated with changes in their normal menstrual bleeding patterns so that they know what to expect.

Manufactured for: Merck Sharp & Dohme Corp., a subsidiary of
MERCK & CO., INC., Whitehouse Station, NJ 08889, USA.

For more detailed information, please read the Prescribing Information. USP-NF:8845-1P7X-7Y0/01/19 Revised: 05/17

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WOMN-126530/0000 03/18
Good morning. Listen up!" All eyes focus on the stocky chief resident as he balances a paper coffee cup on a towering stack of charts. He scans his fresh crop of third-year medical students and quickly targets the weakest among us.

“Sheppard!” Adam Sheppard is a gentle giant who wants to become a pediatrician.

“Yes?”

“Bed 309 is a regular customer. He’s a 70-year-old alcoholic who was re-admitted last night. What do you see?”

Overhead we gaze at an X-ray of the abdomen.

Adam answers, "Bowel obstruction?"

“Good guess.” Student, one point. Resident, zero. Game on.

General surgery in 1989 is all about toughing it out, proving yourself, and when abruptly called upon, spewing out the right answers. I made sure like everyone else to spew out the right answers.

We stop in front of the next room. “Engel!”

“Yes?”

“This lovely lady in bed 311 was sent to us this morning from our friends downstairs, " he adopts a falsetto, "in Psychiatry. " Then he slaps a chest X-ray up on the light board. “Diagnosis, please.” I have never seen anything like it. Neither has my fellow student, Marvin Engel. Meticulous, punctual, and always in the front row, Marvin is enthusiastic about forensic pathology. This should be right up his alley. He carefully crafts each word.

“There appear to be multiple radio-opaque foreign bodies…”

“Yes, and?”

“They are located in sub-dermal fat.”

“Marvin has no clue. Resident one point. Student zero. “Today you will have the opportunity to assist in surgery to remove the sewing needles our patient has imbedded into herself.” We march on.

“Carlson!”

“Here.”

“We know you are here, Carlson. Bed 313 is a young woman with ITP. What is ITP?”

“Idiopathic thrombotic purpura…”

“Idiopathic thrombocytopenic purpura. Cytopenia. It means not enough cells, specifically platelets. She has been unresponsive to medication. She needs surgery. Can you tell us what surgery?” Everyone in the room feels the scoreboard is about to light up in favor of our resident. My throat clenches. Think.

“Something to do with her spleen?”

“Correct. Please consent her for surgery. You will be assisting in splenectomy tomorrow.”

That afternoon I enter her dimly lit room. An acrid odor of disinfectant hangs in the air. Glancing at the chart, I take in her name, Annabelle Sanders. She is 29. She’s my age? The short dark hair on the back of her neck is already starting to mat against a flat pillow. Her rounded face from chronic steroid use obscures once-delicate features. She stares blankly at the television.

“Hello Miss Sanders, I’m a medical student on your surgical team. We need to go over some paperwork.”

She replies to the television. “I don’t want surgery.”

“It’s OK.” I inch toward her. “Removing your spleen will stabilize your condition.”

“Removing my spleen will kill me.”

For a moment or two neither of us speak.

“You people can’t cut me up just because you want to!”

“We don’t want to. We, uh…” I pick up the remote and mute her television. She shoots me a menacing glance.

“You don’t get it, do you?”

“Miss Sanders, we want to do what is best for you.”

Annabelle pulls her knees up close to her chest. She searches me for allegiance. Then her voice drops to despair.

“promise you won’t let me die?”

“Well I can’t, I mean we…” I begin to riffle through the pages of her chart looking for a rope hold, a life ring, any solid ground, but I am confronted only by the blank signature line of her informed consent. All the pride I have earned from pulling high scores on written exams seems instantly outstripped by her life experience. I muster a bit of feigned confidence. “You are in good hands. Don’t worry, you will be just fine.” But something feels wrong. “I’ll tell you what, maybe I’ll come back later?” I take a few steps toward the door. As if bargaining with fate itself, Annabelle pleads.

“Don’t let me die.”

I let the door swing closed.

Back in the doctor’s lounge, our chief resident is not amused. He is certain the patient in bed 313 with ITP simply enjoys the lens of logic and reason. The keystone upon which we build our knowledge is our ability to prove fact and disprove assumption. The exacting discipline of medicine requires that which is measurable and repeatable. It can be frustrated by the enigmatic or the mystical. Intuition does not fit, however, that she dislikes the increasing administrative burden of the profession.

“In medicine, we cast our gaze through the lens of logic and reason. The practice of medicine is a calling,” she says. “Most doctors feel passionate about their role in healthcare,” she says. "When Iretires from medicine, Carlson hopes to devote more time to the activities she now enjoys, medical mission work, crafting pottery, gardening, writing, hiking and kayaking."
It’s Monday morning. Your phones are ringing off the hook, patients are getting squeezed into the schedule any place your staff can find, and it’s looking like it’s going to be another exhausting day.

Does it really have to be like this?

Busy practices rarely have the time to pause, evaluate workflows, and attempt to improve efficiencies across the practice. However, unless you make that time, things are likely to stay the same and you’ll repeat those exhausting Mondays over and over.

**Implement your changes**

Once you’ve established the problem, its cause, and how you can change it, you need to implement those changes in your practice.

Start by drafting a memo to your employees that accomplishes two important things: 1) it ensures that your new process gets captured and disseminated to the staff, and 2) it can be used as part of your training materials going forward. As you perfect more and more processes, that library of literature will grow.

The memo should include a few components. It should identify the nature of the problem, explain why it’s a problem, and state exactly what the team has proposed as the solution. Then ask everyone to support the change, and let them know that you will be measuring the outcome.

**Slow and steady wins the race**

Don’t expect miracles overnight. Employees need time to get used to a process change, particularly if it alters the flow of how they do their work.

The key to ensuring that change will stick is to measure the progress and reinforce the new process any place that you find it is not being implemented routinely. Staff need to practice the new way of carrying out a task, and reinforcement is what gets them there.

Always go with the easier changes first. Having some early wins will allow your employees to feel confident in deploying new processes, and over time the process of continuous improvement itself can become part of the practice culture.

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**Where to start**

Start with the obvious issues. For example, figure out what is the single, most recurring annoyance in your practice. Is it being over-scheduled? Patients not getting timely call-backs? The same questions coming up time and again from patients?

Narrowing it down to an item or two that you’d like to improve is essential to making any progress. Try to do too much at once and you will likely fail, as time is limited and more pressing obligations will always keep popping up.

Second, put together a small team of people to work on the problem and set aside 30 to 45 minutes a week they can devote to it. Tapping into those on the front lines of the issue often reveals quick solutions. Staff usually know what needs to be fixed and how to fix it, but either haven’t been empowered to fix it themselves or simply haven’t had the time to focus on implementing the solution.

Third, make sure that you are solving the right problem by digging into the root cause of the issue. I find that working with the ‘5 Why’s’ process and the ‘How, How’ diagram is very effective at 1) getting to the underlying cause of a problem, and 2) working through how to implement a solution.

A variety of tools can assist you in any area of process improvement, from the more complex Six Sigma methodology to working with an A3 problem solving tool.

But the best process improvement projects are usually those where your team uses the easiest process, and they are able to hone their improvement skills over time from there.
Vaccines are a high-volume service in most primary care practices, but are physicians capturing all of the Medicare revenue they’re entitled to?

Not always, says Yvonne Dailey, CPC, CPC-I, CEO of Dailey Billing Services Inc. in Toms River, N.J. Physicians often don’t report the correct codes, or they forget to report certain codes. During peak flu and pneumonia season, these mistakes can definitely add up, she adds.

Dailey provides five tips to help practices bill Medicare Part B correctly.

1. Know what Medicare Part B covers

Medicare Part B only covers the following immunizations:
- Hepatitis B vaccine (for patients at high or intermediate risk)
- Influenza virus vaccine
- Pneumococcal pneumonia vaccine
- Vaccines directly related to the treatment of an injury or direct exposure to a disease or condition (e.g., tetanus, diphtheria, and pertussis [TDAP])

2. Report two codes—one for the vaccine and one for the administration

When billing Medicare, physicians frequently omit the code for the administration, says Dailey. This is how practices lose revenue, she explains, adding that the omission of a single administration code could cost the practice approximately $20-$25, depending on the Medicare Administrative Contractor.

“You need to review your denials and make sure the right codes were used before you assume it was a contractual write-off,” Dailey says.

Another mistake is that physicians report a CPT code for the administration rather than a HCPCS code, Dailey says. If the EHR auto-posts a CPT code for all immunizations, physicians will receive a denial when administering vaccines that would normally be covered for Medicare patients.

Best practice is to review each administration code manually or create payer-specific rules within the EHR for Medicare versus commercial payers, says Dailey.

The specific drug, dosage, and route of injection will determine the vaccine code that’s reported in addition to the administration code, says Dailey. Consider the following:

- For the influenza vaccine, report one of the following CPT codes: 90630, 90653-90658, 90660-90662, 90672-90674, 90682, 90685-90688, 90756, or 90739-90740. Payment for these codes range from approximately $9 to approximately $55.
- For the hepatitis B vaccine, report one of the following CPT codes: 90739-90740, 90743-90744, or 90746-90747. Payment for these codes range from approximately $26 to approximately $131.
For the pneumococcal vaccine, report one of the following CPT codes: 90670 (pays approximately $205) or 90732 (pays approximately $108).

For the TDAP vaccine, report CPT code 90715 (pays approximately $31).

Medicare also posts updated payment information specifically for the influenza vaccine, so be sure to stay up-to-date.

Don’t forget to report ICD-10-CM diagnosis code Z23

If the sole purpose of the encounter is to administer a vaccine, report Z23 with both the administration and vaccine codes, says Dailey.

However, in many cases, vaccines are given during a visit in which physicians render other services. For example, physicians frequently administer the influenza vaccine (split virus for intramuscular use) during an initial wellness exam.

Report the following codes for this scenario:

- G0234 (for the vaccine) with diagnosis code Z23
- G0008 (for the administration) with diagnosis code Z23
- G0438 (initial wellness exam) with any other relevant diagnosis codes

Use caution when providing the vaccine for TDAP

Medicare Part B covers the TDAP vaccine only when it’s related to a current injury (e.g., accidental puncture wound), says Dailey.

When a patient with a current injury requires the vaccine, physicians must report a diagnosis code from Chapter 19 of the ICD-10-CM manual for the injury rather than Z23, she adds. The last character in the diagnosis code should be ‘A’ to denote an initial encounter (i.e., current injury) rather than a ‘D’ for subsequent encounter or ‘S’ for sequela.

Also be sure to document the type of injury, how and where it occurred, and the area of the body where the injury was sustained, she adds.
Money

“**You need to review your denials and make sure the right codes were used before you assume it was a contractual write-off.**”

—**YVONNE DAILEY, CPC, CPC-I, CEO OF DAILEY BILLING SERVICES INC., TOMS RIVER, N.J.

Also note that unlike other vaccines, TDAP administration requires one or more CPT codes—not a HCPCS code—depending on how many separate vaccines are administered.

### Create rules within the EHR

For example, some EHRs allow physicians to create rules to prevent them from giving a vaccine before it’s due or remind them when one is due, says Dailey. Rules can also specify that Z23 is automatically report ed with every vaccine and administration code, she adds.

### Know what to do if Medicare won’t pay

If Medicare Part B doesn’t cover a certain vaccine, providers can bill the patient—but only if they have a signed Advanced Beneficiary Notice (ABN) on file, says David Glaser, JD, attorney at Fredrikson & Byron PA, a business law firm in Minneapolis, Minn.

The ABN must describe the specific service that Medicare won’t cover, why it isn’t covered, and the anticipated amount the patient will owe, he adds.

“You basically need to know in advance why you’re going to get a denial,” says Glaser. “You can’t just get a blanket ABN for every vaccine.”

He provides this example: A Medicare patient presents for a hepatitis B vaccine as a preventive measure. Medicare Part B only covers this vaccine when it relates to a current injury. If the patient insists on receiving the shot even though it’s not covered, the provider should obtain an ABN stating the patient accepts financial responsibility for the vaccine.

The same is true for an influenza vaccine given more than once during the same flu season or a second pneumococcal vaccine given within one year of the initial vaccine.

Something else to keep in mind is that Medicare Advantage plans may cover vaccines not covered under Medicare Part B as long as the vaccine is reasonable and necessary to prevent illness, says Dailey.

For example, a patient with a Medicare Advantage plan requests the hepatitis B vaccine as a preventive measure. Although Part B won’t cover the vaccine in this instance, Part D may.

To learn more about Part D coverage for vaccines, view MLN Fact Sheet ‘Medicare Part D Vaccines and Vaccine Administration’ dated January 2018. To learn whether a specific Part D plan covers a particular vaccine, visit https://www.medicare.gov/find-a-plan/questions/search-by-plan-name-or-plan-id.aspx.
Understanding the business of medical marijuana

It is crucial for physicians to know how to legally handle what is still considered an illegal substance in some jurisdictions

by CHERYL ALKON Contributing author

Medical marijuana allows Ajay Suman, MD's cancer patients a safer alternative to opioids for chronic pain. It can be an effective treatment for his terminally ill patients, says Suman, a New York-based anesthesiologist and a professor of anesthesiology and pain medicine at Weill Cornell Medicine, who is qualified to evaluate patients in New York State who want to use marijuana for medical reasons.

As of April 2018, medical marijuana was legal in 30 states as well as the District of Columbia, Guam, and Puerto Rico, according to the National Conference of State Legislators’ website.

Meanwhile, medical associations such as the American Medical Association and the American College of Physicians are calling for more scientific research and trials regarding how medical marijuana actually benefits patients. Many also believe physicians and patients shouldn’t face federal penalties for its use in states where cannabis use is legal.

For physicians who want to include medical marijuana in their practices, knowing their state laws is crucial. Federal law deems marijuana a Schedule 1 substance under the Controlled Substances Act, putting it in the same category as heroin, LSD, and Ecstasy for its potential for abuse and addiction.

This makes it a federal offense to distribute marijuana.

Marijuana is used to treat assorted medical conditions including chronic pain, side effects related to cancer, Alzheimer’s disease, and nausea, among others. Marijuana is not covered by medical insurance so patients pay out of pocket for products, which can include marijuana in different concentrations as well as different forms, including edibles, tinctures, and oils.

Here’s what doctors need to know if they want to prescribe marijuana to patients.

MARIJUANA AND THE LAW

Unlike a medical practice that offers ancillary services, generally a medical practice cannot partner with or incorporate an on-site marijuana dispensary due to marijuana’s federal classification as a Schedule I drug, says Michael F. Schaff, JD, an attorney with Woodbridge, NJ-based law firm Wilentz, Goldman & Spitzer.

“As of today, any medical practice relationship with a dispensary puts the physician in a position to risk losing their federal Drug Enforcement Agency (DEA) license,” he says.

Angelo J. Cifaldi, JD, RPh, who co-chairs Wilentz, Goldman & Spitzer’s cannabis law group with Schaff, urges physicians to learn about their state’s medical marijuana laws, suggesting that physicians look at their state’s medical

HIGHLIGHTS

Because of marijuana’s status under federal law, physicians cannot write a prescription for marijuana. Instead, physicians write recommendations or orders, depending on state terminology.

Physicians can earn extra income for evaluating a patient’s eligibility for medical marijuana use by charging a fee for the visit.
society and understand how to work with medical marijuana following state and federal laws.

For example, notes Cifaldi, some states follow a corporate practice of medicine, which is a doctrine that may limit the practice of medicine to restrict non-licensed entities from practicing medicine; so a physician cannot be hired by a non-physician. A physician, therefore, needs to know state law if working for a dispensary as a medical director or is hired by a dispensary to train the staff, he says.

Cifaldi also points out that physicians may not agree on making medical marijuana available to treat specific conditions, despite state laws identifying which diagnoses might benefit from its use.

“Clarify whether you are writing an order or a recommendation. If you use the wrong term on the wrong form, you may be violating the law.”

— ANGELO J. CIFALDI, JD, CO-CHAIR OF CANNABIS LAW GROUP, WILENTZ, GOLDMAN & SPITZER

Physicians need to learn the proper terms used in their state. Because of marijuana’s status under federal law, physicians cannot write a prescription for a dose of medical marijuana. Instead, physicians write “recommendations” or “orders” (depending on state terminology, and comparable to writing a prescription while complying with state laws) for a medical marijuana card, which the patient then fills at a marijuana dispensary. “Clarify whether you are writing an order or a recommendation,” says Cifaldi. “If you use the wrong term on the wrong form, you may be violating the law.”

Physicians can earn extra income for evaluating a patient’s eligibility for medical marijuana use by charging a fee for the visit, but “a medical practice should not just be charging for writing marijuana prescriptions to qualified patients,” says Schaff. He notes an evaluation should be conducted to determine a recommendation or order first versus simply for a visit to gain access to medical marijuana.

Other ways physicians can earn income from medical marijuana, Schaff says, include working at a dispensary, if state laws permit it, or consulting with a dispensary or one of the growing number of marijuana-related companies. Physicians who evaluate patients for medical marijuana cards may see patient volume increase as new patients come into the office for evaluations.

There are other things physicians must follow to maintain compliance with state laws. This can include things like checking with the landlord to determine if working with medical marijuana violates the terms of the practice’s lease or speaking to the practice’s medical partners to ensure that one physician’s views regarding marijuana are consistent with others in the same practice, because there may be limitations on the forms of treatment in company documents, says Schaff.

**BANKING AND TAXATION**

It can be tough for companies that work with medical marijuana to remain compliant with all the financial considerations by and between financial institutions, state licensing agencies, and licensees, particularly as they cross state lines. Since the law varies from state to state, banking options can be challenging, which physicians should keep in mind if they are considering working with marijuana as a way to increase business to an existing medical practice.

Nathaniel Gurien, the founder and CEO of FINCANN, the Cannabis Banking Financial Network, helps businesses in the marijuana industry find banks that are comfortable providing checking accounts and/or MasterCard/Visa credit card processing to marijuana-related businesses.

Often, Gurien says, banks refuse to open checking accounts or provide merchant processing for marijuana-related businesses because of marijuana’s stigmatized reputation. The few banks that do will charge relatively high fees to cover the additional risk and compliance-related costs of providing service to these customers, he says.

Gurien notes, however, that there are more cannabis-friendly banks around the country today than in prior years and that access to such banks is improving as medical marijuana becomes more mainstream. A bank could potentially notice if a medical practice is now advertising medical marijuana evaluations through the practice’s website, and a bank’s representative may reach...
out to its physician customer and terminate the banking relationship if the bank has a problem with marijuana-related businesses.

With any kind of marijuana business, even if it’s illegal, the federal government taxes it, says Eric Foster, director of strategy for the Banks & Company Cannabis Practice Group. “The federal government wants to minimize the tax write-offs of being in that business because cannabis is still a Schedule 1 drug.”

As a result, those who grow, process, or sell marijuana products cannot deduct or write off many expenses related to the business, which reduces the potential return of running the business, says Foster. (Expenses related to the cost of cannabis can be written off, he notes.) However, this law doesn’t apply to physicians who are qualified to evaluate patients for medical marijuana cards, as they are an ancillary service for the industry, Foster notes. Physicians should still check with their practice’s tax advisor just to be sure, he adds.

Ultimately, those who believe that medical marijuana is a valid form of treatment can decide how to best get involved with it. Some physicians may restrict their practice to patients with a specific condition. Others may decide to evaluate patients with any of the multiple diagnoses approved by state laws for medical marijuana treatment, despite its current federal legal status. And while some states have approved the use of medical marijuana, that might change in the future.

“I’m prescribing medical marijuana to patients with terminal cancer. In three or four years, if my charts are audited, I have no question that I am covered.”

—AJAY SUMAN, MD, ANESTHESIOLOGIST, WEILL CORNELL MEDICINE

Education and consulting opportunities for physicians

As more states legalize the use of medical marijuana, questions about dosing and varieties surface. The vast majority of clinicians have no formal training, although there are a handful of continuing medical education courses in marijuana prescribing, including at the University of Vermont and the University of Washington.

“The paradigm of evidence-based medicine is completely turned around,” says Perry Solomon, the chief medical officer of HelloMD, a website for marijuana users. “Doctors are getting feedback from and are being educated by their patients,” he says. There are no decades of U.S.-based double-blind medical studies on marijuana for providers to rely on.

Instead, HelloMD directs physicians to take online continuing medical education courses about medical marijuana before they evaluate patients seeking medical marijuana cards. Physicians examine patients via telemedicine visits using HIPAA-compliant technology and are paid a flat rate for their services. Physicians also get feedback from patients about what forms and dosages of marijuana are effective for treating different medical conditions, as well as what side effects can occur.

Toronto, Canada-based Resolve, a medical device company which manufactures an inhaler for patient marijuana use, is also collecting data and developing insights through artificial intelligence algorithms to provide more education for both physicians and patients about medical marijuana. “People who use cannabis are very proactive with managing their symptoms,” says Rob Adelson, MBA, the CEO and founder of Resolve.

Patients who use Resolve’s inhaler voluntarily enter their data online to manage their side effects, dose effectiveness, note frequency of use, how they feel, and so on. “We focus on collecting data through our devices and using artificial intelligence to put that data to use,” says Adelson. Resolve’s advisory board of physicians uses the information to advise patients about dosing and formulations. Resolve has opportunities for physicians on a consulting basis, says Adelson, providing another way for physicians to get involved in the medical marijuana space.

It’s still unclear how medical marijuana interacts with other medications. “That’s one of the reasons why we got into this business: we are trying to get 25 years of data in the next year and a half,” says Adelson. We want to make sure doctors are making decisions that are safe and effective.”
How was the modern doctor made?

That’s the key question Rajeev Kurapati, MD, MBA, set out to explore in his latest book, “Physician: How Science Transformed the Art of Medicine” not only for himself, a practicing hospitalist for the past decade, but for his fellow physicians.

Kurapati, who practices at St. Elizabeth Medical Center in Northern Kentucky, says you have to start at the beginning—as in 2,000 years ago—to trace how the doctor transformed from a priest and a healer to become today’s technologically driven provider of care. And it’s critical to look at the digitization of medicine not only in the evolution of the profession, but also in terms of what it will mean for the future.

Kurapati recently talked about the book and the state of medicine with Medical Economics. The following are excerpts from that discussion.

Medical Economics: Why is it important to explore the transformation of medicine?

Kurapati: I thought I would write a book on the history of medicine, looking at where we’ve been and where we’re going and why that matters. I wanted to write something conversational and accessible that gave doctors, healthcare providers, and patients a good overview of the field of medicine—how doctors practice, how they think, and how patients are impacted by advances in medicine. That was the idea behind the book.

In the past, practitioners would look at the whole human being and say, “Okay, you have a stomach pain, but how are you sleeping? How are your family members? What are your relationships like? What do you eat?” That sort of holistic thinking came before the invention of disease-centric medicine, because healers needed all this information to make their assessments.

When we switched to a disease-centric approach, specialists emerged. In many ways this was helpful, but it also meant these doctors started seeing people not as human beings in total but mostly as, “This is my organ of interest, so I’m just going to focus here.”

When that happened, we started losing the human touch with our patients. It became a piecemeal approach to practicing medicine. This was the compromise we doctors had to make. There’s so much of an information overload that the explosion of knowledge, this explosion of information,
ME: You talk about the current state of technology in the book. How can physicians find more help than harm from their new tech tools?

Kurapati: We have to endure the growing pains of technology. Even if we don’t embrace technology, it doesn’t mean it’s going to stop—it just means we’ll be imposed upon by industries, profit makers, and governments. Either we embrace it or it moves on without us. The younger physicians—the millennial physicians—they have to take charge of technology and steer it in the direction they see is going to make it the most useful and valuable. And the more experienced physicians have to be ready to go with the flow.

ME: You’ve said you wrote the book “to answer the question of ‘Who am I as a physician?’” What lessons did you learn and what can you share with your peers?

Kurapati: One of the biggest lessons is to embrace technology. This technological revolution is going to transform and help [physicians]. With that in mind, make sure you first understand its usage. The more you resist, the more monstrous it becomes, because it’s just going to keep advancing.

Then, steer it in the direction that you want it to help you. That’s how you enhance its capabilities to become the most useful.

Second, slow down. Doctors are stuck in a fast-paced lane where salary or compensation is based on the number of patients we see and the number of days we work because the practice of medicine is a fixed service that we provide for a fixed price.

I’d caution my peers not to keep seeing more patients because you want to make more money faster. That’s an easy way to lose track of why you signed up for this job in the first place. You signed up so you could help others alleviate or manage their suffering, and that’s where you derive satisfaction in this field.

Recognize that you can slow down, spend some personal time, carve out moments of silence in your life and reflect upon the previous day.

Ask, “How can I make my life better?” and “How can I make the lives of others better?” This mindfulness improves our ability to care for others.

These questions get to the point of the book. When we introduced the scientific method, we decided we were going to examine only the things that could be measured—blood pressure, blood sugar, heart rate and so on. But this method is incapable of taking into account the human attributes that aren’t measurable. Fears, biases, prejudices, beliefs—these are apprised human attributes, and they’re necessary to help paint a complete patient picture.

In many practices today, a patient comes to a physician’s office and is nothing more than a bunch of numbers in a chart because the scientific method trained us this way.

If we don’t realize there are certain human attributes that are beyond the boundaries of this [scientific method style of medicine], then we are losing the human connection, we are losing the reason why we are here in the first place as doctors.”
In the current state of technology in medicine, there's an endemic uneasiness among many twenty-first century medical practitioners. Doctors want the precision that technology affords alongside the ability to use their honed bedside clinical skills. We want to see ourselves as indispensable as we were 100 years ago.

Physicians with this view tend to think the same way our predecessors did when the automation of factories took place in the beginning of the twentieth century. Computerization, though, is not like automation; it is a much more intelligent process. While automation largely replaced blue-collar workers, computerization replaces white-collar workers, too. Automation simply replaced physical labor, but computerization will augment and supplant human intellect.

Because of this, in many ways, technology is seen by some practitioners as a threat to the humanistic side of medicine. Computerization is viewed as something that will potentially erode the sacred doctor-patient relationship.

Consider one increasingly popular use of technology which is the new norm in hospitals: electronic medical records (EMR). Digital health records often contain a person's entire medical history, including their medications and immunization dates, known allergies, lab results, images and scans, and other important information in a single, accessible place. For patients who don't have consistent access to care, or for those who have a long or complex medical history that requires coordination of care from multiple specialists, digital record-keeping can become lifesaving.

Electronic records enable access during times of chaos and disaster. In 2005, when Hurricane Katrina ravaged parts of Louisiana, electronic records were being used for only around 38 per-
cent of patients. Paper records, commonly stored in basements and ground floors of buildings, sat in dirty water or mud for weeks following the storm’s devastation.

At the Medical Center of Louisiana in New Orleans, Health Information Supervisor Dorothy Jones prepared for the storm by moving the bottom rows of medical records to a higher shelf in the facility’s basement-level storage. When the levee broke, flood water filled the building to the ceiling of the first floor, stranding Jones and many of her colleagues. They were evacuated by boat two weeks later, but the hospital never recovered. Every record was lost. In all, it’s estimated that more than 400,000 records from New Orleans-area medical facilities were destroyed in the aftermath of the hurricane.

The impact of this loss was far-reaching. In an interview with ABC News, Dr. Jay Brooks, chief of hematology/oncology at Ochsner Health System in Baton Rouge, Louisiana, recalled seeing New Orleans refugees who didn’t know what kinds of medication they were prescribed, what type of cancer they had, or which treatments they’d received.

Digital records are a positive development, but there’s a flip side to this technology. In my years working as a medical professional, I’ve watched a growing number of doctors stay for one to two hours after the work day is finished, come in on days off, or work late at night from home in order to complete the ever-increasing documentation required of the EMR system.

Weary after a long day or night on the job, nurses sift through notes, charts, orders, and Code Blue records. They wade through page-long lists of checkboxes and entry fields asking for descriptive details of what happened in the chaos of an eight-or-12-hour shift, during which they were expected to function simultaneously as caregivers and data-entry clerks.

If the charting system is so labor-intensive, so counterintuitive to the work we do, that it can’t be successfully used in real time, then shouldn’t it be replaced with something better?

I’m not talking about the reality that, of course, some clinicians will chart more slowly or thoroughly than others. This issue goes far beyond that. When a system consistently causes good and efficient medical professionals to stay long past their shifts, or come in on days off, or chart from their homes (which should be places of recuperation and rest), then we need to acknowledge that perhaps there are flaws in the process.

Doctors and nurses rightfully feel that their jobs are to care for people, not to spend hours documenting and charting. As the popularity of EMR systems have increased, this extra workload has seen rampant growth across the profession.

Craig Lambert, a former editor at Harvard Magazine, has a name for these added-on responsibilities: shadow work. Any task that isn’t done for its own pleasure and that is in some way completed “in the service of an institutional master,” falls into this category.

For Lambert, shadow work isn’t just “a marginal nuisance snipping spare moments away from the edges of life,” but rather “a fire-breathing dragon, operating 24/7 throughout.” Medical staff, like professionals in many industries feel that they’re tasked with this kind of work—tasks that are necessary, even critical, to their jobs but that don’t count directly toward their remuneration.

In 1930, English economist John Maynard Keynes predicted that by 2028 our technology would permit us to work 15 hour weeks and dedicate our lives to leisure. Not even remote signs of such emancipation from toil has happened yet. In fact, it seems to be worsening.

The amount of time spent on clinical documentation has been on the rise since the late 1980s. While electronic records are easier to read, significantly more time is spent on them than on paper charts. And in truth, patients don’t like them much, either. A study in JAMA found that patients rated the care they received lower when doctors frequently looked at a computer screen during an examination.

Recent studies have found that physicians actually spend more time on electronic documentation than on providing direct patient care, and other studies have reported that clinical computer work constitutes the highest proportion of time spent by physicians. The breakdown is jarring: physicians spend an average of 43 percent of their time on data entry and just 28 percent directly caring for patients.

It’s easy to ask ourselves if the time required for EMR systems is time well spent. But it’s important to keep our perspective. We’re still in the initial phases of the digitization of medical records, which means there will be kinks to work out. Over time, as functionality, accessibility, and transparency continue to improve, we’ll re-
alize the true potential of this technology. After all, the goal of technology in medicine is to eliminate shadow work for clinicians, to increase standards of care for patients, and to allow doctors to focus on the job we love most—direct patient care.

Contrary to the expected grumbling that accompanies big changes within the medical industry, technology is going to augment, not diminish, the humanistic attributes of medical care. Here’s how this is going to be realized: Currently, most patients’ information is manually entered into an electronic health record, typically by a doctor, nurse, or other healthcare staff. Once inbuilt sensors are able to collect data from within the body and machine-to-machine communication occurs without the involvement of human data entry and cognitive labor, the real potential of technology will be realized.

Even as record-keeping is becoming more streamlined, medical decision-making is still best performed by the physicians involved in a particular patient’s care. Cognitive aptitude (or inaptitude) of a medical professional is the only method through which treatment choices are proposed to patients.

Eventually, though, the most prized of our unique assets—human cognition—will be supplanted by technology, too. In general, technology will carry out the routinizable operations that fill the intervals between decisions. And as we continue to make forward strides, technology will eventually surpass the routinizable to perform many specialized tasks.

As doctors continue to attempt to keep up with a knowledge base that’s expanding exponentially, the natural next step in this evolution of medicine is the digitization of the diagnostic approach—the ability to curb human error and cognitive limitation from the decision-making process. Technology is able to provide support to make timely decisions, further standardize medical practice, and provide more data for research than ever before. Through data analytics, we will be able to sift through mounds of data to gain levels of insight never before possible, thus providing new and improved conclusions to long existing problems.

The entire patient-physician encounter is being largely computerized, with applications designed to aid clinicians in everything from diagnosing to developing treatment strategies. These applications serve as a sort of care continuum the doctor follows throughout the appointment, providing quick access to data-driven decision-making and the ability to alert the physician to previously unrecognized patterns within a patient’s history. The distinct characteristics of individual patients are then analyzed against the computer’s massive knowledge base that includes all academic literature, all possibly relevant genetic mutations, and all the clinical trials that target these particular mutations to generate patient-specific recommendations. The system then presents the doctor with reports outlining various options and treatment alternatives, as well as explaining how it came to these conclusions by referencing the original data. Cognitive support to physicians extends to include reminders of overdue preventative measures, advice for prescribing, critiques of existing orders, and suggestions for active care. These decision-support systems are ideally geared to save the clinician time and the patient money.

Technology has far more capacity to consider variables than the average doctor could ever hope to do, all the while leaving much less room for error. A doctor can’t remember the last 200 research articles on a specific heart disease, for instance, but a computer can. Technology can provide a multitude of options for patients to choose from, based on real-time data and the latest available research. This influx of health data will change the game forever. Once we have a large enough dataset and an addressable database of research studies, we’ll be able to...
identify patterns and physiological interactions in ways never before possible.

At present, many computerized diagnosis aids do not yet measure up to the performance of human doctors. But when this happens, the doctor will be released from a number of cognitive activities that can instead be automated. Future bioprocessoers, for instance, will not only gather information, but could also diagnose illnesses and even forecast our health. They’ll give us instantaneous analysis of various parameters, including cholesterol levels, stress-hormone levels, tissue perfusion, oxygen-saturation levels, blood pressure, blood sugar, heart rate, body temperature, sleep habits, exercise patterns, eating habits, family history, and genetic sequencing.

A risk profile could then be generated using these data points, incorporating the latest research to make predictions about a patient’s well-being. And all of this could occur without the active participation of the physician.

A high-tech brain pacemaker that could internally communicate with a continuous blood-glucose monitoring device, for example, might detect when an individual’s blood sugar is low. This, in turn, could identify those individuals who might potentially have a seizure when their blood sugar drops to critically low levels. The brain pacemaker would then send feedback messages to the pancreas to temporarily inhibit insulin release and immediately correct these sugar levels to avert the seizure. If a seizure was still imminent, then the pacemaker might instead autocorrect the electrical signals within that part of the brain and prevent the seizure from occurring.

In the near future, technology is going to be able to answer many routine questions that patients ask surgeons before they go under the scalpel: What’s the success rate of this procedure? How long is the recovery? How much time should I take off from work? How will this impact the rest of my life? Eventually, technology might provide the answers with you in mind instead of just being based on population statistics alone, which is the standard practice today.

As we extend our human abilities with new tools and as nascent artificial intelligence matures and makes its way into our workflows, we’ll enter a new period of bios electronics. We will see medical research grow more and more individualized, a metamorphosis beyond labs or in controlled randomized studies. Through the use of real-time data, 3D visualizations, virtual reality, and lifelike digital simulations, what we’ll see is that research and education, as well as practical application of care, can eventually become customized for every patient.

The goal of the digitization of the cognitive process is to circumvent limitations of human decision making. Technology will help eliminate some of the many errors that naturally occur in our current medical climate. And although technology can help reduce our errors, it can never create a fully error-free system for one simple reason: machines are built and designed by human agency, and we will unavoidably transfer some element of our own limitations onto them.

Regardless of how much technology augments areas of medicine, we will always need an expert to guide a machine through the scope of choices or specifics technology provides. In one capacity or another, human touch is indispensable for the foreseeable future.

Nevertheless, the transformation offered by technology will grant physicians more time and opportunities to be involved in the emotional and existential needs of patients. For doctors who are too preoccupied with a disease-centered approach, this shift will allow practitioners to focus more fully on patient-centered care.

Training in present-day medical schools has already started to incorporate didactics in interpersonal skills to address the existential needs of the sick. Instructors will continue to teach these skills, along with professionalism and other communication tactics, with as much emphasis as is currently placed on the instruction of clinical acumen. The age-old apprenticeship model of learning to diagnose diseases or training in surgical skills from experienced teachers will be largely replaced by simulators.

However, at each major disruption in medical technology, there will be resistance among primary stakeholders—doctors and patients—as they adjust to these new systems. Throughout the nineteenth century, we treated symptoms. In the twentieth century, we treated diseases. In the twenty-first century, technology will increasingly predict and prevent disease—and when it can’t, it will replace damaged and failing organs at impressive rates.

In the future, a separation of medicine into two fields—art and science—is going to become even more visible. Technology will replace the scientific side of a doctor’s practice and will allow them to focus instead on a more personalized approach to healing, restoring the art of medicine in the process.

It’s hard to imagine now, but as our technology becomes more advanced and ubiquitous, we might grow that much more human. Doctors will remain as the face of this science because of the breadth and depth of our day-to-day interactions with the sick and dying. Technology experts, biochemical researchers, and entrepreneurs—while critical players—will remain our collaborators. And it’s this collective team of experts working together that will propel us into new frontiers of healthcare.

A condensed excerpt from Physician: How Science Transformed the Art of Medicine.
Financial Strategies

6 back-office billing strategies

The front desk staff is essential for checking in patients, collecting copays, and verifying insurance. But there’s more to the story, and out of sight doesn’t mean out of mind. Much of the heavy lifting for billing and collections is done in the back office, so it’s even more important to have a deep bench of talent, says Tammie Olson, manager and coding and compliance strategist at Management Resource Group.

Here are six strategies Olson suggests to get your back office team to bring their best game to your billing and collections efforts.

1. **Train select employees to set up payment plans.** Often, the front desk will discover the need to set up a payment plan with self-pay patients or patients with an outstanding balance. But the actual arrangement is made by the back office staff. It’s crucial these plans be consistent and fair for all patients. You need to have one or two people in your back office who know how to correctly set up plans. Training back office staff will also alleviate the pressure on the front desk to make decisions about waiving payments—or let their emotions cloud their decision-making.

2. **Reconcile encounter forms and bill claims daily.** If there are any questions about the services rendered, seek clarification from the provider. Your billers should be knowledgeable about appropriate modifiers and when to use them. Make sure your billers are submitting clean claims. Clean claims get paid the first time around and stand up to a potential audit.

3. **Analyze insurance denials and develop processes to reduce them.** Is there misuse of modifiers? Are denials related to medical necessity? Outdated codes? If you make the effort to track the denials and see where you’re making mistakes, the time spent will be rewarded with higher and prompter payments. Similarly, have processes in place for correcting and resubmitting denied claims in a timely manner.

4. **Follow up on accounts receivable daily.** Run insurance aging reports and review anything more than 60 days old. You may have to call the payer in some cases, but most claims pay within 21 to 30 days of submission. If this is not the case, you need to investigate what’s going on.

5. **Conduct patient flow analyses regularly.** Time is money, and anytime there is a patient flow problem, it costs the practice. The office manager or practice manager should analyze patient flow for all services provided, find problems, and identify ways to streamline the processes. For example, you might perform a patient flow study. This will tell you how long it takes patients to complete the check-in process and be placed in the exam room. This will help you track and streamline processes at the front desk. A shorter check-in process can improve patient satisfaction and help keep providers from falling behind schedule.

6. **Designate one person to follow-up on patient balances.** Your front office is making sure patients are aware of their balances. Someone in the back needs to be tasked with calling the patients and asking for payments. Many practices outsource this responsibility. It’s less important who makes the calls so long as follow-ups are conducted on an ongoing and regular basis. When the back office takes these tasks seriously, processes proceed more smoothly throughout the practice. When that happens, your bottom-line will see a bump in revenue. That’s a bonus for everyone in the practice.

Avery Hurt is a contributing author. Send your financial questions to: medec@ubm.com

MedicalEconomics.com
Addressing social determinants of health

by DEBORAH ABRAMS KAPLAN Contributing author

C linicians see the results of patients not following their treatment plan, whether it’s medication adherence, lifestyle recommendations, or attending follow-up visits. But there are often social factors influencing a patient’s lack of adherence. They may struggle with basic survival needs like housing and food, lack transportation, or not understand their health condition and how they can improve it.

About 40 percent of factors contributing to a person’s health are social and economic, according to Health Research and Educational Trust, and only 20 percent are related to clinical care. Healthcare systems around the country are realizing that addressing these social determinants of health can improve patient health, while also sometimes saving the medical system money by reducing treatment costs. Here are three programs to watch, and ways that health systems can implement something similar.

FOOD IS HEALTH: PROGRAM FOR PATIENTS WITH DIABETES

Physicians at Riverside Family Practice in Columbus, Ohio, rarely asked patients about food insecurity. That is, until the Mid-Ohio Food Bank reached out to them to pilot a food and health initiative. The practice sampled its patient population, which includes many patients with diabetes, to see if food insecurity was an issue. It turned out to be a much larger problem than they expected: 43 percent of patients said they had problems getting healthy foods to eat.

Laurie Hommema, MD, a primary care doctor and program director of Riverside Methodist Hospital family medicine residency, says they were surprised by the results, because any who responded positively have private health insurance, full-time jobs, and own their own homes. The USDA estimates that Ohio has a 16 percent food insecurity rate, compared to a U.S. average of 13.66 percent. In Franklin County, which encompasses Columbus, the rate is 32.2 percent, according to a 2017 study by The Ohio State University.

In May, 2018, the practice started its “Food is Health” program for its patients with diabetes, adding a food bank inside their practice. They give participants fresh produce each week, along with recipes, cutting boards, peelers, and a short nutrition-related class.

Miriam Chan, PharmD, a certified diabetes educator and director of research and evidence-based medicine education at OhioHealth Riverside Methodist Hospital, devised 12 sessions that residents teach, on topics like portion size, eating less sugar, and choosing healthy fats. They introduce produce like butternut squash, explaining how to cut it up and cook it. After the class,
patients choose their own produce, though residents often suggest items, encouraging them to take and try more. “Avocados were the big hit,” Hommema says. “A lot of people had never tried an avocado.”

One program goal is to increase the amount of healthful and fresh foods patients and their families have access to, though they also offer foods like whole wheat pasta, canned beans, and canned vegetables. Family members can come to the group education sessions to learn and pick out food. “Seeing the next generation of patients getting that benefit is really rewarding,” Chan says.

Clinicians don’t weigh patients or do testing at these sessions, but at clinic visits they monitor weight, blood pressure, and hemoglobin A1C levels. They want patients to recognize the impact of eating healthier foods on their own. “They see changes in their health,” including lower weight, Chan says.

Food is Health sees 40-50 patients a week, also providing fresh produce for families, which means serving around 110 individuals weekly. When reviewing medical charts from the first four months of the program, 12 patients showed reduced A1C levels after participating, with seven patients experiencing more than a 1 percent reduction, and two patients reducing theirs by 1.5 percent. Anecdotally, Chan says patients enjoy coming to the sessions and have a high attendance rate, but it’s too early to know if the program has reduced hospitalizations or emergency department visits, but they are going to track these trends.

The program costs about $7 per person per week, with a $40,000 yearly budget, which comes from the residency program’s operating budget. The residency program can sustain this amount for now, says Hommema, but their ultimate goal is to get funding from Medicare and Medicaid, as it can save them treatment money. “Insulin is way more expensive,” Hommema says. One of her patients is already on the verge of stopping her oral diabetes medication as a result of the healthier eating. “She’s out of that range now where she needs them. That’s our goal.”

One unanticipated benefit is that the program is increasing physician satisfaction and reducing physician burnout. Residents and medical students appreciate the meaningful interactions with patients. “One resident said, ‘This is why I got into medicine. This is exactly what my heart needed, and I didn’t realize it,’” Hommema says.

Practices who are not able or ready to start their own food bank can still screen patients for food insecurity as part of the intake process, and counsel them on food issues. MedStar Health in the District of Columbia uses the website AuntBertha.com, which has an accurate database of support systems, including food banks, searchable by ZIP code. Of course the problem with food banks is that you don’t always get fresh food and you’re at the mercy of whatever is donated/purchased by them. Not all the food is healthful.

Pete Celano, MBA, director of consumer health initiatives at MedStar Institute for Innovation says that nurses and social workers can quickly access the site, print out resource lists, refer patients to the organizations, and save search results for specific patients in the HIPAA-compliant website. That way they can follow up with patients during subsequent visits and even ascertain whether the patient visited the recommended organization.

**HEALTH LITERACY HOUSE CALLS**

OhioHealth Doctors Hospital in Columbus, Ohio also, started the pilot Health Literacy program focusing on patients hospitalized with congestive heart failure (CHF) and COPD. Nationally, 20 percent of patients over age 40 who are hospitalized have a COPD diagnosis, according to the Agency for Healthcare Research and Quality. Of those hospitalized with COPD complications, 20 percent will be readmitted to the hospital within 30 days. The national readmission rate for those with CHF is about 22 percent.

OhioHealth’s program reduced its 30-day readmission rates with participating patients with these diagnoses from 18 percent to 10.3 percent. “This tells me that people aren’t noncompliant, but that we haven’t done a good enough job meeting patients where they’re at. They’re able and willing to adhere to information they can understand,” says Joseph Geskey, DO, an internist and vice president of medical affairs at Doctors Hospital.

**Examples include:**
- Housing stability
- Socioeconomic conditions
- Local food markets
- Access to educational, economic and job opportunities
- Access to healthcare services
- Quality of education and job training
- Availability of community-based resources
- Transportation options
- Public safety
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Neighborhood safety (Exposure to crime and violence)
- Residential segregation
- Language/Literacy

**Source:** U.S. Office of Disease Prevention and Health Promotion
Participating patients admitted to Doctors Hospital with a COPD or CHF diagnosis are given the Newest Vital Sign screening. Patients answer six questions about an ice cream nutrition label, requiring them to read the label and sometimes perform basic calculations relating to allergies, fat and daily percentage of calories.

Geskey says that when introducing the screening, his colleagues scored six out of six, while half the patients scored zero or one, showing a high likelihood of impaired health literacy. “That’s incredibly illuminating to the physicians,” he says, and the staff couldn’t predict which patients did poorly. Without understanding a patient’s health literacy level, doctors may not change their communication styles or realize that their patients may be missing necessary information for their care and follow up.

Nationally, only 12 percent of Americans have proficient health literacy, according to the U.S. Department of Health and Human Services, and more than one-third have difficulty with common health tasks like following prescription medication labels.

They also screen patients with PAM13 (patient activation measure), a 13-item tool assessing patients’ self-management skills and knowledge. These screenings have helped clinicians become more empathetic toward hospitalized patients who, for a variety of reasons, are unable to process health information given to them.

Doctors Hospital has admitted 125 individuals into the program, who meet the criteria of a COPD or CHF diagnosis, low health literacy and low activation screening scores, and Medicare homebound criteria. The program includes one-hour home visits once a week for four weeks. They ask the patient to pick something they want to do but can’t, due to their illness. A patient might say she wants to attend a grandson’s baseball game. Once the patient reaches the goal, they can see how their actions are positively affecting their health, motivating them to continue.

Clinicians use a teach-back method, asking patients what they understand about their disease, and how to take their medications. They may teach the patient how to set up a weekly pill box, or discuss dietary or exercise issues. The last visit focuses on problem solving and how patients can advocate for themselves. The program measures success by whether the patient is readmitted to the hospital in 30 days, and if they’re motivated to take charge of their care.

“Many with lung or heart disease can’t explain their disease, understand what medications are, and how take them, let alone what they need to do when they get sick,” Geskey says. When clinicians write hospital discharge summaries, they overestimate people’s skills and understanding about their chronic disease therapy. “We end up seeing them back in the emergency department or in our clinics, and we label them as noncompliant. That immediately turns off our creative ability to meet patients where they’re at.”

The program is funded completely through philanthropic grants. Geskey attends the initial home visits during the pilot, but they’re generally handled by a health coach or nurse, often one who lives in the community. They’re trained for motivational interviewing and patient education.
Large health systems that treat CHF or COPD patients could potentially see large cost reductions from lower readmission rates, especially if they’re receiving bundled payments from Medicare, says Geskey. The savings can more than pay for the program costs. More than half of healthcare systems pay penalties to Medicare for hospital readmissions, according to JACC.

**RIDE HAILING PROGRAMS**

Healthcare facilities have historically arranged taxi rides for some indigent patients for non-urgent clinical care. What is new is the lower cost, trackability and increased flexibility of doing so through ride hailing companies. Earlier this year, Uber Health and Lyft Concierge rolled out programs with secure, HIPAA-compliant web-based dashboards for healthcare providers to hail rides for their patients.

MedStar Health has seen the Uber Health program help patients keep appointments that otherwise might be missed or rescheduled. “The use of Uber Health for qualifying patients who lack transportation reliably helps enable an appointment that otherwise could not happen, for a minimum cost,” says Pete Celano, MBA, director of consumer health initiatives at MedStar Institute for Innovation.

Since the healthcare organization is principally fee-for-service, Celano says MedStar Health’s cost is balanced by the additional revenue they bring in from keeping those appointments. MedStar determines which indigent patients are habitual cancelers or reschedulers. Using the ride hailing programs, MedStar can still bring patients in whose appointment is within an hour. Patients don’t need a smartphone or ride code.

For practices that already provide rides to indigent patients, instituting one of the ride hailing platforms should be an easy switch, especially since it’s web-based. Confirming appointments by phone is time-consuming, but can pay off if there are fewer cancelled appointments that can’t be filled last minute.

**FINDING COMMUNITY RESOURCES**

In addition to food banks, sites like Aunt-Bertha.com compile resources including housing assistance options, low-cost or free transportation programs, health services, financial resources for low income individuals and families, support for navigating social services and other areas.

Without a stable foundation, these are all areas that impact a person’s ability to care for their own health and their family’s health. Talk to patients about what struggles they have and what stands in the way of them fully focusing on their health. This can be done by a nurse during the intake, or by a physician when discussing a care plan or prescribing a medication. Even telling a patient that if the medication isn’t covered by their insurance or if they have trouble paying for it, to let the physician know. There are community resources and pharmaceutical resources available to help patients with some drug costs.

“**One [medical] resident said, ‘This is why I got into medicine. This is exactly what my heart needed, and I didn’t realize it.’**”

— LAURIE HOMMEMA, MD, RIVERSIDE FAMILY PRACTICE, COLUMBUS, OHIO

Programs addressing social determinants of health can be replicated and scaled at other healthcare systems, and don’t have to be a financial drain on the system. Experts say that reaching patients through creative programs such as the ones covered in this article engage patients more in their own health, helping them to attain lifestyle and health goals. Much of the daily work with patients can be done by healthcare extenders and residents whose cost to the healthcare system is lower than physicians, but who are also already intimately involved in patient care.
Five years ago, Jim Butler took his car to a garage in Dayton, Ohio, for service. Before the mechanic started working on his car, he gave Butler a written estimate of what everything would cost: parts, labor, disposal fees, all of it. While waiting for his car to get fixed, Butler asked himself, "Why can’t healthcare prices be made this clear up front?"

So Butler, an Ohio state representative and lawyer, drafted The Ohio Price Transparency Law, a bill that would require health providers, except in case of emergency, to give patients up-front, good-faith estimates of what their care would cost before they got treatment.

What a concept.
The estimate would have to include all fees: physician, hospital, facility, anesthesia, labs, imaging. It would let consumers know not only the total price, but also what portion insurance would cover and their out-of-pocket obligation.

Everyone loved the idea—well, almost everyone. In fact, the price transparency bill was so refreshing, the Ohio legislature passed it unanimously. That’s right. Because transparency is one aspect of healthcare that both parties agree on, as well as virtually all Americans, lawmakers in both houses on both sides of the aisle were all in favor.

They passed the bill in 2015, and the law was to go into effect on Jan. 1, 2017.

“If you want to create a business that rains money, that allows you to consistently charge people five- to ten-times more than is reasonable and get away with it, today’s healthcare system is your model.”

But it didn’t. Those most threatened by the fact that consumers might learn the cost of their overpriced treatments and shop around blocked it. Heaven forbid that competition might enter the market.

The Ohio Hospital Association and seven other state health organizations went to court to oppose the law. Ohio Gov. John Kasich sided with the hospitals and helped stall the law further by not writing the regulations needed for it to take effect. Today the law remains mired in Ohio’s court system.

While Ohio’s situation is stark, it is not unique. Similar laws also are being blocked or diluted to the point of meaninglessness in other states. All over the country, hospital associations, medical associations and insurers are working double time to keep healthcare pricing impenetrable.

In September, the Wall Street Journal reported on the secret deals between hospitals and insurers which, the Journal reported, were the norm. “Dominant hospital systems use an array of secret contract terms to protect their turf and block efforts to curb health-care costs,” the article read. “Other terms allow hospitals to mask prices from consumers ... In some cases, contract clauses prevent patients from seeing a hospital’s prices by allowing a hospital operator to block the information from online shopping tools that insurers offer.”

Meanwhile, at the federal level, a bipartisan bill sponsored by Ed Pelmutter, (D-Colo) and Mike Gallagher (R-Wisc) would require hospitals to post their prices. House bill 4808, the Transparent Health Care Pricing Act of 2018, “requires entities that offer or furnish healthcare related products or services to the public to disclose the price for those products and services at the point of purchase and on the Internet,” according to the government website.

This sounds promising, but when I called one of the lawmaker’s offices to ask about the bill’s chances, the healthcare aide said the bill had a long way to go. “We’re still socializing the idea,” he said, as if we were discussing a puppy and not a needed reform in the law.
Butler, the Ohio state representative, said he fears that the bill is just more window dressing, an effort to make it appear as if lawmakers are taking steps to improve a broken system.

“Even if it were to pass,” Butler said, “it would not help transparency. Any strategy of posting prices online or somewhere else will never work so long as we have a third-party-payer system.”

Patients almost never search for healthcare prices online partly because, to get an accurate estimate, they would need CPT codes, the numbers billing departments use to bill payers. These codes are not easy to come by, and even harder to understand. A single procedure, say a knee replacement, can fall under five or six different codes.

What’s more, a hospital can list the price for a procedure, but not include all the related charges, like the facility fee, physician professional charges, specialist charges, lab charges and more.

A PERFECT MONEY-MAKING MODEL
The more you look into our healthcare system and its lack of transparency, the more you appreciate how ingenious it is. If you want to create a business that rains money, that allows you to consistently charge people five to 10 times more than is reasonable and get away with it, today’s healthcare system is your model. It goes like this:

“Complete price transparency is the first step. The second step is to break apart the networks that hem patients in and funnel them into the costliest settings.”

1. Take the matter out of the consumer’s hand.
2. Give the task of negotiating costs and choosing who delivers it to third parties.
3. Have the third parties convince consumers that they can spend consumers’ money better than the consumers can, and for that presumed benefit these middlemen can help themselves to a large portion of the consumers’ money.
4. Make the pricing structure unnecessarily complicated. Have many cost components (i.e., doctors, networks, facility fees, labs, medications). Create codes.
5. Charge absurd retail prices (Chargemaster) to make consumers believe they really are getting a deal.
6. Keep prices hidden, so consumers cannot know costs, and must purchase products and services on blind faith.

7. Only provide the price after the non-refundable services are rendered, then demand payment.
8. Send those who don’t pay to collections, then threaten to put a lien on their house.
9. Obstruct any bill or law that threatens the system.
10. If you’re really clever, call yourself a nonprofit, so you can avoid paying any taxes.

Sadly, as long as special interests continue to line lawmakers’ pockets, this perfect plan will continue. The best hope for disruption will be for consumers to get informed and then get angry. Complete price transparency is the first step. For patients to be empowered, they need information. The second step is to break apart the networks that hem patients in and funnel them into the costliest settings.

Meanwhile, doctors can help by saying no to employment contracts that take pricing out of their hands, by working to opt out of insurance and creating a direct payment practice where feasible and by posting their cash prices the way a car center does.

Until then, special interests will continue shutting down laws that would upset their money train, and keeping patients in the dark, right where hospitals and insurance companies want them.

Marni Jameson Carey is the executive director of the Association of Independent Doctors www.aid-us.org. You may reach her at info@aid-us.org.
What is on your personal playlist right now?

Maria Young Chandler, MD, MBA
Business of Medicine / Pediatrics
Irvine, Calif.
“Luciano Pavarotti and Yo-Yo Ma.”

George G. Ellis, Jr., MD
Internal Medicine
Boardman, Ohio
“Anything country.”

Antonio Gamboa, MD, MBA
Internal Medicine / Hospice and Palliative Care
Austin, Texas

Jeffrey M. Kagan, MD
Internal Medicine / Hospice
Newington, Conn.
“James Taylor, Gloria Estefan, Billy Joel, Barbara Streisand and Taylor Swift.”

Melissa E. Lucarelli MD, FAAFP
Family Medicine
Randolph, Wis.
“Lorde, Prince, Sia, Pharrell Williams, Barenaked Ladies and Amanda Palmer.”

Joseph E. Scherger, MD
Family Medicine
La Quinta, Calif.
“Elton John.”

Salvatore Volpe, MD
Pediatrics/Internal Medicine / Pediatrics
Staten Island, N.Y.
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RAJEEV KURAPATI, MD, MBA, ST. ELIZABETH MEDICAL CENTER, KENTUCKY  PAGE 41

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