Four policy debates doctors must follow

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HEALTHCARE’S FUTURE

Four policy debates doctors must follow

PAGE 16
Digital healthcare is the future. Are physicians ready for it?

I was recently waiting in line at the airport, and my mind began to wander. It finally settled on a crucially important question—what was Phoebe’s sister’s name on Friends? My mind gave me hazy hints. After several seconds of intense concentration passed, I considered pulling my phone out of my backpack so I could Google the answer. (I didn’t, as these types of mental exercises are increasingly important for me to engage in as I proceed through my 40s.)

That made me consider what I would’ve done years ago when I didn’t have a smartphone continuously connected to the internet. What would I have done? Asked somebody, maybe. Or waited until the next time I watched the show and smacked my head in frustration when it finally came to me.

You may be wondering what this has to do with the practice of medicine. My organization is exploring our future forays into digital health. In theory, there are so many benefits to enhanced connectivity between our patients and their caregivers. Digital health will provide us with access to information we currently don’t have or would need our patients need to come into the clinic to provide. It will be quicker and more convenient for caregivers and patients alike. Once healthcare reimbursement catches up, it should theoretically reduce overall cost of care. This all may be true, but I wonder how my organization will predict the other changes in usability that may accompany digital connectivity in healthcare.

We are all aware that the EHR, while providing us with many benefits, has not saved time or reduced the length or improved the quality of clinical notes, and has led directly to physician burnout. Similarly, when my organization started our patient portal, there were promises of decreased phone volume and more efficient care provided between visits. This too has not been proven in practice.

Just like my example at the beginning of this essay, easy connectivity and accessibility can lead to over- or inappropriate utilization of the resource. I am sure Google is thrilled that I think of them when I am wrestling with the answer to an important piece of trivia. However, since our healthcare organizations remain largely set up to have people respond to these digital inquiries, I doubt we’d be thrilled with the healthcare equivalent of Google.

Google spends a lot of money, time, and talent developing algorithms to help me find the answer to pop culture trivia questions in seconds. The medical equivalent does not exist—if my patient messages me about a cough, we do not have the computer “smarts” to apply digital triage, likelihood algorithms, or even robust clinical decision support.

Essentially, the current system digitalizes inefficient processes, which serves to increase the volume of patient requests, and, in trying to mimic the ease and accessibility of email or the Google search engine, we frustrate patients who have grown accustomed to quick and accurate answers and solutions at their fingertips.

Digital health is the future—of this I have no doubt. However, this will have results similar to the EHR if we are not smart about how it is implemented.

*Answer: Ursula

Jennifer Frank, MD, is a family physician and physician leader in Northeastern Wisconsin and finds medicine still to be the best gig out there. Married with four kids, she is engaged in intensive study and pursuit of work-life balance.
A shot of adrenaline for your retirement savings

Many doctors are simply not saving enough money. A late start to saving for retirement due to years of school and training combined with low retirement plan contribution limits creates the potential for an underfunded retirement portfolio. Many doctors also build their practices, assuming that they will one day sell them and use this financial gain to retire. Unfortunately, this may not be enough money to maintain the lifestyle that they are accustomed to.

It is generally considered safe and recommended to take retirement money distributions of no more than 3.5 to 4 percent as this will maintain a retirement account portfolio balance without drawing it down too quickly, and perhaps even allow it to grow. This means that a $1 million portfolio will provide $35,000 to $40,000 per year. Savings of $3 million or more may be necessary for many physicians.

Physicians who want to adequately fund their retirement must consider a cash balance plan. Like a shot of adrenaline, a cash balance plan can inject the funds necessary to stimulate weak retirement savings.

A cash balance plan is a type of qualified retirement plan that typically is layered on top of a combination 401(k)/Profit Sharing Plan. It is a defined benefit pension plan with similar characteristics to a defined contribution plan such as a 401(k) plan. For example, like a 401(k) plan, the participant sees their own individual account balance. Additionally, the cash balance plan allows for a portable account balance so upon departure from the company the participant may roll over the balance into another qualified plan such as an Individual Retirement Account (IRA).

Participants are promised a quantified benefit at retirement; this may be in the form of an annuity or a lump sum. At age 62 the payable annuity amount is up to $225,000 per year, or a lump sum amount up to $2,877,495.

To read more, visit bit.ly/adrenaline-for-retirement-savings.

Bloggers

“As hospitals across America continue to buy up medical practices and turn independent doctors into employees, which studies show is one of the leading drivers behind higher healthcare costs, finding a medical group with the wherewithal to reverse course is both admirable and hopeful.”

—Marni Jameson Carey, on how one medical group’s path to independence lights the way for others.

“There’s health insurance, which should be called sickness insurance. And medical care, which is what physicians do. People have to be responsible to take care of their own health with their own unique value systems.”

—Craig M. Wax, DO, on what “healthcare” is.
FIRST TAKE

The future is digital
Physicians need to get ready for the onslaught, writes Jennifer Frank, MD.

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Nurse practitioners rise because primary care has changed radically

Keith Dinklage, MD, in his letter “Nurse practitioners are valuable members of the team—but they aren’t doctors” (January 25, 2019 issue) disapproves of nurse practitioners providing primary care because they are not doctors, but I disagree.

The scope of primary care has changed radically. Much of the training that primary care doctors receive has little relevance in primary care today. Most no longer see hospital or nursing home patients. Primary care doctors spend most of their days treating non-life threatening diseases and coordinating care with specialists. These are services that nurse practitioners are able to provide, a role supported by the National Academy of Medicine. Moreover, many states have already given them licenses to practice independently.

The shrinking scope of primary care, the increase in administrative tasks, insurers’ low fees and the pressure to see too many patients in order to make a decent living have made most medical students shun primary care. And who can blame them?

Less than 20% of American medical students enter primary care residencies. A national shortage of primary care doctors exists. Unless it is streamlined by simplifying the basic science curriculum and providing clinical training in community health centers, not hospitals, it will get worse because it takes about 11 years to train a primary care doctor.

In rural areas there will still be a need for primary care doctors who are broadly trained to do obstetrics, office orthopedics, even some surgery like appendectomies. They can get extra training to prepare them. But most primary care doctors live in areas where specialists are available to take care of these problems.

In the future primary care doctors’ training and scope of practice and that of nurse practitioners will be similar. Both groups may combine their training and result in a new classification called ‘primary care practitioner.”

Edward Volpintesta, MD
BETHEL, CONN.

Just like with physicians, there are good and bad nurse practitioners

I would like to respond to Dr. Dinklage’s opinion in your last issue. First, his statement: “It seems that everyone wants to be a doctor, but not everyone wants to go to medical school.” I would give anything for the opportunity to go to medical school. As the sole provider in my household, I cannot quit work and go to medical school. If there were an articulation program for nurse practitioners that would allow me to continue working full time to support my family, I would proudly go to medical school.

You are correct in the statement that our training is not the same as an MD. You did forget, however, that many of us spent countless hours of clinical time caring for critical patients and catching problems for the physicians that rounded for about 5 minutes on the patient. We learned to critically think. We learned pathophysiology, pharmacology, and differential diagnosis. I agree that some students lack a significant clinical experience, however, please do not generalize all of us into the same category.

From my current perspective, I am responsible for basically an internal medicine practice seeing 20 to 30 patients a day and diagnosing patients that have previously been seeing an MD who “did not listen to them” or ‘never put his hands on me.”

There are good and bad practitioners on both sides of this coin. It is sad that we do not get compensated for what we do and we do not receive the recognition or respect from administration or other providers. Many of us are very capable of ascertaining zebras from horses. Please do not judge all of us by the few that you have been in contact with.

Carrie Franzel, FNP
BAD AXE, MICH.
The rise of urgent care

Are urgent cares replacing primary care practices?

A survey of the industry suggests that’s not the case.

- 35% of patients seeking urgent care are not affiliated with a primary care physician
- 86% of urgent cares only provide episodic care, while
- 14% provide some form of “urgent or ongoing primary care”

“Urgent care centers continue to expand their scope of services, catering to the needs of local patient populations.”

— Laurel Stoimenoff, CEO, Urgent Care Association

Who uses urgent care centers the most?

- **Millennial** patients drive demand.
- **Baby Boomers** aging into Medicare are also a fast-growing cohort using urgent care services.

Source: Urgent Care Association, 2018 Benchmarking Survey

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of U.S. Urgent Cares</th>
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<tbody>
<tr>
<td>2013</td>
<td>6,100</td>
</tr>
<tr>
<td>2014</td>
<td>6,400</td>
</tr>
<tr>
<td>2015</td>
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<td>2016</td>
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<td>2017</td>
<td>8,125</td>
</tr>
<tr>
<td>2018</td>
<td>8,774</td>
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</tbody>
</table>
As an adjunct to diet and exercise for appropriate adults with type 2 diabetes

POWERFUL A1C LOWERING with STEGLATRO

STATISTICALLY SIGNIFICANT REDUCTIONS IN A1C WHEN ADDED

Primary end point: A1C change from baseline at week 26

<table>
<thead>
<tr>
<th>Group</th>
<th>LS mean change from baseline A1C, %</th>
<th>DIFFERENCE FROM PLACEBO, %</th>
<th>P-value</th>
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</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.001</td>
</tr>
<tr>
<td>STEGLATRO 5 mg</td>
<td>-0.7</td>
<td>-0.5 (P&lt;0.001)</td>
<td></td>
</tr>
<tr>
<td>STEGLATRO 15 mg</td>
<td>-0.8</td>
<td>-0.6 (P&lt;0.001)</td>
<td></td>
</tr>
</tbody>
</table>

* N includes all randomized and treated patients with a baseline measurement of the outcome variable. At week 26, the primary A1C end point was missing for 10%, 11%, and 7% of patients, and during the trial, rescue medication was initiated by 16%, 1%, and 2% of patients randomized to placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively. Missing week 26 measurements were imputed using multiple imputation with a mean equal to the baseline value of the patient. Results include measurements collected after initiation of rescue medication. For those patients who did not receive rescue medication and had values measured at 26 weeks, the mean changes from baseline for A1C were -0.2%, -0.8%, and -0.9% for placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively.

b Intent-to-treat analysis using ANCOVA adjusted for baseline value, prior antihyperglycemic medication, and baseline estimated glomerular filtration rate (eGFR).

ANCOVA=analysis of covariance; BL=baseline; LS=least squares.
Study design: 463 adults with type 2 diabetes, inadequately controlled (A1C between 7% and 10.5%) on metformin (≥1500 mg/day for ≥8 weeks) and sitagliptin 100 mg once daily participated in a randomized, double-blind, multicenter, 26-week, placebo-controlled study to evaluate the efficacy and safety of STEGLATRO. Study subjects were randomized to STEGLATRO 5 mg, STEGLATRO 15 mg, or placebo administered once daily in addition to continuation of background metformin and sitagliptin therapy. The primary efficacy end point was the change from baseline in A1C at week 26.

STEGLATRO is indicated as an adjunct to diet and exercise for appropriate adults with type 2 diabetes. STEGLATRO is not recommended in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.

SELECTED SAFETY INFORMATION

Contraindications: STEGLATRO is contraindicated in patients with severe renal impairment, end-stage renal disease, or on dialysis, and/or a history of a serious hypersensitivity reaction to ertugliflozin.

Hypotension: STEGLATRO causes intravascular volume contraction. Symptomatic hypotension may occur after initiating STEGLATRO, particularly in patients with impaired renal function (estimated glomerular filtration rate [eGFR] less than 60 mL/min/1.73 m²), elderly patients (≥65 years), patients with low systolic blood pressure, or patients on diuretics. Before initiating STEGLATRO, volume status should be assessed and corrected if indicated. Monitor for signs and symptoms after initiating therapy.

Ketoacidosis: Ketoacidosis, a serious life-threatening condition requiring urgent hospitalization, has been reported in patients with type 1 and type 2 diabetes receiving sodium glucose cotransporter 2 (SGLT2) inhibitors, including STEGLATRO. Some cases were fatal. Assess patients with signs and symptoms of metabolic acidosis for ketoacidosis, regardless of blood glucose level. If ketoacidosis is suspected, STEGLATRO should be discontinued, patients should be evaluated, and prompt treatment should be instituted. Before initiating STEGLATRO, consider risk factors for ketoacidosis, including pancreatic insulin deficiency from any cause, caloric restriction, and alcohol abuse. In patients treated with STEGLATRO, consider monitoring for ketoacidosis and temporarily discontinuing STEGLATRO in clinical situations known to predispose to ketoacidosis (eg, prolonged fasting due to acute illness or surgery).

Additional Selected Safety Information on next page.
Choose STEGLATRO™ (ertugliflozin) for appropriate adults with type 2 diabetes

STEGLATRO is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. STEGLATRO is not recommended in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.

SELECTED SAFETY INFORMATION (continued)

Acute Kidney Injury and Impairment in Renal Function: STEGLATRO causes intravascular volume contraction and can cause renal impairment. There have been postmarketing reports of acute kidney injury, some requiring hospitalization and dialysis, in patients receiving SGLT2 inhibitors. Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury. Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake or fluid losses; monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment. STEGLATRO increases serum creatinine and decreases eGFR. Patients with moderate renal impairment (eGFR 30 to less than 60 mL/min/1.73 m²) may be more susceptible to these changes. Renal function abnormalities can occur after initiating STEGLATRO. Renal function should be evaluated prior to initiating STEGLATRO and periodically thereafter. Use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m² and is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m².

Urosepsis and Pyelonephritis: There have been postmarketing reports of serious urinary tract infections, including urosepsis and pyelonephritis, requiring hospitalization in patients receiving SGLT2 inhibitors. Cases of pyelonephritis also have been reported in patients treated with STEGLATRO in clinical trials. Treatment with SGLT2 inhibitors increases the risk for urinary tract infections. Evaluate patients for signs and symptoms of urinary tract infections and treat promptly, if indicated.

Lower Limb Amputations: An increased risk for lower limb amputation has been observed in clinical studies with another SGLT2 inhibitor. Across seven Phase 3 clinical trials with STEGLATRO, nontraumatic lower limb amputations were reported in 1 (0.1%) patient in the comparator group, 3 (0.2%) patients in the STEGLATRO 5-mg group, and 8 (0.5%) patients in the STEGLATRO 15-mg group. A causal association between STEGLATRO and lower limb amputation has not been definitively established. Before initiating STEGLATRO, consider factors that may predispose patients to the need for amputations. Monitor patients and discontinue STEGLATRO if complications occur. Counsel patients about the importance of routine preventative foot care.

Hypoglycemia With Concomitant Use With Insulin and Insulin Secretagogues: Insulin and insulin secretagogues (eg, sulfonylurea) are known to cause hypoglycemia. STEGLATRO may increase the risk of hypoglycemia when used in combination with insulin and/or an insulin secretagogue. Therefore, a lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with STEGLATRO.

Necrotizing Fasciitis of the Perineum (Fournier’s Gangrene): A rare but serious and lifethreatening necrotizing infection requiring urgent surgical intervention has been reported in postmarketing surveillance in females and males with diabetes mellitus receiving SGLT2 inhibitors. Serious outcomes have included hospitalization, multiple surgeries, and death. Patients treated with STEGLATRO presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise, should be assessed for necrotizing fasciitis. If suspected, start treatment immediately with broad-spectrum antibiotics and, if necessary, surgical debridement. Discontinue STEGLATRO, closely monitor blood glucose levels, and provide appropriate alternative therapy for glycemic control.

Genital Mycotic Infections: STEGLATRO increases the risk of genital mycotic infections. Patients who have a history of genital mycotic infections or who are uncircumcised are more likely to develop genital mycotic infections. Monitor and treat appropriately.

Increases in Low-Density Lipoprotein Cholesterol (LDL-C): Dose-related increases in LDL-C can occur with STEGLATRO. Monitor and treat as appropriate.

Macrovascular Outcomes: There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with STEGLATRO.

The most common adverse reactions associated with STEGLATRO (≥5%) were female genital mycotic infections.

Please read the adjacent Brief Summary of the Prescribing Information.
**Brief Summary of the Prescribing Information**

**STEGLATRO™ (ertugliflozin) 5 mg, 15 mg tablets**

**INDICATIONS AND USAGE**

STEGLATRO™ is indicated as an adjunct to diet and exercise to improve glycaemic control in adults with type 2 diabetes mellitus.

**Limitations of Use**
- STEGLATRO is not recommended in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.

**DOSAGE AND ADMINISTRATION**

**Recommended Dosage.** The recommended starting dose of STEGLATRO is 5 mg once daily, taken in the morning, with or without food. In patients tolerating STEGLATRO 5 mg once daily, the dose may be increased to a maximum recommended dose of 15 mg once daily if additional glycaemic control is needed. In patients with volume depletion, correct this condition prior to initiation of STEGLATRO (see Warnings and Precautions).

**Patients with Renal Impairment.** Assess renal function prior to initiation of STEGLATRO and periodically thereafter (see Warnings and Precautions). STEGLATRO is not recommended in patients with an eGFR less than 30 mL/min/1.73 m² (see Contraindications). Initiation of STEGLATRO is not recommended in patients with an eGFR of 30 mL/min/1.73 m² to less than 60 mL/min/1.73 m² (see Warnings and Precautions in Specific Populations). Continued use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m². No dose adjustment is needed in patients with mild renal impairment.

**CONTRAINDICATIONS**
- Severe renal impairment, end-stage renal disease (ESRD), or dialysis (see Warnings and Precautions in Specific Populations).
- History of a serious hypersensitivity reaction to STEGLATRO.

**WARNINGS AND PRECAUTIONS**

**Hypotension.** STEGLATRO causes intravascular volume contraction. Therefore, symptomatic hypotension may occur after initiating STEGLATRO (see Adverse Reactions) particularly in patients with impaired renal function (eGFR less than 60 mL/min/1.73 m²) (see Use in Specific Populations), elderly patients (≥65 years), in patients with low systolic blood pressure, and in patients on diuretics. Before initiating STEGLATRO, volume status should be assessed and corrected if indicated. Monitor for signs and symptoms of hypotension after initiating therapy.

**Ketoadisasis.** Reports of ketoadisasis, a serious life-threatening condition requiring urgent hospitalization, have been identified in clinical trials and postmarketing surveillance in patients with type 1 and type 2 diabetes mellitus receiving sodium glucose co-transporter-2 (SGLT2) inhibitors and cases have been reported in STEGLATRO-treated patients in clinical trials. Among the clinical programs, ketoadisasis was identified in 3 of 3,409 (0.1%) of STEGLATRO-treated patients and 0% of comparator-treated patients. Fatal cases of ketoadisasis have been reported in patients taking SGLT2 inhibitors. STEGLATRO is not indicated for the treatment of patients with type 1 diabetes mellitus (see Indications and Usage).

Patients treated with STEGLATRO who present with signs and symptoms consistent with severe metabolic acidosis should be assessed for ketoadisasis regardless of presenting blood glucose levels, as ketoadisasis associated with STEGLATRO may be present even if blood glucose levels are less than 250 mg/dL. If ketoadisasis is suspected, STEGLATRO should be discontinued, patient should be evaluated, and prompt treatment should be instituted. Treatment of ketoadisasis may require insulin, fluid and carbohydrate replacement.

In many of the reported cases, and particularly in patients with type 1 diabetes, the presence of ketoadisasis was not immediately recognized and institution of treatment was delayed because presenting blood glucose levels were below those typically expected for diabetic ketoadisasis (often less than 250 mg/dL). Signs and symptoms at presentation were consistent with dehydration and severe metabolic acidosis and included nausea, vomiting, abdominal pain, generalized malaise, and shortness of breath. In some but not all cases, factors predisposing to ketoadisasis such as insulin dose reduction, acute febrile illness, reduced caloric intake due to illness or surgery, pancreatic disorders suggesting insulin deficiency (e.g., type 1 diabetes, history of pancreatitis or pancreatic surgery), and alcohol abuse were identified.

Before initiating STEGLATRO, consider factors in the patient history that may predispose to ketoadisasis, including pancreatic insulin deficiency from any cause, caloric restriction, and alcohol abuse. In patients treated with STEGLATRO consider monitoring for ketoadisasis and temporarily discontinuing STEGLATRO in clinical situations known to predispose to ketoadisasis (e.g., prolonged fasting due to acute illness or surgery).

**Acute Kidney Injury and Impairment in Renal Function.** STEGLATRO causes intravascular volume contraction and can cause renal impairment (see Adverse Reactions). There have been postmarketing reports of acute kidney injury requiring hospitalization and dialysis in patients receiving SGLT2 inhibitors. Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury including dehydrated, chronic renal problems, hypertension, and concurrent use of medications (diuretics, ACE inhibitors, ARBs, NSAIDs). Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake (such as acute illness or fasting) or fluid losses (such as gastrointestinal illness or excessive heat exposure); monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment.

STEGLATRO increases serum creatinine and decreases eGFR. Patients with moderate renal impairment (eGFR 30 to less than 60 mL/min/1.73 m²) may be more susceptible to these changes. Renal function abnormalities can occur after initiating STEGLATRO (see Adverse Reactions). Renal function should be evaluated prior to initiating STEGLATRO and periodically thereafter. Use of STEGLATRO is not recommended when eGFR is persistently between 30 and less than 60 mL/min/1.73 m² and is contraindicated in patients with an eGFR of less than 60 mL/min/1.73 m² (see Dosage and Administration, Contraindications, and Use in Specific Populations).

**Urosepsis and Pyelonephritis.** There have been postmarketing reports of serious urinary tract infections, including urosepsis and pyelonephritis, requiring hospitalization in patients receiving SGLT2 inhibitors. Cases of pyelonephritis also have been reported in STEGLATRO-treated patients in clinical trials. Treatment with SGLT2 inhibitors increases the risk for urinary tract infections. Evaluate patients for signs and symptoms of urinary tract infections and treat promptly, if indicated (see Adverse Reactions).

**Lower Limb Amputation.** An increased risk for lower limb amputation (primarily of the toe) has been observed in clinical studies with another SGLT2 inhibitor. Across seven Phase 3 clinical trials in the STEGLATRO development program, non-traumatic lower limb amputations were reported in 0.0% of patients in the comparator group, 3 (0.2%) patients in the STEGLATRO 5 mg group, and 8 (0.5%) patients in the STEGLATRO 15 mg group. A causal association between STEGLATRO and lower limb amputation has not been definitively established.

Before initiating STEGLATRO, consider factors in the patient history that may predispose them to the need for amputations, such as a history of prior amputation, peripheral vascular disease, neuropathy and diabetic foot ulcers. Counsel patients about the importance of routine preventive foot care. Monitor patients receiving STEGLATRO for signs and symptoms of infection (including osteomyelitis), new pain or tenderness, sores or ulcers involving the lower limbs, and discontinue STEGLATRO if these complications occur.

**Hypoglycemia with Concomitant Use with Insulin and Insulin Secretagogues.** Insulin and insulin secretagogues (e.g., sulfonylurea) are known to cause hypoglycemia. STEGLATRO may increase the risk of hypoglycemia when used in combination with insulin and/or an insulin secretagogue. Therefore, a lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with STEGLATRO.

**Necrotizing Fasciitis of the Perineum (Fournier’s Gangrene).** Reports of necrotizing fasciitis of the perineum (Fournier’s gangrene), a rare but serious and life-threatening necrotizing infection requiring urgent surgical intervention, have been identified in postmarketing surveillance in patients with diabetes mellitus receiving SGLT2 inhibitors. Cases have been reported in females and males. Serious outcomes have included hospitalization, multiple surgeries, and death.

Patients treated with STEGLATRO presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise, should be assessed for necrotizing fasciitis. If suspected, urgent treatment immediately with broad-spectrum antibiotics and, if necessary, surgical debridement. Discontinue STEGLATRO, closely monitor blood glucose levels, and provide appropriate alternative therapy for glycemic control.

**Genital Mycotic Infections.** STEGLATRO increases the risk of genital mycotic infections. Patients who have a history of genital mycotic infections or who are uncircumcised are more likely to develop genital mycotic infections (see Adverse Reactions). Monitor and treat appropriately.

**Increases in Low-Density Lipoprotein Cholesterol (LDL-C).** Dose-related increases in LDL-C can occur with STEGLATRO. Patient and treatment appropriately.

**Macrovascular Outcomes.** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with STEGLATRO.

**ADVERSE REACTIONS**

**Clinical Trials Experience.** Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

**Pool of Placebo-Controlled Trials Evaluating STEGLATRO 5 and 15 mg.** The data in Table 1 are derived from a pool of three 26-week, placebo-controlled trials. STEGLATRO was used as monotherapy in one trial and as add-on therapy in two trials. These data reflect exposure of 1,029 patients to STEGLATRO with a mean exposure duration of approximately 25 weeks. Patients received STEGLATRO 5 mg (N=519), STEGLATRO 15 mg (N=510), or placebo (N=515) once daily. The mean age of the population was 57 years and 2% were older than 75 years of age. Fifty-three percent (53%) of the population was male and 73% were Caucasian, 15% were Asian, and 7% were Black or African American. At baseline the population had diabetes for an average of 7.5 years, had a mean HbA1c of 8.1%, and 19.4% had established microvascular complications of diabetes.
Table 1 shows common adverse reactions associated with the use of STEGLATRO™ (ertugliflozin). These adverse reactions were not present at baseline, occurred more commonly on STEGLATRO than on placebo, and occurred in at least 2% of patients treated with either STEGLATRO 5 mg or STEGLATRO 15 mg.

Table 1: Adverse Reactions Reported in ≥2% of Patients with Type 2 Diabetes Mellitus Treated with STEGLATRO* and Greater than Placebo in Pooled Placebo-Controlled Clinical Studies of STEGLATRO Monotherapy or Combination Therapy

<table>
<thead>
<tr>
<th></th>
<th>Placebo N=515</th>
<th>STEGLATRO 5 mg N=519</th>
<th>STEGLATRO 15 mg N=510</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female genital mycotic infections*</td>
<td>3.0%</td>
<td>9.1%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Male genital mycotic infections*</td>
<td>0.4%</td>
<td>3.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Urinary tract infections†</td>
<td>3.9%</td>
<td>4.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Headache</td>
<td>2.3%</td>
<td>3.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Vaginal pruritus*</td>
<td>0.4%</td>
<td>2.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Increased urination*</td>
<td>1.0%</td>
<td>2.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Nasopharyngitis</td>
<td>2.3%</td>
<td>2.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Back pain</td>
<td>2.3%</td>
<td>1.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Weight decreased</td>
<td>1.0%</td>
<td>1.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Thrust†</td>
<td>0.6%</td>
<td>2.7%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

* The three placebo-controlled studies included one monotherapy trial and two add-on combination trials with metformin or with metformin and sitagliptin.
† Includes: genital candidiasis, genital infection fungal, vaginal infection, vulvitis, vulvovaginal candidiasis, vulvovaginal mycotic infection, and vulvovaginitis. Percentages calculated with the number of female patients in each group as denominator: placebo (N=235), STEGLATRO 5 mg (N=252), STEGLATRO 15 mg (N=245).
‡ Includes: balanitis candida, balanoposthitis, genital infection, and genital infection fungal. Percentages calculated with the number of male patients in each group as denominator: placebo (N=280), STEGLATRO 5 mg (N=267), STEGLATRO 15 mg (N=245).
¶ Includes: vulvovaginal pruritus and pruritus genital. Percentages calculated with the number of female patients in each group as denominator: placebo (N=235), STEGLATRO 5 mg (N=252), STEGLATRO 15 mg (N=245).
§ Includes: cystitis, dysuria, streptococcal urinary tract infection, urethritis, urinary tract infection.
Þ Includes: hypernatremia, dehydration, dizziness postural, presyncope, syncope, hypotension, and orthostatic hypotension were reported in 0%, 4.4%, and 1.9% of patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively. STEGLATRO may also increase the risk of hypotension in other patients at risk for volume contraction (see Use in Specific Populations).

Volume Depletion. STEGLATRO causes an osmotic diuresis, which may lead to intravascular volume contraction and adverse reactions related to volume depletion, particularly in patients with impaired renal function (eGFR less than 60 mL/min/1.73 m²). In patients with moderate renal impairment, adverse reactions related to volume depletion (e.g., dehydration, dizziness postural, presyncope, syncope, hypotension, and orthostatic hypotension) were reported in 0%, 4.4%, and 1.9% of patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively. STEGLATRO may also increase the risk of hypotension in other patients at risk for volume contraction (see Use in Specific Populations).

Ketoacidosis. Across the clinical program, ketoacidosis was identified in 3 of 3,409 (0.1%) ertugliflozin-treated patients and 0.0% of comparator-treated patients (see Warnings and Precautions).

Impairment in Renal Function. Treatment with STEGLATRO was associated with increases in serum creatinine and decreases in eGFR (see Table 2). Patients with moderate renal impairment at baseline had larger mean changes. In a study in patients with moderate renal impairment, these abnormal laboratory findings were observed to reverse after treatment discontinuation (see Use in Specific Populations).

Table 2: Changes from Baseline in Serum Creatinine and eGFR in the Pool of Three 26-Week Placebo-Controlled Studies, and a 26-Week Moderate Renal Impairment Study in Patients with Type 2 Diabetes Mellitus

<table>
<thead>
<tr>
<th></th>
<th>Placebo N=515</th>
<th>STEGLATRO 5 mg N=519</th>
<th>STEGLATRO 15 mg N=510</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>0.83</td>
<td>0.82</td>
<td>0.82</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>89.5</td>
<td>88.2</td>
<td>89.0</td>
</tr>
<tr>
<td>Week 6 Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>0.00</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>-0.3</td>
<td>-2.7</td>
<td>-3.1</td>
</tr>
<tr>
<td>Week 26 Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>-0.01</td>
<td>0.00</td>
<td>0.01</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>0.7</td>
<td>0.5</td>
<td>-0.6</td>
</tr>
</tbody>
</table>

Renal-related adverse reactions (e.g., acute kidney injury, renal impairment, acute renal failure) may occur in patients treated with STEGLATRO, particularly in patients with moderate renal impairment where the incidence of renal-related adverse reactions was 0.6%, 2.5%, and 1.3% in patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively.

Lower Limb Amputation. Across seven Phase 3 clinical trials in which STEGLATRO was studied as monotherapy and in combination with other antihyperglycemic agents, non-traumatic lower limb amputations occurred in 1 of 1,450 (0.1%) in the non-STEGLATRO group, 3 of 1,716 (0.2%) in the STEGLATRO 5 mg group, and 8 of 1,693 (0.5%) in the STEGLATRO 15 mg group.

Table 3: Incidence of Overall* and Severe† Hypoglycemia in Placebo-Controlled Clinical Studies in Patients with Type 2 Diabetes Mellitus

<table>
<thead>
<tr>
<th>Monotherapy (26 weeks)</th>
<th>Placebo (N = 153)</th>
<th>STEGLATRO 5 mg (N = 156)</th>
<th>STEGLATRO 15 mg (N = 152)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall (N %)</td>
<td>1 (0.7)</td>
<td>4 (2.6)</td>
<td>4 (2.6)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>2 (1.3)</td>
</tr>
<tr>
<td>Add-on Combination Therapy with Metformin (26 weeks)</td>
<td>Placebo (N = 209)</td>
<td>STEGLATRO 5 mg (N = 207)</td>
<td>STEGLATRO 15 mg (N = 205)</td>
</tr>
<tr>
<td>Overall (N %)</td>
<td>9 (4.3)</td>
<td>15 (7.2)</td>
<td>16 (7.8)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>1 (0.5)</td>
<td>1 (0.5)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Add-on Combination Therapy with Metformin and Sitagliptin (26 weeks)</td>
<td>Placebo (N = 153)</td>
<td>STEGLATRO 5 mg (N = 156)</td>
<td>STEGLATRO 15 mg (N = 153)</td>
</tr>
<tr>
<td>Overall (N %)</td>
<td>5 (3.3)</td>
<td>7 (4.5)</td>
<td>3 (2.0)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>1 (0.7)</td>
<td>1 (0.6)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>In Combination with Insulin and/or an Insulin Secretagogue in Patients with Moderate Renal Impairment</td>
<td>Placebo (N = 133)</td>
<td>STEGLATRO 5 mg (N = 148)</td>
<td>STEGLATRO 15 mg (N = 143)</td>
</tr>
<tr>
<td>Overall (N %)</td>
<td>48 (36.1)</td>
<td>53 (38.5)</td>
<td>39 (27.3)</td>
</tr>
<tr>
<td>Severe (N %)</td>
<td>3 (2.3)</td>
<td>5 (3.4)</td>
<td>3 (2.1)</td>
</tr>
</tbody>
</table>

* Overall hypoglycemic events: plasma or capillary glucose of less than or equal to 70 mg/dL.
† Severe hypoglycemic events: required assistance, lost consciousness, or experienced a seizure regardless of blood glucose.
Genital Mycotic Infections. In the pool of three placebo-controlled clinical trials, the incidence of female genital mycotic infections (e.g., genital candidiasis, genital infection fungal, vaginal infections, vulvovaginitis, vulvovaginal mycotic infection, vulvovaginitis) occurred in 3%, 9.1%, and 12.2% of females treated with placebo, STEGLATRO™ (ertugliflozin) 5 mg, and STEGLATRO 15 mg, respectively (see Table 1). In females, discontinuation due to genital mycotic infections occurred in 0% and 0.6% of patients treated with placebo and STEGLATRO, respectively.

In the same pool, male genital mycotic infections (e.g., balanitis candida, balanoposthitis, genital infection, genital infection fungal) occurred in 0.4%, 3.7%, and 4.2% of males treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively (see Table 1). Male genital mycotic infections occurred more commonly in uncircumcised males. In males, discontinuations due to genital mycotic infections occurred in 0% and 0.2% of patients treated with placebo and STEGLATRO, respectively. Phimosis was reported in 8 of 1729 (0.5%) male ertugliflozin-treated patients, of which four required circumcision.

Laboratory Tests. Increases in Low-Density Lipoprotein Cholesterol (LDL-C). In the pool of three placebo-controlled trials, dose-related increases in LDL-C were observed in patients treated with STEGLATRO. Mean percent changes from baseline to Week 26 in LDL-C relative to placebo were 2.6% and 5.4% with STEGLATRO 5 mg and STEGLATRO 15 mg, respectively. The range of mean baseline LDL-C was 96.6 to 97.7 mg/dL across treatment groups (see Warnings and Precautions).

In increases in Hemoglobin. In the pool of three placebo-controlled trials, mean changes (percent changes) from baseline to Week 26 in hemoglobin were -0.21 g/dL (1.4%) with placebo, 0.46 g/dL (3.5%) with STEGLATRO 5 mg, and 0.48 g/dL (3.5%) with STEGLATRO 15 mg. The range of mean baseline hemoglobin was 13.9 to 14.0 g/dL across treatment groups. At the end of treatment, 0.4%, 0.2%, and 0.4% of patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively, had a hemoglobin increase greater than 2 g/dL and above the upper limit of normal.

Increases in Serum Phosphate. In the pool of three placebo-controlled trials, mean changes (percent changes) from baseline in serum phosphate were 0.04 mg/dL (1.9%) with placebo, 0.21 mg/dL (6.8%) with STEGLATRO 5 mg, and 0.26 mg/dL (8.5%) with STEGLATRO 15 mg. The range of mean baseline serum phosphate was 3.53 to 3.54 mg/dL across treatment groups. In a clinical trial of patients with moderate renal impairment, mean changes (percent changes) from baseline at Week 26 in serum phosphate were 0.01 mg/dL (0.8%) with placebo, 0.29 mg/dL (9.7%) with STEGLATRO 5 mg, and 0.24 mg/dL (7.8%) with STEGLATRO 15 mg.

Drug Interactions. Concomitant Use with Insulin and Insulin Secretagogues. STEGLATRO may increase the risk of hypoglycemia when used in combination with insulin and/or an insulin secretagogue (see Adverse Reactions). Therefore, a lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with STEGLATRO (see Warnings and Precautions).

Positive Urine Glucose Test. Monitoring glycosmic control with urine glucose tests is not recommended in patients taking SGLT2 inhibitors as SGLT2 inhibitors increase urinary glucose excretion and will lead to positive urine glucose tests. Use alternative methods to monitor glycosmic control.

Interference with 1,5-anhydroglucitol (1,5-AG) Assay. Monitoring glycosmic control with 1,5-AG assay is not recommended as measurements of 1,5-AG are unreliable in assessing glycosmic control in patients taking SGLT2 inhibitors. Use alternative methods to monitor glycosmic control.

Use in Specific Populations. Pregnancy. Risk Summary. Based on animal data showing adverse renal effects, STEGLATRO is not recommended during the second and third trimesters of pregnancy. The limited available data with STEGLATRO in pregnant women are not sufficient to determine a drug-associated risk of adverse developmental outcomes. There are risks to the mother and fetus associated with poorly controlled diabetes in pregnancy (see Clinical Considerations).

In animal studies, adverse renal changes were observed in rats when ertugliflozin was administered during a period of renal development corresponding to the late second and third trimesters of human pregnancy. Doses approximately 13 times the maximum clinical dose caused renal pelvic and tubule dilatations and renal mineralization that were not fully reversible. There was no evidence of fetal harm in rats or rabbits at exposures of ertugliflozin approximately 300 times higher than the maximal clinical dose of 15 mg/day when administered during organogenesis (see Data).

The estimated background risk of major birth defects is 6-10% in women with pre-gestational diabetes with a HbA1c ≥7.7 and has been reported to be as high as 20-25% in women with HbA1c ≥10. The estimated background risk of miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2%-4% and 15%-20%, respectively.

Clinical Considerations. Disease-Associated Maternal and/or Embryo/Fetal Risk. Poorly-controlled diabetes in pregnancy increases the maternal risk for diabetic ketoacidosis, pre-eclampsia, spontaneous abortions, preterm delivery, stillbirth, and delivery complications. Poorly controlled diabetes increases the fetal risk for major birth defects, stillbirth, and macrosomia related morbidity.

Data. Animal Data. When ertugliflozin was orally administered to juvenile rats from PND 21 to PND 90, increased kidney weight, renal tubule and renal pelvis dilatation, and renal mineralization occurred at doses greater than or equal to 5 mg/kg (13-fold human exposures, based on AUC). These effects occurred with drug exposure during periods of renal development in rats that correspond to the late second and third trimester of human renal development, and did not fully reverse within a 1-month recovery period.

In embryo-fetal development studies, ertugliflozin (50, 100 and 250 mg/kg/day) was administered orally to rats on gestation days 6 to 17 and to rabbits on gestation days 7 to 19. Ertugliflozin did not adversely affect developmental outcomes in rats and rabbits at maternal exposures that were approximately 300 times the human exposure at the maximum clinical dose of 15 mg/day, based on AUC. A maternally toxic dose (250 mg/kg/day) in rats (707 times the clinical dose), was associated with reduced fetal viability, and a higher incidence of a visceral malformation (membranous ventricular septal defect). In the pre- and post-natal development study in pregnant rats, ertugliflozin was administered to the dams from gestation day 6 through lactation day 21 (weaning). Decreased post-natal growth (weight gain) was observed at maternal doses ≥100 mg/kg/day (greater than or equal to 331 times the human exposure at the maximum clinical dose of 15 mg/day, based on AUC).

Lactation. Risk Summary. There is no information regarding the presence of STEGLATRO in human milk, the effects on the breastfed infant, or the effects on milk production. Ertugliflozin is present in the milk of lactating rats (see Data). Since human kidney maturation occurs in utero and during the first 2 years of life when lacational exposure may occur, there may be risk to the developing human kidney. Because of the potential for serious adverse reactions in a breastfed infant, advise women that the use of STEGLATRO is not recommended while breastfeeding.

Data. Data. The lactal excretion of radioabeled ertugliflozin in lactating rats was evaluated 10 to 12 days after parturition. Ertugliflozin derived radioactivity exposure in milk and plasma were similar, with a milk/plasma ratio of 1.07, based on AUC. Juvenile rats directly exposed to STEGLATRO during a developmental period corresponding to human kidney maturation were associated with a risk to the developing kidney (persistent increased organ weight, renal mineralization, and renal pelvic and tubular dilatations).

Pediatric Use. Safety and effectiveness of STEGLATRO in pediatric patients under 18 years of age have not been established.

Geriatriac Use. No dosage adjustment of STEGLATRO is recommended based on age. Across the clinical program, a total of 876 (25.7%) patients treated with STEGLATRO were 65 years and older, and 152 (4.5%) patients treated with STEGLATRO were 75 years and older. Patients 65 years and older had a higher incidence of adverse reactions related to volume depletion compared to younger patients; events were reported in 1.1%, 2.2%, and 2.6% of patients treated with comparator, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively (see Warnings and Precautions and Adverse Reactions). Therefore, STEGLATRO is expected to have diminished efficacy in elderly patients with renal impairment (see Use in Specific Populations).

Renal Impairment. The safety and efficacy of STEGLATRO have not been established in patients with type 2 diabetes mellitus and moderate renal impairment. Compared to placebo-treated patients, patients with moderate renal impairment treated with STEGLATRO did not have improvement in glycemic control and had increased risks for renal impairment, renally-related adverse reactions and volume depletion adverse reactions (see Dosage and Administration, Warnings and Precautions and Adverse Reactions). Therefore, STEGLATRO is not recommended in this population. STEGLATRO is contraindicated in patients with severe renal impairment, ESRD, or receiving dialysis. STEGLATRO is not expected to be effective in these patient populations (see Contraindications). No dosage adjustment or increased monitoring is needed in patients with mild renal impairment.

Hepatic Impairment. No dosage adjustment of STEGLATRO is necessary in patients with mild or moderate hepatic impairment. Ertugliflozin has not been studied in patients with severe hepatic impairment and is not recommended for use in this patient population.

OVERDOSAGE. In the event of an overdose with STEGLATRO, contact the Poison Control Center. Employ the usual supportive measures as dictated by the patient’s clinical status. Removal of ertugliflozin by hemodialysis has not been studied.

For more detailed information, please read the Prescribing Information. usp-nm8835-1810001

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Most legal experts believe the Affordable Care Act will survive the most recent challenge to the law’s constitutionality.

A bipartisan consensus is emerging in Congress for reining in the escalating cost of prescription drugs, but how lawmakers will achieve that goal is still unclear.
Doctors rarely have the time or inclination to follow developments in federal healthcare policy, but 2019 may well be a year where physicians start paying more attention to events in Washington. That’s because lawmakers, judges and regulators are poised to take—or at least consider—steps that could affect the nation’s $3.5 trillion healthcare system for years to come. Here’s a look at what 2019 may hold in four areas of healthcare policy of importance to doctors: the future of the Affordable Care Act, expanding healthcare insurance coverage, the cost of prescription drugs and changes to accountable care organizations.

The future of the Affordable Care Act

Since becoming law in 2010, the ACA has survived several near-death experiences, including a 5-4 U.S. Supreme Court vote to uphold it in 2012, an effort to defund the law via a government shutdown in 2013, and a 51-49 vote in the U.S. Senate against repealing it in 2017.

The latest threat to the ACA came in December 2018, when a federal judge in Texas, ruling on a lawsuit brought by a group of Republican attorneys general and governors, declared the law unconstitutional. The judge agreed with the plaintiffs that when Congress zeroed out the financial penalty for not having health insurance (which was part of the 2017 tax reduction law) and because the Supreme Court had previously ruled that the penalty was actually a tax, both the tax and the entire law were invalid.

The judge agreed to stay his ruling pending appeals, but few legal experts believe the ruling will be upheld. “I wish I could tell you that the judge’s reasoning makes good sense from a jurisprudence standpoint, but it doesn’t,” says C. Timothy Gary, JD, a healthcare attorney with the law firm Dickinson Wright in Nashville, Tenn. “Removing the mechanism requiring everyone to have insurance might call into question the financial viability of the law, but saying it makes the entire statute unconstitutional doesn’t really work.”

A group of Democratic attorneys general is appealing the judge’s decision in various U.S. Courts of Appeals. That process is likely to take up much of the year, Gary says, adding that the losing side will almost certainly appeal the circuit court’s decision to the U.S. Supreme Court. If the Supreme Court decides to hear the case—which Gary says is not certain—it could wind up issuing its ruling just before the 2020 presidential election.

Gary attributes the courts’ frequent involvement with the ACA to Congressional dysfunction, noting the long and often convoluted process required to get the law passed, and the fact that no Republicans voted for it.

“When Congress can’t make decisions, the courts step in to try and do that, and courts aren’t particularly well-suited to the task,” he says. “And what you end up with is a lot of surprise.”

Continued on page 18

“When Congress can’t make decisions, the courts step in to try and do that, and courts aren’t particularly well-suited to the task. And what you end up with is a lot of surprise.”

— C. TIMOTHY GARY, JD, HEALTHCARE ATTORNEY, DICKINSON WRIGHT, NASHVILLE, TENN.
In the wake of Democrats gaining control of the U.S. House of Representatives following the 2018 Congressional elections, and with the 2020 presidential election already in full swing, the possibility of extending healthcare insurance to more Americans is again being widely discussed.

For many in the public and the media—and some Democratic presidential candidates—the discussion translates into some version of “Medicare-For-All,” a slogan popularized by Vermont Sen. Bernie Sanders during his 2016 bid for the Democratic nomination. And while that term does apply to some of the ideas being floated for expanding coverage, others are more limited in scope.

In a study published late last year, the nonprofit Kaiser Family Foundation identified eight pieces of legislation aimed at making insurance more widely available, which the study groups into four categories:

- Two proposals for instituting single-payer coverage for all Americans—in effect, Medicare For All.
- Three plans for creating a Medicare-like “public option” that would be available to all individuals and some or all employers via the ACA insurance exchanges
- Two bills enabling Americans younger than 65 to buy into Medicare. One proposal would allow buy-ins starting at age 55, the other at age 50.
- One proposal allowing states to offer their residents a Medicaid buy-in option through the ACA marketplaces.

A ninth bill, the Medicare for America (MFA) Act of 2018, was introduced after the Kaiser study was published. It would cover the uninsured, those who buy insurance on the individual market, and individuals on Medicare and Medicaid. Employer-sponsored insurance would remain, but employees who have it would have the option of enrolling in MFA coverage instead.

While all the proposals would come with costs and tradeoffs, the most difficult to navigate would come under Medicare-For-All, or some other form of single-payer system. Some method would be needed to pay for coverage of people who get insurance through their employer, says Joseph White, Ph.D., a professor of public policy at Case Western Reserve University and author of False Alarm: Why the Greatest Threat to Social Security and Medicare is the Campaign to “Save” Them.

“There are likely to be a lot of losers [with Medicare for All], or at least people who think of themselves as losers in the short run, and that’s going to create a lot of political backlash.”

— JOSEPH WHITE, PH.D., PROFESSOR OF PUBLIC POLICY, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND

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- Two bills enabling Americans younger than 65 to buy into Medicare. One
publican hands, the chances for any type of Medicare expansion occurring before 2021 are virtually nonexistent. Nevertheless, they say, just the fact that the idea is being discussed, and will likely be the subject of Congressional hearings, is significant.

“The advantage of hearings is that members of Congress, as well as the general public, will begin to sort of kick the tires and learn more about the mechanics of these proposals and the trade-offs they would involve,” says Tricia Neuman, Sc.D., MS, director of the Kaiser Foundation’s program on Medicare policy and a co-author of the study on Medicare expansion.

Her views are echoed by Robert Doherty, senior vice president for government affairs and public policy for the American College of Physicians. “Having a debate of ideas ultimately is in the best interest of finding last- ing policy solutions,” Doherty says.

Prescription drug prices

The escalating price of many prescription drugs—particularly those such as insulin used to treat chronic diseases—has angered physicians and patients alike for years. Congress and the administration began to address the problem last year, and those efforts are likely to accelerate in 2019.

Congress made its intentions clear late in January, when committees in both the U.S. House of Representatives and Senate held hearings on drug prices on the same day. U.S. Rep. Elijah E. Cummings (D-MD), chairman of the House Committee on Oversight and Reform, said that a “strong bipartisan consensus” exists in Congress for reining in “out-of-control price increases.” The two committees heard testimony from parents of children with diabetes who had died because they couldn’t afford insulin.

But translating general agreement that prescription drug prices are too high into actual legislation won’t be easy, warns David Pugach, JD, senior vice president for public policy for the American Osteopathic Association. “Everybody recognizes there is a problem, but the source of the problem is going to be viewed differently and the proposed solutions are going to vary significantly,” he says.

Pugach cites the example of a proposal the Trump administration developed last year for lowering the cost of drugs administered under Medicare Part B, where the price Medicare would pay for certain drugs would be tied to an index of prices paid for those drugs in other industrialized countries. While Pugach calls the proposal well-intentioned, he adds that the AOA is concerned it could stifle pharmaceutical innovation and make it harder for Medicare beneficiaries to obtain the medications. “It has to be a balancing act,” he says.

Doherty is hopeful that Congress will pass some sort of legislation in 2019 addressing drug prices, given that Democrats now control the House. Another reason for optimism, he says, is that the Senate Finance Committee, which holds a lot of sway over healthcare legislation, is now chaired by Iowa Sen. Charles Grassley, (R-Iowa), who has a reputation for ferreting out wasteful government spending.

One possibility for legislative action on drug prices, according to Doherty, is a vote on the Creating and Restoring Equal Access to Equivalent Samples Act. First introduced in 2016, the law, which has bipartisan support, would allow generic drug manufacturers to sue pharmaceutical companies for refusing to provide them with enough samples of brand-name drugs to create generic equivalents.

Grassley has already signaled his interest in the bill. “His emphasis has always been on cost-effective government and going after wasteful spending,” Doherty says. And with the House now under Democratic control,
For doctors in ACOs, the biggest issue in 2019 almost certainly will be the impact of "Pathways to Success," the CMS rule overhauling the Medicare Shared Savings Program.

Released at the end of 2018, the "Pathways" rule takes effect July 1. It reduces the length of time an ACO can remain on the program’s "upside only" track, where it shares in savings if its spending is lower than its benchmark, but does not incur losses if its spending exceeds its benchmark. Currently, an ACO entering the program can be on an upside only track for up to six years. The rule lowers that to two or three years, depending on the ACO’s revenue.

"Pathways" consolidates the program’s four tracks into two—a "basic" track that allows new ACOs to start by sharing only in savings and begin transitioning after two years to a model where it also incurs financial risk, and an "enhanced" track that provides an ACO with potential for greater financial rewards, along with greater financial risk.

In addition, the rule creates a distinction between "low revenue" and "high revenue" ACOs, extends the length of ACO contracts from three years to five, and reduces the percentage of shared savings available to newly formed ACOs from 50 percent to 40 percent.

Clif Gaus, Sc.D., president and CEO of the National Association of Accountable Care Organizations, says that while it will take time for the effects of the "Pathways" rule to play out, the association is concerned that the lower shared savings and decreased time allowed for transitioning to a risk-sharing model could inhibit the formation of new ACOs.

“We believe two years is too short a time for ACOs to get their bearings in no-risk models before they’re forced to take on risk.”

— CLIF GAUS, PRESIDENT AND CEO, NATIONAL ASSOCIATION OF ACCOUNTABLE CARE ORGANIZATIONS
I am an internist with my own practice and am called on by specialists to evaluate patients for diabetes management and for pre-operative clearances. Can I bill these services as consultations? Also, can my nurse practitioner bill consultations for these services?

A: These are great questions, and we will need to delve into the definition of consultations in order to answer them.

Who can provide a consult?
First, per Current Procedural Terminology (CPT) guidelines, consults may be requested by persons other than physicians (e.g., physician assistants, nurse practitioners, chiropractors, physical therapists, occupational therapists, speech-language pathologists, psychologists, social workers, lawyers or insurance company representatives).

So yes, consults can be performed by a physician or other qualified non-physician practitioner (NPP) (e.g., nurse practitioner and physician assistant) if the service is within his or her scope of practice and licensure requirements in the state where he or she practices and the requirements for physician collaboration and physician supervision are met.

Consultation basics
Let’s look at the basic elements that are required for consultations. Medicare no longer reimburses for consultation; nevertheless, the guidelines were developed by the Centers for Medicare and Medicaid Services (CMS). Check with your local payers to see if they reimburse for consultations.

According to CPT, a consultation is an Evaluation and Management (E/M) service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem, or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem.

Per CMS, the basic consultation elements include:

- The consultation request,
- The reason for the request,
- The services rendered, and
- The report from the consulting physician.

You can remember these as the four R’s: request, reason, render and report. Here are the steps to document these requirements:

1. The requesting physician should document the request for consultation in the patient record, including the specific reason for the consultation and how the consultant physician was contacted (e.g., phone, fax or letter). Likewise, the consultant physician should document that the consultation was requested, by whom and why.

2. The consultation services rendered should be documented following the Evaluation and Management (E/M) guidelines. Consultation codes require all three elements (i.e., history, exam, medical decision making) to be met in order to support a code level. Time-based coding can also be utilized when more than 50% of the time is spent in counseling/coordination of care.

3. The consultant physician should provide a written report of services provided, findings and recommendations or planned follow-up. When the requesting physician and consulting physician share a common patient record, this documentation can be included in the patient’s progress notes. Otherwise, a copy of the consultant’s written report should be included in the patient’s record.

If any of these requirements aren’t met, then the appropriate code should be billed based on place and type of service.

Continued on page 30
When is a consultation not a consultation?

A consultation is not a transfer of care. A transfer of care occurs “when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patient’s complete care for the condition and does not expect to continue treating or caring for the patient for that condition” (Medicare Claims Processing Manual, chapter 12, section 30.6.10.B).

For instance, if a patient who doesn’t have a medical home seeks care at an urgent care facility, the nurse practitioner at the facility might recommend that the patient contact a certain family physician to establish ongoing care. This is not a consultation because the nurse practitioner in the urgent care facility is not requesting advice or an opinion on managing the patient’s condition.

The same reasoning applies when a patient is referred from an emergency department. A referring physician documents or intends a “referral and treat.” You know your referring physicians/NPP’s. If you know that the referring physician expects you to treat the patient’s condition, the visit is not a consultation.

These scenarios are transfers of care or referrals. A consultation is not when a surgeon asks you to manage an aspect of the patient’s care in the post-op period. The surgeon is not asking for your opinion or advice, so this care is concurrent to the surgeon’s care.

A consultation is not a request from a patient or family member. The fundamental requirements of a consultation is a provider or other source (listed above), so requests from a family member or patient should be reported using office visit, home service or domiciliary/rest home care codes, not consultation codes.

Consultations are not routine between physicians in the same group. Consultations can be requested of another physician in your group who has expertise in a specific medical area; however, these requests should be kept to a minimum.

A consultation is not a split/shared visit. The guidelines preclude a consultation being performed as a split/shared visit.

A consultation cannot be billed more than once per consultant per facility admission.

A consultation cannot be billed as a 99211. This is a minimal service and doesn’t meet consultation guidelines.

Pre-operative clearances

It’s not uncommon for a surgical specialist to request preoperative clearance from the patient’s family physician. As with other consultation services, the preoperative clearance consultation should involve a request for opinion or advice. For example, do the comorbid conditions of this patient require any special considerations? Can this patient safely undergo this procedure?

When you report a consultation for preoperative clearance, use the appropriate CPT code for the level of service and setting where the consultation services were rendered as well as diagnosis codes that indicate the necessity of the consultation. Also, code any diagnoses that arise during your consultation.

Medicare guidelines state that, following a preoperative consultation, if the consultant assumes responsibility for managing a portion of the patient’s condition(s) during the postoperative period the consultation codes should not be used. In this situation, you should use the appropriate subsequent hospital care codes to bill for the concurrent care in the hospital setting and use the appropriate established patient visit codes for services provided in the office.

Additional initial and subsequent consultations instructions

Here are some additional tips to keep in mind:

- In an office or outpatient setting, if an additional request for a consultation regarding the same or a new problem with the same patient is received from the same or another physician or qualified NPP and documented in the medical record, the Office or Other Outpatient Consultation codes may be used again.

- For a second opinion evaluation (patient and/or family requested) in the facility setting arranged through the attending physician, the evaluation is reported as an Initial Inpatient Consultation service if the consultation requirements are met.

- Medicare does not require a written report to be sent to a physician or qualified NPP when a second opinion evaluation visit has been requested by the patient and/or family.

- A written request for a consultation should be included in the requesting physician’s or qualified NPP’s plan of care, but the absence of a request should not be held against the consultant in a post-payment review.

- A consultation request may be written on a physician order form in a shared medical record.

- The reason for the consultation service must be documented by the consultant in the patient’s medical record.

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your billing and coding questions to medec@ubm.com.
Get paid for using the patient portal

by LISA A. ERAMO, MA Contributing author

In an age of healthcare consumerism, patients increasingly use the EHR portal to communicate with physicians. It’s about convenience. They ask for prescription refills, request appointments, pose clinical questions, and more—all without having to call the office or come in to see a provider. Until now, physicians haven’t been able to bill for responding to these messages.

But there’s good news: effective this year, physicians can potentially report HCPCS codes G2010 (remote evaluation of pre-recorded patient information) and G2012 (brief communication technology-based service) to receive Medicare reimbursement, depending on the specific services rendered.

Here’s an example of how it would work:
A patient takes a picture of their rash or records a video of their gait following knee surgery and uploads it to the portal. The patient’s physician reviews the image or video and provides additional instructions or feedback to the patient. The physician may be able to bill G2010, provided all other requirements for the code are met, says Nathaniel Lacktman, a healthcare lawyer at Foley & Lardner and chair of the firm’s national telemedicine & digital health industry team.

HCPCS code G2012 offers another potential portal tie-in, though this code also requires an element of synchronous communication. For example, a patient has symptoms of a cold, but she isn’t sure whether she needs to schedule an in-person visit with her physician.

The patient provides some information via the portal that the physician reviews. The physician then briefly communicates with the patient in real-time (e.g., via telephone or via a portal with audio-video capabilities) to advise whether the patient actually needs to come into the office for an in-person appointment.

The physician determines that no in-person visit is necessary and instructs the patient to call the office if symptoms worsen. The physician may be able to bill G2012 as a virtual check-in, permitted all other requirements for the code are met, says Lacktman.

Another example is a patient who remotely transmits physiologic data (e.g., blood sugar levels taken from a glucometer) to the physician via the portal. The physician reviews that data and calls the patient to discuss the results in real time. In this scenario, G2012 may potentially apply if the physician determines no in-person visit is needed.

WHY THESE CODES MATTER
Using the portal for these types of communications can be highly efficient, particularly when the physician uses clear protocols and care pathways, explains Lacktman. In addition to generating revenue, a benefit of asynchronous remote evaluations and virtual check-ins is that physicians may be able to care for additional patients without

HIGHLIGHTS

- Physicians can advocate for payers to accept and pay portal codes by explaining how these services improve access to timely care and ultimately reduce costs.
- Using the portal for patient communication can be highly efficient, particularly when the physician uses clear protocols.
Portal communications

Technology

having to add more hours to their workday, he adds.

“These codes could reduce physician burnout and the need to double- or triple-book appointments,” says Lacktman. “Unlike traditional Medicare telehealth services, these codes have no rural geographic limitations. The patient can be anywhere, including at home. These are game-changing codes.”

However, there are some caveats with these codes. If the remote evaluation or virtual check-in originates from a related E/M service provided within the previous seven days by the same physician or other qualified healthcare professional, then the service is considered bundled into that previous E/M service, says Lacktman.

In this case, G2010 and G2012 are not separately billable, which means physicians can’t bill the patient or Medicare, he adds. The same is true when the remote evaluation or virtual check-in results in an E/M service within the next 24 hours or during the next available appointment.

GETTING PAID BY COMMERCIAL INSURERS

Jaci Kipreos, CPC, CPMA, president of Practice Integrity LLC in Henrico, Va. is encouraged by these new codes but is unsure whether commercial payers will accept them. “Do they look good? Yes, Medicare is finally recognizing all of the additional work providers perform. But you’ve got to start talking to your private payers so you know what they’re going to do—or not do—for you,” says Kipreos.

6 ways to put your portal to better use

By Gary Hamilton, contributing author

1. Access health records in one place.
Patients can use the portal to share a full picture of their records, which can help them more proactively manage their health.

Obtaining outcomes requires modifying patient behavior. Enabling patients to engage in self-management and then tracking whether they are fulfilling the desired actions is a critical step in determining which interventions are most successful at an individual patient level.

To save time and make scheduling vastly more efficient, patients can be given the ability to schedule their own appointments online or via a mobile app. This saves time for front-office staff and allows them to be more efficient and focus on other priorities.

Being able to fill out necessary forms online before and after visits is a big convenience for patients. Having information imported into the EHR so it only has to be completed once is even bigger, reducing friction in the patient experience while making data collection much more efficient in the process.

5. Make communication easier.
Giving patients the option to choose how they receive communications, including automated emails, texts, or phone calls, can streamline communications while helping organizations comply with additional requirements. The portal can also be used to coordinate medication refill requests, pay bills, and supply visit and discharge summaries.

6. Set up home device monitoring.
Wireless monitoring devices that automatically transmit data and store it in the patient portal can help patients better manage their chronic conditions, while helping clinicians manage their care plans, spot trends, and improve and sustain their clinical and financial outcome goals.

Gary Hamilton is chief executive officer of patient portal software provider InteliChart.
She advises practices to contact the provider representative at each payer, and ask whether the payer accepts G2010 and G2012 as reimbursable codes.

If the answer is no, ask the payer whether they will allow the code to at least pass through its system and trigger a single line item denial—or whether it will deny the entire claim. Practices can also flag these claims and review them manually after payer processing occurs.

“These codes could reduce physician burnout and the need to double or triple book appointments. . . . These are game-changing codes.”

— NATHANIEL LACKTMAN, FOLEY & LARDNER

If the payer allows the codes to pass through with a single line item denial, physicians should continue to report them—even if they receive a denial. “You need something to bring to the table,” says Kipreos. “You can’t just say, ‘I’m doing this, will you pay me?’ The payer will want to know the frequency, and there’s no way to account for what you’re doing unless you report the codes.”

Physicians can also advocate for payers to accept and pay these codes by explaining how these services improve access to timely care and ultimately reduce costs, she adds. As with any new code, CMS will be watching G2010 and G2012 closely for inappropriate use, says Lacktman. “There’s a learning curve. I definitely recommend that practices take the time to understand these new codes and make sure they’re billing them correctly,” he adds.

HCPCS code G2010

Work RVUs: 18
Non-facility practice expense RVUs: 16
Malpractice RVUs: .01
Reimbursement: Approximately $13

When to use it: When a physician or other qualified healthcare professional remotely evaluates pre-recorded patient-submitted images and/or video

Other requirements:
- Can only be used with established patients
- Requires interpretation and follow-up with the patient within 24 business hours via phone call, audio/video communication, secure text messaging, email, or patient portal communication
- Cannot originate from a related E/M service provided within the previous seven days by the same physician or other qualified healthcare professional
- Cannot result in an E/M service or procedure by the same physician or other qualified healthcare professional within the next 24 hours of soonest available appointment
- Providers must obtain and document consent from the patient to receive this service

When not to use it: When a physician or other qualified healthcare professional remotely evaluates a pre-recorded health risk assessment. Instead, report CPT code 96160.

HCPCS code G2012

Work RVUs: 25
Non-facility practice expense RVUs: 14
Malpractice RVUs: .02
Reimbursement: Approximately $15

When to use it: When a physician or other qualified healthcare professional (i.e., one who can report E/M services) performs a brief non-face-to-face check-in via communication technology to assess whether a patient’s condition necessitates an office visit

Other requirements:
- Can only be used with established patients
- Requires telephone interactions or synchronous, two-way audio interactions enhanced with video or other kinds of data transmission
- Cannot originate from a related E/M service provided within the previous seven days by the same physician or other qualified healthcare professional
- Cannot result in an E/M service or procedure by the same physician or other qualified healthcare professional within the next 24 hours of soonest available appointment
- Requires 5-10 minutes of medical discussion
- Providers must obtain and document verbal consent from the patient to receive this service

When not to use it: When a physician and patient exchange emails without any synchronous communication.
Debt: How much is too much?

For many physicians, living with debt is an integral part of their training; but few learn how to manage it once their “real” paychecks begin rolling in.

In fact, many physicians continue to dig themselves deeper into debt as their careers progress, says Cory S. Fawcett, MD, a personal finance coach and author. “As can happen to anyone, physicians often just become totally numb to the consequences of debt,” says Fawcett.

“We end up feeling like it’s Monopoly money,” agrees James M. Dahle, MD, editor and founder of the White Coat Investor LLC. “We owe so much money, what’s a little bit more?”

Here are four signs that a physician may already owe too much:

1/ Not knowing how much is owed

“You would be surprised by how many physicians there are who have not sat down and written out what they owe altogether—because it’s terrifying,” Dahle says. “But you can’t formulate a plan until you know what you’re up against.”

Once a physician musters the courage to analyze his or her problem, he or she can create a budget and work toward resolving the debt.

“The word ‘budget’ can be difficult for some people,” Fawcett says. “But you have a limited amount of income. You already have a restriction on the amount you want to spend. So why not be in charge of the restriction by being proactive—not reactive—about what you want to spend?”

2/ Living paycheck to paycheck

As a result of a mentality in which debt is the norm, it’s not unusual for established physicians to live paycheck to paycheck—albeit with larger checks than the average American, says Fawcett.

“Just because your income jumped to $260,000 a year doesn’t mean you have to spend it all this month,” he says. For new residents coming out of training, he recommends they live on roughly $60,000 a year until their finances catch up.

A key danger of depending on one’s entire income every month, he adds, is that there is no cushion to protect the physician from loss of income due to job loss, illness, or maternity leave.

3/ Paying with plastic

Physicians’ financial problems can be compounded by a societal expectation that conflates practicing medicine with wealth. Thus, physicians can easily fall prey to misconceptions such as, “I’m a doctor. I can afford it,” or “I work hard. I deserve a nice car and vacations,” says Gail L. Clifford, MD, an internist in Phoenix, Ariz.

In reality, these purchases are premature if they need to be bought with credit cards.

“Physicians are just like everybody else, and we all want to have stuff before we can actually afford to do it,” says Dahle, who recommends that physicians avoid taking on any debt besides student loans and a mortgage.

4/ Unclear goals

When physicians are fuzzy on what they owe or what standard of living they can afford, it’s nearly impossible to plan for the future. Specific, individual financial goals can help physicians ascend from a rut, says Fawcett.

Whether that goal is to buy a new home, retire at a certain age, or live debt-free, you can make a plan to get there. “Once you see where you are and where you want to go, you can plot out a map to get there. Following it isn’t as hard as you’d think,” he says.

Debra A. Schute is a contributing author. Send your financial questions to medec@ubm.com.
Doctors are fond of complaining that they didn’t go to medical school in order to practice business, but independent physicians do spend much of their time on their practices’ finances.

That requires mastering revenue cycle management (RCM), the financial process practices use to administer all the functions associated with claims processing, payment, and revenue generation.

At the level of the individual patient, RCM begins when that patient makes an appointment and ends when all claims and payments resulting from the appointment and subsequent services have been settled. At a higher level, it means ensuring that the practice generates enough income to pay expenses and yield a profit.

Revenue cycle management has never been easy, but the move to value-based care and reimbursement, as well as more risk-based payer contracts, has made it harder than ever. A 2016 survey by research firm Black Book found that 90 percent of small, independent practices were unprepared financially and technologically to implement value-based care.

Difficult thought it may be, efficient and disciplined RCM is key to an independent practice’s ability to remain so. “Effective revenue cycle management isn’t going to guarantee your practice’s financial success, but neglecting revenue cycle management might result in its failure,” says Melissa Lucarelli, MD, a family physician in Randolph, Wis., and a member of the Medical Economics editorial advisory board.

A MOVE TO OUTSOURCING

As RCM becomes increasingly demanding, more practices are turning to vendors to handle part or all of it.

The Black Book study predicted that the U.S. market for physician and ambulatory RCM outsourcing and extended business office services would grow by 42 percent between the end of 2016 and the beginning of 2019. The same survey of 2,000 independent physician practices found that 59 percent of providers intended to outsource some or all of their billing.

“High-impact drivers of the physicians practice outsourcing market include the increasing emphasis on compliance and risk management, and the need for more efficient and cost-effective processes,” Black Book managing partner Doug Brown says in the study.

The rising costs of operating a practice also underscore the importance of RCM. A 2018 Medical Group Management Association study found that over the past five years median operating costs for primary care practices have risen by 13 percent, from $391,798 to $441,559 per physician. And while revenue can fluctuate, expenses such as salaries, rent, insurance, and equipment payments must be paid on a regular schedule.

Outsourcing revenue cycle management can be a way for small practices to get a better handle on their finances and provide more time for treating patients.

Many practices, however, worry that introducing a third party would hurt long-standing patient relationships.

HIGHLIGHTS

Outsourcing revenue cycle management can be a way for small practices to get a better handle on their finances and provide more time for treating patients.

Many practices, however, worry that introducing a third party would hurt long-standing patient relationships.
“Effective revenue cycle management isn’t going to guarantee your practice’s financial success, but neglecting revenue cycle management might result in its failure.”

—MELISSA LUCARELLI, MD, FAMILY PHYSICIAN, RANDOLPH, WISC.

Outsourcing RCM is comparable to a primary care physician referring a patient to a specialist, says Todd Van Meter, senior vice president, ambulatory care, for Optum360, a revenue cycle management firm based in Eden Prairie, Minn.

The specialist has greater resources, knowledge, and expertise to handle the task than does the generalist, he says. And unlike a practice whose primary mission is providing healthcare, a vendor is focused solely on RCM, making it easier for them to stay current on regulatory and reporting requirements while discovering new efficiencies.

Lucarelli says outsourcing much of her RCM has been a boon for her small, rural practice. “These are tasks we could do and we used to do, but the system does the heavy lifting and the drudgery stuff that keeps us away from the medical stuff we want to do,” she says.

Lucarelli uses her EHR vendor, Athenahealth, for coding, billing, verifying insurance coverage, interfacing with payers, and other functions. She adds that outsourcing the RCM function has made it possible for her to reduce the practice’s back office staff from four to two, a part-time billing clerk who posts claims and an office manager.

The system has been particularly helpful for meeting reporting requirements under the Merit-based Incentive Payment System, as well as providing upgrades, such as free interfaces with labs. “There is no way that I would go back to the old way and be able to provide medical care the way I want to,” she says.

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**KEEPING IT IN THE PRACTICE**

Not all practices find it beneficial to outsource RCM, however.

Associated Physicians is a 20-doctor independent practice in Madison, Wis., that offers comprehensive primary care services, including physical therapy, nutrition counseling, and diabetes education while operating its own lab.

The accompanying volume and complexity of paperwork, reporting, and regulations would push some practices to outsource their RCM, but Associated Physicians does nearly everything with its own employees.

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**Five factors driving RCM outsourcing**

1. **Inefficient billing processes.** Decreasing collections and increased collection time was indicated by 100 percent of all practices choosing to outsource.

2. **Office turnover and lack of skilled help.** 97 percent of independent group and solo practices experience high business staff turnover. Finding employees experienced in ICD-10, value-based care, risk contracting, and the Medicare Access and CHIP Reauthorization Act is a challenge.

3. **Poor technical skills.** 95 percent of practices with fewer than five physicians self-identify as “not tech savvy.” Financial investment in hardware and applications, training, regular software upgrades, and occasional technical issues are too much to handle, according to most small groups.

4. **Avoiding staff management.** All 244 newer practices in the survey reported outsourcing RCM in order to be able to concentrate on the other challenges of starting a practice.

5. **Freeing up time for patients.** 77 percent of physicians believe they need to find more direct patient care time currently taken up by business office-related issues.

Source: Black Book 2016 Revenue Cycle Management Survey
“We want to remain independent. Part of that independence is wanting to do as much inside as possible,” says Executive Director Terri Carufel-Wert, RN, MHA.

The practice employs 11 back office personnel, including coders and billing and payment specialists. While that’s substantial overhead, Carufel-Wert and Business Operations Manager Margaret Wilkinson, CMC, say the team saves money by performing at a very high level.

Communication and coordination are key, Carufel-Wert says. Everyone, from physicians to billing clerks, works from the same guidelines, and new providers are quickly trained on office procedures. The coders are so well-versed in regulations that they seldom make billing errors and even occasionally correct private payers, she adds.

Employees are cross-trained on jobs so there’s no drop-off in performance during someone’s absence. The staff analyzes potential new practice offerings and equipment to determine if reimbursement will make them profitable.

The practice is proactive with patients as well. Whenever possible, it obtains payment upfront and frequently has to educate patients about what their insurance covers and how much it pays.

The hard work pays off. The average time between billing and reimbursement from payers and patients is 22 days, which Wilkinson says is much shorter than average.

“We had to do a lot of training and educating, but we are now able to deliver quality care at an affordable price,” Wilkinson adds.

A PERSONAL TOUCH
Newton Family Physicians has done its own RCM for all 37 years of its existence and expects to continue to do so, says practice administrator Melissa White.

“We find it just works better for us,” says White. The Newton, N.C. practice has six physicians and four nurse practitioners. Doing its own RCM requires three full-time-equivalent employees doing coding, billing, and other back office tasks, while White and a part-time employee handle collections.

The practice has considered using a vendor for RCM and probably would save money by doing so, White says, but worries

Choosing an RCM vendor

Using an RCM vendor does not have to be an all-or-nothing proposition. Many independent physicians, like Melissa Lucarelli, MD, a solo practitioner in Randolph, Wis., choose to outsource some functions and keep others.

She recommends developing policies and processes for each phase of RCM, from pre-authorization to collections, then scrutinizing them to determine if it makes financial sense to outsource that phase. That self-examination led her from doing virtually everything in-house to outsourcing most of the work.

Whether outsourcing all RCM functions or only some services, here are some guidelines for selecting a vendor from industry sources:

1. Choose a reputable and experienced vendor. Ask about qualifications, certifications, and association memberships. Check references.

2. Know what you’re paying for. Vendors offer a variety of services and packages and comparison shopping can be confusing. Make sure you get what you need and aren’t paying for services you don’t need. Ask an experienced attorney to review the contract.

3. Make sure the vendor provides a customizable and usable dashboard. This is a practice’s interface with RCM and if it’s hard to use or difficult to read the operation will suffer.

4. Get analytics. A good RCM vendor will not only handle coding and billing, but offer real-time analytics tools that filter data, generate the necessary reports, and make it easy to identify problem areas that should be addressed.

5. Make sure the vendor provides regular updates. Reimbursement is constantly changing, and RCM software must be current to avoid problems with denials and failure to meet reporting and performance standards.

6. Check the vendor’s customer service record and references and know exactly what type and how much help your contract stipulates.

7. Make sure it’s compatible with your EHR system and that you will be able to run your own reports.

8. Set agreed-upon performance goals. You’re hiring a vendor in order to improve RCM and having benchmarks in place will let you know if that’s being accomplished.
money

Revenue cycle management

that introducing a third party would hurt long-standing patient relationships in the rural communities it serves.

For example, the practice knows when a patient has lost a job or been sick and will take that into consideration during billing, White says. It also offers no-interest payment plans.

“It’s not always about saving two cents,” she says. “From a community perspective, we just have better reception.”

While the practice will use a collection agency for some unpaid debts, it prefers to rely on the personal touch, White says, adding, “We found that it works better for us because when you call someone and they know you they’re more likely to deal with you than they are with a collection agency.”

Their personal, in-house approach works, she says, adding that Newton has a reimbursement rate of 97 percent to 99 percent.

rcm patterns

As part of his RCM, Jeffrey Kagan, MD, an internist and member of the Medical Economics editorial advisory board, meets with his accountant annually to project income and expenses for his two-physician practice in Newington, Conn.

The accuracy of those predictions determines whether the practice is profitable or if Kagan must tap into a line of credit to pay himself and employees. After 25 years in practice, he has identified reimbursement patterns, such as slower and fewer patient payments in the first half of the year because people have not yet met their insurance deductibles.

This trend has gotten worse as more employers switch to high-deductible plans, he says.

The practice uses an outside vendor for billing and occasionally hires a collection

improve your bottom line by improving your patients’ billing experience

By Jordan Rosenfeld Contributing author

No matter how good the quality of clinical care a physician offers, if the billing experience is bad for the patient it can have a negative impact on a practice, says Joe Polaris, senior vice president of R1 RCM, a healthcare technology company based in Chicago, Ill.

“The revenue cycle management industry’s track record on patient experience over the long term is not good,” Polaris says. He says that patients often describes their billing experience as “a nightmare” because there isn’t enough price transparency up front, bills are not integrated across physicians and there aren’t always easy payment options.

“We’ve created this administrative burden historically for the patient navigating, accessing and paying for care,” Polaris says. “We really ought to invest in transforming the experience.”

The transformation he recommends is to catch up to other industries that have made customer experience seamless and simple. He cites the example of the airline industry. “You go in and there’s a [self-serve] kiosk everywhere. Or you can virtually do everything on your phone: book the flight, choose your seat, pay for the flight, get your mobile boarding pass.”

It’s the responsibility of the revenue cycle management industry, he says, to automate and simplify everything from scheduling to billing. He says the goal should be to find a platform that is either built into an EHR or integrates wirelessly into one, that solves patients’ main pain points.

“Select a platform that can do more than what you’re looking to do today,” Polaris says. “Over time digital transformation is taking place in healthcare, and you’re going to want a platform that’s there for the patient regardless of their needs.”

Polaris says the most important pain points to solve are as follows:
agency, but performs other functions itself. Kagan does everything he can to get patients to pay their co-pays and other costs at the time of their appointment. “If I can get my money in three months, I’m thrilled,” he says. “There are some who take longer, but none of my expenses get held up for three months.”

He takes payments via credit cards, accepting the service fee if it means getting paid faster. He also has had to get stricter with non-paying patients, either dropping the worst offenders or refusing to schedule new appointments until their debts are settled.

His staff also knows to verify insurance eligibility at the beginning of an appointment. “It only takes a few minutes to do that in the beginning, but it probably takes an hour to fix it later,” he says.

**Price transparency**
Patients need to know up front what they can expect to pay out of pocket, through some sort of estimator that can help ascertain what portion insurance will cover, and what portion the patient will.

**Personalized payment options**
A crucial way to improving the customer’s billing experience is to personalize the patient’s experience based on their financial realities, Polaris says. “With scoring models and big data, we can predict the difference between a patient who can get a bill and just pay versus a patient who may have a hardship and need us to proactively offer discounts, financial counseling or payment arrangements over time.”

He says physicians should think of their patients in three segments: A third of people who can pay their bills without any problem; a third of people who don’t like getting a bill but can make it work to pay it; and the third who struggle financially to pay for their medical care for a variety of reasons.

**Insurance support**
Physicians billing managers or teams should not rely upon patients to be fully up to speed on their own insurance coverage. He recommends software that can address insurance validation, check for prior authorizations and check medical necessities.

“All those checks ensure that we’re foolproofing the patient visit and making sure the provider’s going to get paid,” he says. Polaris urges physicians to remember that no single platform can do everything for the patient. While there is a move toward better interoperability between systems, it’s up to the physician practice “to stitch together the platforms on the back end and create a seamless experience for the patient, either on the web, or on a mobile device,” he says.

**“We’ve created this administrative burden historically for the patient navigating, accessing and paying for care. We really ought to invest in transforming the experience.”**

—JOE POLARIS, VICE PRESIDENT, R1 RCM
Over the past two years, Congress has taken steps to address the opioid crisis. Most recently, the legislature has done this through the passage of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The SUPPORT Act addresses various aspects related to the opioid crisis through a series of more than 120 separate bills. Here are five sections in particular that physicians should hone in on.

**Section 6032**
The Centers for Medicare and Medicaid Services (CMS) has been tasked with recommending changes to its programs for enhancing the treatment and prevention of opioid addiction as well as coverage and payment of medication-assisted treatment. Physicians should check the CMS website for announcements.

**Section 5042**
States must establish a qualifying prescription drug monitoring program (PDMP) and require healthcare providers to check the PDMP for a Medicaid enrollee’s prescription drug history before prescribing controlled substances. For physicians, this means checking the PDMP database. There has been a great deal of discussion about the ability of physicians and pharmacies to track usage in other states as well. Tennessee, for example, has six bordering states. Detection becomes hard and more problematic because drug seekers merely need to cross state borders to fill a prescription.

**Section 6001**
The Center for Medicare and Medicaid Innovation may test models for behavioral health providers. These providers may be offered incentive payments for adopting electronic health records and for using that technology to improve the quality and coordination of care. There are two crucial items related to this section:

1. As with Meaningful Use incentive payments in general, care should be taken not to misrepresent compliance; and
2. This funding, at least for now, is limited.

**Section 8122**
This section of Eliminating Kickbacks in Recovery Act of 2018 (EKRA) is one of the SUPPORT Act’s related bills. This provision makes it a federal crime to receive or offer “illegal remunerations for referrals to recovery homes, clinical treatment facilities, and laboratories,” the Recovery Kickback Prohibition.

For physicians, this wording is broad and extends beyond clinical laboratory arrangements with treatment facilities. It includes other payers in addition to federal and state government programs, such as Medicare and Medicaid. Penalties under this new law carry a $200,000 per occurrence fine and up to 10 years in prison. Although similar to the federal Anti-Kickback Statute, which includes some of the AKS safe harbors, EKRA created an entirely new offense.

In sum, the SUPPORT Act and its constituent laws create both new opportunities—and new liabilities—for physicians. From my perspective, if physicians are charting medical necessity, prescribing in accordance with the law, checking the PDMP, and staying abreast of the changes in both the prescribing of opioids and treatment of patients with opioid disorders, then these changes could lead to better patient outcomes.

Rachel V. Rose, JD, MBA, advises clients on compliance and transactions in healthcare, cybersecurity, corporate and securities law. Send your legal questions to medec@ubm.com.
How to attract provider talent to your practice

by MARY K. PRATT Contributing author

In a small Kansas town, an independent medical practice is taking an innovative step to attract talent.

The practice owner and his team of six clinicians believe they need at least one more physician but expect the position will be part time, at least to start.

The owner developed a training program with a local hospital that allows new physicians he hires to get hours at the hospital, thereby creating the equivalent of a full-time position attractive enough to draw high-quality applicants, says Jillian Schneider, MHA, manager of practice support at the American College of Physicians, who has worked with the practice.

Many practices have difficulty recruiting and retaining clinical staff, but small and independent practices often face the biggest challenges as they try to compete for talent against larger entities that are better able to promote all they can offer.

Small, independent and rural practices don’t have as many recruitment and retention resources. They typically don’t have the financial capacity to offer compensation packages as generous as larger or system-owned practices, or offer the high-profile work environments that exist in major research healthcare centers. They might not even have a full-time schedule to offer to start, as the Kansas example illustrates.

Management experts stress that a well-crafted plan can help these practices be more successful in hiring the right people for their teams, ensuring the longevity of their practices, and, ultimately, serving their patients in the most efficient and effective manner. “At a small practice, there’s only so much money that can be spent on compensation, so they have to consider the types of the benefits they can offer, like flexibility and work-life balance. Those are big perks that money can’t buy,” Schneider says.

TARGET THE TALENT

Smaller, rural and independent practices can be particularly hard-pressed to attract qualified candidates, says Travis Singleton, executive vice president of the physician recruiting firm Merritt Hawkins.

These practices sometimes struggle to attract physicians and other clinicians because prospective employees are often unfamiliar with smaller practices, how they operate, and why they can be good places to work. Singleton says younger physicians typically train at hospitals or in larger practices affiliated with healthcare systems, so they’re only familiar with practicing in such settings.

To attract physicians, Singleton says, independent practices should search for candidates who come from rural areas and are therefore likely familiar with life in those areas, the sense of community they often have and perhaps even how healthcare practices in those areas operate. Practices should use professional networks, medical schools or physician associations to identify clinicians who fit that profile.
But that is just the first step. Independent practices also should work with medical schools or regional medical associates to attract potential candidates. "Physicians in small and rural practices should be reaching out to schools, saying, 'We want students to come to us. We want them to learn about small-practice medicine, rural medicine, so let’s form programs so they can be exposed to this kind of environment,'" she says.

Russell Kohl, MD, had a solo family practice in rural Oklahoma from 2006 to 2012. He relied on networking to help attract candidates when he had positions to fill. But he also worked with his local vocational high school and area colleges, offering to be a preceptor for nursing students.

"Some physicians say they don’t want to be a training center. Some might think it slows down the practice. But if you think about it as an on-the-job interview for both—you get to see these people, they get to see the culture of your practice—then you realize you both really get a feel for whether it’s the right fit," he says.

Indeed, Kohl, who now practices in Stilwell, Kan., and is a board member of the American Academy of Family Physicians, had hired a nurse practitioner and two licensed practical nurses from the training programs he had established with area schools when he was still with his previous practice in Oklahoma.

**OFFER COMPETITIVE COMPENSATION**

An attractive compensation package includes a competitive salary and standard benefits, such as health and dental insurance as well as paid time off for vacations, sick days, and bereavement. Schneider acknowledges that small and independent practices don’t often have the money to fund a new position as soon as they recognize the need for more staff, so she advises practices to plan strategically so they can start budgeting for new positions a year or two in advance of recruiting and hiring.

To ascertain the compensation that other practices in their region offer, practice owners can access compensation surveys, such as those done by the Medical Group Management Association (MGMA), and talk to colleagues, says Nick Fabrizio, Ph.D., FACMPE, FACHE, a MGMA principal consultant.

"One of the best strategies is to talk with others. People will share what they’re paying, or share a range. That gives the hiring physicians the best benchmark," Fabrizio says.

He notes that physicians don’t have to offer the exact same compensation package that others in their region do, particularly because small practices generally can’t afford to match the benefits packages offered by the largest healthcare systems. Still, Fabrizio says, the practice must be close to what others in their area offer their employees. That could mean a higher salary but a less generous benefits package, or vice versa.

**HAVE OPTIONS ON EMPLOYMENT, OWNERSHIP ARRANGEMENTS**

While salary is important, small practices can also attract and retain staff by structuring compensation to reward hard work or finding other ways to boost the total compensation package.

"Even more important than competitive pay is providing employees a sense of how they can earn more," says Laurie Morgan, MBA, a practice management consultant and partner at the practice management consulting firm Capko & Morgan.

She suggests creating bonuses for clinicians who meet productivity goals. "Creating that type of job structure, and then communicating it clearly, can be a powerful way to compete against larger organizations with more cookie-cutter employment policies for doctors," she says.

Kohl established an employee profit-sharing program, which became an effective tool for retaining staff and boosting practice efficiency. "It made my employees very creative in getting work done. They were very focused on being effective and efficient, so we could do all the procedures we needed to do," he says.

Similarly, Singleton advises practice owners to be open to various types of employment arrangements. He points out that...
many physicians don’t want to be practice owners, so there should be a career path for them, as well as an option for those who want to become partners. Practices should also determine ways for their physicians, non-physician providers, and support staffs to grow professionally, Morgan says. “Not all employees are interested in doing the same job forever; many people are aiming to progress. Enabling employees to pursue more education, moving from medical student to intern to resident as they ramp up is important, but also think about that long-term development.”

TE KEY TO RETENTION

The survey found that physicians are generally quite satisfied in their jobs but are also willing to change employers if they can find a better fit. The key to retention, Grabl notes, is listening to physicians to ensure their needs are being met. She suggests holding interviews after the physician has been recruited—at intervals of three months, six months and a year—where they can monitor how the physician and his or her family are integrating into the practice and community. This would involve simply talking to the doctor and his or her family about what they like, what they feel is missing in their lives, and what in the community can support the spouse or partner.

Jennifer Moody, an associate principal at ECG Management Consultants, a Dallas, Texas-based medical staffing company, says physicians in their first job are looking to build upon the clinical expertise they’ve been developing in residency/fellowship. “It is important to many that they find a practice opportunity that allows them an interesting case mix,” she says.

Also important, she notes, are opportunities for improved financial stability—such as loan forgiveness, net income guarantees or a signing bonus, because new physicians frequently have a great deal of educational debt. Chris Borasz, manager of physician and provider recruitment for OhioHealth in Columbus, Ohio, says when recruiting, it’s important to think about the entire family, not just the physician, and consider what in the community can support the spouse or partner. “It’s finding things that are helping to engage that person in connectivity to community,” Borasz says. “The development and support as they ramp up is important, but also think about that long-term development.”

FINDING WORK

According to the CompHealth study, 40 percent of placements are a result of referrals and networking. Only 12 percent of young doctors use social media to find work, despite spending between five and 19 hours a week online for personal reasons. Moody says that millennials often will use social media to look for practice opportunities, confer with peers about salary norms or contract requirements on social-media-based message boards, and research potential job locations on the internet. Therefore, if practices are only advertising in specialty journals or hoping to network at society meetings, they will miss out on many candidates.

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Grabl says this is important because young physicians today want more than just a good working opportunity. “They are still willing to work, and work hard, but they also want more in their lives,” she says. “That could be implementing more flexible schedules, reducing on-call requirements or bringing in locum tenens physicians to allow for vacation time or help with patient load.”

by Keith Loria Contributing author

Recruiting and retaining young physicians

With the physician shortage remaining a major concern for healthcare providers, a 2018 study from medical employment firm CompHealth identified ways young physicians find their first positions, what they want in a job, and why they leave. Not surprisingly, the survey found that young physicians want good compensation. But money’s not all they’re looking for. Lisa Grabl, president of Midvale, Utah-based CompHealth, says facilities should be aware that young physicians also want to work in a place that has a great culture and offers a good work/life balance.

“If you’re not strong in these areas, look for ways to improve, or you’re going to lose out on attracting the best talent,” Grabl says.

For many years, physicians were willing to work long hours and make their career the center of their lives. Younger physicians still care about their patients and career, but they also want to have time for family, friends and interests outside of medicine, which is why many healthcare facilities have adjusted their recruiting tactics to show how they can meet all of their physicians’ needs—not just their workplace requirements.

Jennifer Moody, an associate principal at ECG Management Consultants, a Dallas, Texas-based medical staffing company, says physicians in their first job are looking to build upon the clinical expertise they’ve been developing in residency/fellowship. “It is important to many that they find a practice opportunity that allows them an interesting case mix,” she says.

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“One of the benefits of having a small practice is you have the flexibility to meet [employees’] needs. That’s a big selling point, particularly for younger physicians who are raising kids or still going to school.”

—RUSSELL KOHL, MD, FAMILY PHYSICIAN, STILWELL, KAN.

Kohl says he used professional development opportunities as a recruitment tool. He encouraged members of his clinical team to pursue further education, and he worked with individuals who continued their studies to create schedules that gave them time to take classes yet still have the practice adequately covered. As a result, he retained top talent and his practice gained more skilled employees.

OFFER UNIQUE BENEFITS, PERKS
During his years running his small practice, Kohl says he learned that his staff members often didn’t use the benefits he expected them to need, but did want some degree of individualized benefits.

For example, he found that most of his staff members did not need health insurance because they were already covered by their spouses. Some, however, were more interested in flexible hours or more vacation time. Kohl says he sought to learn what his staff members valued most and tailored what he offered to each one as a way to help retain them.

“One of the benefits of having a small practice is you have the flexibility to meet [employees’] needs. That’s a big selling point, particularly for younger physicians who are raising kids or still going to school,” he adds.

Practice owners should determine what benefits or perks they can offer, such as flexible schedules, and then highlight that to prospective candidates.

For example, practice owners could offer new physicians the ability to hire their own care teams, determine how broad to make the scope of their practice coverage, and even set their office hours, Singleton says.

“That control goes a long, long way in recruiting and retaining physicians,” he says, citing a group of physicians that decided to join an independent practice where they’d make less money but could have more say in the way they provided care for their patients.

Management consultants say practice owners should also emphasize the unique qualities or professional opportunities that their practice offers as a way to attract clinicians seeking professional experiences different than those offered in larger settings.

For example, Schneider says, rural practices can sell the fact that physicians working in them generally practice a broader range of medicine and that they’re often a bigger part of these communities than their suburban and urban counterparts.

FORMAL POLICIES NEEDED
Although management consultants say small and independent practices should use individualized employment packages as a way to recruit and retain top talent, they advise practice owners to have policies and procedures in place to establish available benefits so that even if employment packages are individualized they won’t seem capricious.

“To a certain extent, you have to determine what you can do for each one and still maintain a practice, and you have to be fair,” Fabrizio says.

Fabrizio adds that practice owners who want to recruit and retain skilled professionals need to focus on being good employers—not just good healthcare providers. He adds: “Be the best employer you can be. Respect your staff, be responsive to your staff.”
Rudeness
Complaints in this category range from being verbally attacked by a receptionist to feeling insulted by a physician. One writer, the relative of a patient, spent countless hours in the waiting room during her loved one’s multiple treatments and claimed the entire office, including the specialist, was on a network of gossip behind the couple’s back.

Other circumstances deemed rude by patients include having to wait for every appointment, feeling that they weren’t being listened to by a distracted doctor, and not being introduced to the strangers in the room (interns, residents, other staff, etc.)

One patient wrote to tell me about the time a billing clerk suddenly entered the examination room mid-procedure to discuss another patient’s insurance claim with the doctor.

It’s understandable that patients can misinterpret visual and verbal cues, especially when they’re concerned about their health. While a physician’s eyes are on a computer, the patient might be longing for eye contact with them. And they can easily mistake the slightest hint of brusqueness in a doctor’s voice as exasperation.

Practices may want to host a meeting to develop a set of guiding principles with all employees, making sure those standards include injecting an element of kindness and compassion into every patient interaction. This applies to all departments, from reception to billing.

Rushing
Patients are frustrated and confused when they’re not granted adequate time to have a complete conversation with a medical professional about their symptoms, results, treatments, medications, diagnoses, and plans. They clearly don’t like being rushed. When the physician is behind, they’re affronted.

While most people understand that doctors need to deal with urgent situations and unexpected booking changes, they appreciate being notified if there’s going to be a delay. This courtesy allows them to alter their plans accordingly, because their time is valuable, too.

A big part of this problem lies in unrealistic scheduling. Depending on the practice, there may be little or no say about how much time is allotted for each appointment or how many patients are seen in a day. If a physician is in the enviable position of controlling her calendar, she should do what she can to make the day flow more smoothly.

Brainstorm with staff to find ways to educate patients about what they can expect during their appointments. Fine-tune messaging by asking the receptionist or booking clerk to explain to patients how long they’ll have for their visit. If, for example, the policy is to deal with only one concern per visit, make that clear.

Reproach
Some patients say they’ve been made to feel that they’re to blame for their medical condition. And let’s face it, that’s often the case. But they don’t appreciate being scolded or talked down to. What they’d rather have is understanding, support, and advice, which can be challenging when the practice is seeing the same people with the same problem time after time.

A lot of people are scared and intimidated when they visit a doctor. The last thing they need is to feel belittled, too. I’ve received lamentations about everything from a loss of character and morality in the medical profession to a lack of transparency in healthcare in general. And while it’s not possible to validate these one-sided complaints without a full investigation, it is wise to consider them as examples of potential problems in a practice.

Sue Jacques is a professionalism expert, keynote speaker, consultant, and author who specializes in medical and corporate civility. Send your practice management questions to medec@ubm.com.
10 ways to manage workplace conflict

by TRACEY WALKER Contributing author

Workplace conflict is unavoidable, so it’s vital that physicians learn how to resolve and manage diverse perspectives to create a high-performing organization.

“Conflict is not inherently negative; it flows naturally from having diversity,” says Natalie M. Thigpen, vice president of marketing and communications for Summit Health Management in New Providence, NJ. “Since I believe diverse perspectives are critical and absolutely necessary to arrive at the best solutions for complex problems—managing team conflict is an essential skill to master for high-functioning teams.”

Laizer Kornwasser, MBA, president and chief operating officer for CareCentrix, a manager of post-acute services, calls conflicts a natural part of human interaction.

“It’s important not to shy away from them but rather promote open, honest dialogue that, in the end, will always help the company thrive,” she says.

Here are 10 ways experts say you can manage team conflict:

**Step into counselor mode.**

“I do a lot of re-stating and re-phrasing to help each side see the other point of view—not as a ‘contradiction,’ but as an alternate perspective that might help us arrive at an even better solution,” says Thigpen. “When this fails, which it sometimes does—ego is healthy, but sometimes non-constructive—I make an appeal for professional respect and trust. Worse-case scenario is that we’ll choose one path over another, be proven wrong, and learn something along the way.”

**Tune in to the company culture and environment.**

“There’s no one strategy for managing team conflict, but there are important guidelines: keep the conflict professional, define the goal and allow for a healthy debate on how to get there, create a basis of trust with no ramifications, and center the discussion around facts,” says Kornwasser. “Additionally, to be successful in resolving team conflicts it’s important for managers to know the personalities of those involved and listen carefully to both the tone and the content of the discussion. A manager is not a media-tor, but rather a leader who knows when to make decisions and when to turn it over to the team.”

**Have effective one-on-one meetings.**

“Most companies are good at business meetings and status updates. But there also needs to be time on the calendar for employees to talk with their leaders about more than just work,” says Kevin Ricklefs, senior vice president of talent management for CHG Healthcare, a healthcare staffing company in Salt Lake City. “Regular one-on-one meetings—driven by the employee, rather than the leader—not only help create trust,
but give an opportunity to share and address issues before they become problems."

**Lead by example.**

"As simple and obvious as this may seem, it is incredibly difficult to avoid office politics when in a position of power," according to Cheryl Nagowski, senior director, federal markets for D2 Consulting, a life sciences consulting firm for pharmaceutical, biotechnology, and medical device manufacturers based in Chesterfield, Missouri. "Even when we attempt to hide that tension, staff are incredibly attuned to a host of indirect cues that reveal our reality. "Walking the talk" and navigating difficult interactions with poise will set a certain standard and tone for what is expected from others in that operating environment.

**Get in front of the problem.**

"What are we waiting for? People often ignore the first signs of conflict because they are busy doing their jobs and/or hope the conflict will go away on its own," says Camille Khodadad, JD, a labor and employment attorney for Much Shelist, a law firm based in Chicago. "Often, not only does the conflict not go away, but it escalates until it reaches a boiling point. By the time you get there, team dynamics may not be salvageable. Rather than address conflict when it has reached a crisis level, acknowledge conflict when it first appears. Only when conflict is acknowledged can a leader take the steps necessary to address it."

**Recognize the benefits of conflict.**

This includes enhancing creativity, developing closer relationships among teams and managers, and giving those involved an opportunity to grow and learn from each other, according to Kornwasser. "Conflict can also grow and strengthen a company, as it offers managers the opportunity to celebrate and appreciate employee differences—their different points of view, personalities, and backgrounds," he says.

Embracing productive conflict is useful, Ricklefs says. "Conflict doesn’t have to be a negative thing," he says. "Productive conflict happens when you involve the team during the decision-making process. More opinions—especially those that are diverse and even conflicting—lead to better decisions."

**Know your limits.**

Healthcare executives may be tempted to handle all team conflict internally without the help of outside counselors, but they need to evaluate each situation carefully. "Executives should immediately seek assistance from human resources, in-house counsel, and/or outside counsel when the conflict involves potential legal issues, such as violations of wage and hour laws, allegations of discrimination or harassment, or alleged violations of other federal, state, and local laws," Khodadad says.

**Redirect when tensions are high.**

Activities focused on shared goals and objectives can help staff reconnect and reestablish trust with each other, according to Nagowski. "Even introducing a new party to the situation may serve to ‘reset’ the team dynamic," she says.

**Remain neutral and demonstrate compassion.**

"Egos run high in the workplace, and nowhere is this truer than in healthcare," Nagowski says. "Tremendous talent pools are trying to collectively make decisions that will often affect lives. These unique dynamics can serve as a breeding ground for emotional involvement in business. Leaders should remember that every conflict is a loaded situation and respond with empathy and a willingness to assist in resolution."

**Foster an environment where ideas are exchanged respectfully.**

Disagreement among team members can be a positive thing, but we don’t often think of it that way, according to Khodadad. "Teams that freely and openly exchange diverse ideas tend to produce more successful, innovative, and creative results," she says. "The clash of ideas can lead to that ‘spark’ that fuels the advancement of a team’s goal. Train your team on how to effectively consult about work issues and solutions. Effective consultation involves creating a respectful environment where members can safely contribute their ideas with the goal of advancing the team." —KEVIN RICKLEFS, SENIOR VICE PRESIDENT OF TALENT MANAGEMENT, CHG HEALTHCARE

**Editor’s note:** This article was first published in our partner publication, Managed Healthcare Executive.
Best advice ever given to you by a peer

Maria Young Chandler, MD, MBA
Business of Medicine / Pediatrics
Irvine, Calif.

“Treat your life as a business (Me, Inc.) and you’re the CEO.”

George G. Ellis, Jr., MD
Internal Medicine
Boardman, Ohio

“One of my professors once told me the day you stop learning is the day you hang up your stethoscope.”

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

“Focus on your family, and don’t let your wife and kids ever feel like they don’t know you anymore.”

Jeffrey M. Kagan, MD
Internal Medicine / Hospice
Newington, Conn.

“The hospital is not your friend.”

Melissa E. Lucarelli, MD, FAAFP
Family Medicine
Randolph, Wis.

“Always thank a patient for asking about your family or about your health, and always send a sympathy card when your patient dies.”

Joseph E. Scherger, MD
Family Medicine
La Quinta, Calif.

“Spoken words evaporate. Written words are eternal.”

Salvatore Volpe, MD
Pediatrics/Internal Medicine / Pediatrics
Staten Island, N.Y.

“Slow down.”

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“There’s no way that I would go back to the old way [of doing revenue cycle management].”

MELISSA LUCARELLI, MD, FAMILY PHYSICIAN, RANDOLPH, WIS.

“There are likely to be a lot of losers [with Medicare for All]... and that’s going to create a lot of political backlash.”

JOSEPH WHITE, PHD, PROFESSOR OF PUBLIC POLICY, CASE WESTERN RESERVE UNIVERSITY

“Code doctors can potentially use to get paid for telehealth”

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“If we can’t reduce patient wait time at least we can make it more entertaining for them.”

Dealing with patient empowerment

Patients are more empowered as partners in their care than ever before. We examine the state of the physician-patient relationship today, and ask how the role of physicians needs to change to meet patients where they are. In today’s healthcare landscape, what do physicians owe patients and what do patients owe physicians?
Your complex challenge.
Our collaborative approach.

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