n 2018, we were inundated with terrible news about how 2017 was worse than any previous years due to the sheer number of data breaches—even though there was a decrease in the total number of records exposed.

To top this off, we saw definitive proof that healthcare as a whole is significantly behind similarly-sized industries in terms of information security. For 2018, 75 percent of healthcare organizations planned to spend just six percent of their IT budgets on cybersecurity which is half what other sectors spend on security.

Fortunately, reality has not been as harsh on our industry as many expected. One of the most promising developments from 2018 was news that cybersecurity at healthcare organizations is improving at a faster pace than other sectors, although it must be noted that we started from further back, too.

But just because we are getting better does not mean we have stopped the bleeding yet. One major problem is finding qualified cybersecurity talent that will work in the healthcare industry. A HHS 2017 report found that due to the lack of competitive salaries, staffing woes have not improved. Additionally, the report found that three in four organizations are operating without a designated Information Security leader.

The biggest news stories revolve around large organizations that have large breaches, but there is plenty of evidence that the attackers see the value in smaller healthcare organizations’ data too. The bottom line is that health records are valuable individually and attackers have realized that small practices are relatively easy targets.

In the last year, we have seen a major uptick in phishing attacks that specifically target payroll direct deposit accounts. Attackers have shown signs of moving from pure money-making efforts (like ransomware) into disruption of operations and destruction of critical data. These are significantly harder to recover from than a ransomware attack or other more common attacks. This, coupled with the obvious value that medical records have to criminals, has created a treacherous situation for healthcare organizations.

Fortunately, not all the news is quite so dire. Why? Because more of the leadership, executives, and boards of healthcare organizations recognize the need for data security and organizational support. This recognition is, without a doubt, the most powerful tool available to improve the industry’s overall security posture. Their support provides the resources—money, time and organizational focus—that is helping healthcare improve the overall security posture of the industry.

At the same time, don’t let yourself believe that we can let our foot off the gas. While we are making major strides toward becoming as secure as our non-medical counterparts, we are not there yet.

The most important thing that we can do to keep the momentum going is to keep security on the forefront of leadership’s minds. The costs of ignoring the risks are catastrophic.

Finally, we can never forget that as we improve our defenses, the off enders improve their tools, tactics and strategies. Security is never final, it is a continuous journey that must be adjusted and adapted to new threats constantly.

Nye is senior director, Cybersecurity Research and Communications, for CynergisTek.
The cyber threat

Hackers are targeting you—here’s how to thwart them

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Direct pay

Transitioning to models that ditch payers

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LAST WORD

Defeat burnout

Physician burnout is about a broken system, and doctors must be part of the solution, writes Jennifer Frank, MD.

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Beyond burnout: The real problem facing doctors is moral injury

Doctors are dissatisfied and demoralized with how they are required to practice today, and as a result physician burnout is taking a huge toll on medicine. Innumerable surveys show that more than 50 percent admit to at least one symptom of burnout and that many are relocating in hopes of finding a better practice climate, or exiting clinical practice through early retirement, moving to administration, or simply leaving medicine altogether. But we contend burnout is an inaccurate diagnosis for the condition and instead, that physicians are experiencing moral injury.

Moral injury is generally defined as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations." This concept better describes the untenable double- and triple-binds that physicians are finding themselves in, whereby the countless roles they are expected to undertake often place them in conflict with their primary moral imperative: taking care of the patient.

The underlying problem is, we are being pulled in too many directions. We took oaths to put the needs of our patients above all else, but over time that priority has eroded in the face of economic drivers in healthcare and competitive realities. Too often now, physicians must choose between the needs of their patients and the demands imposed by their employers, productivity metrics, insurance companies, mandates to reduce "leakage," and satisfaction surveys. The patients' needs cannot always win—and often don't.

Physicians are not taught when, why or how to set boundaries, nor are we often encouraged or empowered to do so. In fact, much of a physician's training contravenes establishing boundaries of reasonableness or responsibility.

"As an independent, solo, family doctor, my practice's existence is in jeopardy. Insurers reimburse me at lower rates than large groups and exclude me from ever-narrowing networks. Far too much of my professional time is spent providing quality and cost data to insurers and the government. I am not alone. My experience has become woefully common in American medicine."

—John Machata, MD, on the survival of small independent practices.

"I think that DPC is the best model we have at this time. I believe I give better care than most other doctors out there, and it's not because I am smarter or more talented; I think it's because the model encourages me to give good care, not bad (as is the case with regular fee-for-service medicine)."

—Rob Lamberts, MD, on the potential risks of direct primary care.
Unknown threats.
At ISMIE, we know that just like you, cyber threats don’t work 9 to 5. That’s why our comprehensive 24/7 cyber liability coverage – offering some of the industry’s highest coverage limits and dedicated coverage for breach response services – gives our nearly 10,000 policyholders peace of mind, all the time. Visit ismie.com/cybersafe to learn more on how ISMIE keeps cyber threats at bay.
Physicians who transition to direct primary care aren’t abandoning their patients

I want to thank Rob Lamberts, MD, for his March 25, 2019, article addressing the issues of potential “dangers” and “negatives” as they relate to the DPC model of healthcare delivery. I am thankful to comment. Dr. Lamberts addresses three topics: abandonment, consistency in the model, and leadership.

After reviewing the definition of “patient abandonment,” a physician making the transition from an established practice to DPC would be hard-pressed to be in the position of abandoning patients. It behooves the physician to follow proper procedure when leaving an established practice for DPC or he/she would risk malpractice. How does this situation differ from a physician leaving a practice if moving away, taking a new job (consider physician administrators leaving their patients), retiring, or quitting medicine altogether? Would that be called “patient abandonment” too?

Let’s talk about “care abandonment” which are words appropriate to a system that gives patients 7-10 minutes with their doctor (at no fault of the physician) surrounded by mounds of useless red tape, gives limited access, and causes patients to forgo personal medical care due hurdles in cost, attention, access. The discussion should be about “care abandonment.”

Careful consideration is necessary when using the moniker “patient abandonment” before assigning it to anything or anyone; perhaps paying attention to “care” rather than “abandonment” is more appropriate since doctors who embrace DPC do so to be able to provide improved medical care to patients.

When and by whom was it determined that a patient panel of 2,500 to 3,000 is the standard for primary care? Clearly it is not working for patients or physicians. A higher absolute number of patients does not translate into more or better “care” for numerous reasons that do not need to be summarized.

Direct Primary Care is the most patient-centric, consumer-driven form of healthcare delivery this country has seen in decades.

“Direct Primary Care is the most patient-centric, consumer-driven form of healthcare delivery this country has seen in decades.”

Direct Primary Care is the most patient-centric, consumer-driven form of healthcare delivery this country has seen in decades. Patients are driving this model too. Maybe 800 patients, or any number the physician feels is adequate for their practice, should be the new standard. And maybe panels of 800 is why there is growing interest in Direct Primary Care from medical students and residents.

Consistency in the model is an interesting topic and has been discussed among DPC leadership. There are criteria for DPC practices incorporated into office workflows. These criteria are for public consumption in 25 state DPC bills and on www.dpcfrontier.com.

Specialists are starting direct care models, too. Trying to exclude imposters and those who practice non-traditional medicine is, in my opinion, not our job. State boards of medicine and medical malpractice companies will enforce standards and consistency within scope of training. Patients will choose. Individual DPC physicians will practice medicine while being held appropriately accountable by these entities and by their patients.

Thankfully the criteria are not restrictive but outline necessary legalities. The proposition of a Direct Primary Care certifying board/society would provide an added layer of bureaucracy which would inhibit innovation. Innovation must continue for real working solutions to our healthcare crisis. DPC, with its “risks,” is providing just that.

As with any grassroots movement, flexibility is necessary to promote change. DPC physicians are responding to our patients’ needs and the DPC movement is responding to the American healthcare system’s deficiencies. That is our leadership.

Kimberly Legg Corba, DO, CHCO
CORBA SERVES ON THE BOARD OF DIRECTORS FOR DPC ACTION, IS A FOUNDING MEMBER OF THE DPC ALLIANCE, AND OWNS A DIRECT PRIMARY CARE PRACTICE.
Despite burnout and stress, physicians are happy

Physicians hear every day about how they work too many hours, see too many patients and deal with too many hassles. But does the real burnout and lack of work-life balance impact their happiness?

A new survey by CompHealth and the American Academy of Family Physicians suggests the answer is no.

Here are four key takeaways from the results.

**Takeaway: Physicians are happy.**

Healthcare consolidation has made it more difficult for small practices to thrive, the authors note, thus leaving physicians more interested in selling their practice. When private equity comes calling:

- 71% told surveyers they are happy.
- 59% said they were satisfied with their lives.
- 61% said they would still become physicians if they had a do-over of their life.

**Takeaway: The key to happiness is professional and patient relationships.**

Physician relationships with key stakeholders (percent who said the relationship was positive):

- Other physicians: 84%
- Patients: 88%
- Staff: 87%
- Administrators: 50%

“An interest in the science of medicine is what brought most physicians into the field, but keep them happiest with their jobs are the personal relationships they have with family, friends and patients.”

**Takeaway: Lack of control causes unhappiness.**

The top reasons for physician unhappiness were:

- Lack of control: 72%
- Clerical burdens: 71%
- Being emotionally exhausted: 69%

**Takeaway: Physicians mostly feel unappreciated.**

Only 34% of physicians said they felt appreciated for their work.
How medical records differ—and what’s legally required

“Lions and tigers and bears, oh my!” This line from The Wizard of Oz often comes to my mind when I present on the subject of the differentiating between a medical record, a designated record set, and a legal medical record.

That’s only the first part of the equation. The second part involves the nuances of an electronic health record (EHR) versus an electronic medical record (EMR). Regardless of the term used, something that invariably arises with these presentations is a discussion about what information needs to be included in a patient’s medical record.

Let’s begin with the basic definitions.

- A medical record, whether paper or electronic, can be thought of as the clinical aspects of patient care.
- The designated record set is defined in 45 CFR § 164.501 and is more comprehensive than a medical record because it includes the billing items and releases.
- The legal medical record is a combination of both a clinical medical record and a designated record set. It is the most comprehensive record and serves as the organization’s complete business record across the continuum of care. This includes text messages and emails to patients.
- An electronic medical record (EMR) is a digital version of a traditional paper chart that contains a patient’s entire medical history from one practice.

An electronic health record (EHR) is a more comprehensive report of the patient’s overall health.

Now that you know the basics, let’s dig in to what a medical record must contain.

At a minimum, a medical record must include the patient’s identifying information, including name, date of birth, Social Security number, address, contact information, insurance information, emergency contact information, HIPAA Authorization, and advance directives.

Beyond those basics, the medical record must also include adequate clinical documentation that substantiates medical necessity, such as SOAP notes:

- **Subjective**—a description of the patient’s current condition in narrative form, e.g., chief complaint or reason for seeking diagnosis or treatment
- **Objective**—documents objective, repeatable and traceable facts about the patient’s status; and includes vital signs, labs, and other findings from the physical exam
- **Assessment**—medical diagnosis for the medical visit and the date the note was written
- **Plan**—the plan of treatment, next steps, and follow-up.

The information included in the medical record should meet medical treatment protocols, which are based on scientific evidence and professional standards of care. (See §88.15, public health service.)

Tantamount to an accurate, complete and up-to-date medical record is an appreciation for the sensitive and personal information these records contain. It is always important to remember a patient’s right to privacy. It’s not just a HIPAA issue, it is a Constitutional issue.

Medical records must be comprehensive enough to substantiate medical necessity; appropriately identify the patient; accurately document insurance information; and have adequate technical, administrative, and physical safeguards in order to protect a patient’s privacy.

Rachel V. Rose, JD, MBA, advises clients on compliance and transactions in healthcare. Send your legal questions to medec@ubm.com.
Level of care coding tips to boost revenue, mitigate risk

by LISA A. ERAMO, MA, contributing author

The clock is ticking, and you’re trying to select the right E/M level from a drop-down menu in the EHR. Choose a level that’s too high, and you run the risk of post-payment audits and recoupments. Choose one that’s too low, and you may lose revenue to which you’re entitled. You decide just to trust your instincts and go with a code that feels right so you can move on to the next patient.

Choosing an E/M code based on a gut feeling is one of the biggest mistakes a physician can make, says Sonal Patel, CPMA, CPC, a healthcare coder and compliance consultant with Nexsen Pruet LLC, a business law firm in Charleston, S.C. Payers and auditors use a quantitative scoring process that requires specific elements (i.e., history, exam, and medical decision-making [MDM]—or time spent counseling and coordinating care) for each E/M level.

If physicians don’t document these elements adequately—or the elements they document don’t make sense given the patient’s presenting problem (e.g., performing a comprehensive exam for a patient with a sinus infection)—payers and auditors may down-code the service or even conduct a more in-depth audit that could expose additional documentation vulnerabilities, she adds.

It’s equally risky to report the same E/M level for all patients with the same diagnoses (e.g., diabetes or congestive heart failure) without first considering medical necessity—a trap into which many physicians fall because they assume all patients with the same diagnoses generally require the same work, says Toni Elhoms, CCS, CPC, director of coding and compliance at RT Welter & Associates Inc., a healthcare consulting company in Arvada, Colo. “In reality, every single visit could be a different level based on the documentation and circumstances of the encounter,” she says.

FOCUS ON QUALITY E/M DOCUMENTATION—AND THE DOLLARS WILL FOLLOW

Knowing what documentation is required for each E/M level is paramount. For example, the history, exam, and MDM meet or exceed certain requirements for all new patients. The only exception is when the physician selects the E/M level using time as the controlling factor. In this case, documentation must indicate that the physician spent more than 50 percent of the encounter face-to-face with the patient and/or family providing counseling and/or coordination of care. The physician must also explain the specific services rendered and the reasons for them.

Only two of three key components must

HIGHLIGHT

Be as descriptive as possible in your documentation. Specify the location, quality, severity, timing, context, modifying factors, and associated signs and symptoms that are significantly related to the presenting problem.
Money

Level of care coding

meet or exceed certain requirements for established patients unless the physician bills based on time. Elhoms provides an E/M scoring guide that includes a visual depiction of documentation requirements for each specific E/M level based on whether the patient is new or established.

Sound confusing? Experts agree that even the most experienced medical coders have difficulty translating physician documentation into an accurate E/M code. They cite several reasons why E/M coding is so difficult for physicians—lack of formal training on E/M guidelines, complex documentation requirements that don’t align with clinical practices, and the subjective nature of the MDM component.

We’ve asked our experts to share their best documentation tips to ensure accurate E/M reporting. Here’s what they said.

HISTORY

When billing a level 4 or 5 new patient E/M code (i.e., 99204 or 99205), remember to document one specific item from the past medical history (i.e., illness, operations, injuries, treatments, medications, or allergies), one specific item from the family history (i.e., medical events or hereditary diseases that place the patient at risk), and one item from the social history (e.g., use of tobacco, drugs, or alcohol).

Also document a review of systems that relates directly to the problem identified in the history of the present illness (HPI) in addition to a review of all additional body systems, says Elhoms. Physicians frequently forget to include all of these elements, often leading payers to down-code these services to a level 2 or 3 on post-payment review, she adds. That means physicians could lose as much as $133 per encounter.

Similarly, when billing a level 3 new patient E/M code (i.e., 99203), don’t forget to document one specific item from either the past, family, and/or social history that’s directly related to the problem in the HPI. Omitting one or more of these details usually prompts payers and auditors to down-code the service to a level 1 or 2 on post-payment review, says Patel. Revenue loss in this case could be as much as $64 per encounter.

Be as descriptive as possible when documenting the HPI.

Specify the location, quality, severity, timing, context, modifying factors, and associated signs and symptoms that are significantly related to the presenting problem, says Patel. These descriptors help physicians gain points when choosing an E/M level, she adds.

Don’t repeat the same HPI for every visit.

This is true even for follow-up appointments related to chronic conditions. Payers want to see what’s new with the patient—for example, new pain, new flare-ups, new concerns, or new lab results—or some acknowledgement that the patient has been stable and symptoms are controlled, says Patel. The same repetitive HPI could be a red flag that a physician is cloning their documentation, she adds.

EXAM

Only review body areas or organ systems that affect MDM for the current encounter, says Michael Miscoe, JD, CPC, founding partner of Miscoe Health Law LLC in Central City, Pa. Most subsequent visits, for example, don’t require a multi-system exam even though it’s very easy in an EHR to pull this information forward from the initial visit. Doing so inflates the E/M level and could expose a physician to audit risk, says Miscoe. “More isn’t necessarily better,” he adds. “Because many docs either don’t understand this or let their EHR system flood the record with irrelevant content, we see skewed E/M profiles that lead to post-payment liability.”

Explain negative findings.

Miscoe says documentation should reflect the following: For example, what did the physician specifically ask the patient about each body system, and how did they respond? How did this contribute to the physician’s overall assessment and evaluation?
In the examination, what element of the organ system did the physician evaluate, and why?

Physicians who don’t explain their analysis in the context of the patient’s complaints often end up with what Miscoe terms “healthy sick people records” (i.e., level 4s and 5s with mostly negative findings and no explanation of why the physician performed certain services) that tend to raise a red flag with payers and auditors.

**Know whether your Medicare Administrative Contractor uses the 1995 or 97 E/M guidelines.**

These guidelines differ in their options for the exam component of the E/M level, says Patel. More specifically, the 97 guidelines provide additional options for single organ system exams, allowing providers to report higher-level services for intensive, problem-specific examinations. Once you know which of the guidelines your MAC uses, ensure your EHR vendor incorporates them into any templates you use, she adds.

**MDM**

**Know how payers calculate the MDM.**

“MDM is all about the cognitive labor a physician puts into the encounter,” says Elhoms. This includes the number of diagnoses and management options considered, the amount and/or complexity of data reviewed (e.g., urinalysis, EKG, lab results, or additional workup planned), and the risk of complications, morbidity, or mortality. Therefore, documenting each of these elements is critical because it can help justify a higher-level E/M code, she adds.

**Know how your Medicare Administrative Contractor interprets MDM.**

Contractors publish frequently-asked questions and other guidance describing what they look for in terms of all E/M documentation, including MDM. For example, some MACs define ‘additional workup’ as any service that’s performed outside of the current encounter while others state it’s any work that goes beyond the E/M service—even when the physician performs it during the

### Five E/M best practices

1. **Invest in training.**
   - This includes annual E/M refresher training for all physicians and staff.

2. **Hire an outside consultant.**
   - Ask this individual to audit E/M documentation and ensure it supports the level of codes assigned.

3. **Be mindful of time-saving functionality.**
   - The Office of Inspector General (OIG) monitors copy-paste functionality (often referred to as cloned documentation) as well as auto-populated fields within E/M templates. Experts suggest turning off this functionality to avoid inappropriately upcoding E/M services. They also suggest turning off the automatic E/M calculator. This calculator is often based on a vendor-proprietary algorithm that may not accurately correlate with E/M scoring guidelines. The calculator also isn’t able to consider the medical decision-making or complexity of care that’s provided.

4. **Always consider medical necessity.**
   - Is it medically necessary to bill a higher-level E/M code when a lower level of service is warranted? For example, even though CPT guidelines permit physicians to report a level 5 E/M code when performing a comprehensive history and comprehensive exam, it may be appropriate to report a level 3 if the medical decision-making is straightforward (i.e., minimal risk of complications, morbidity, or mortality; minimal or no data reviewed; and minimal number of diagnoses or management options considered). Per the Medicare Claims Processing Manual, CMS considers medical necessity the overarching criterion in selecting an E/M code.

5. **Partner with a certified coder to validate codes prior to claim submission.**
   - Certified coders are well-versed in E/M guidelines and documentation requirements and can help increase compliance and minimize post-payment audit risk.
CMS created quite a stir in 2018 when it proposed consolidating E/M levels 2 through 5 into one payment rate. After listening to concerns from medical associations and others, the merging of payment levels has been delayed to 2021, and as currently proposed, will collapse levels 2-4 into a single payment rate, while retaining level 5 as a separate rate.

“If equating a level 2 visit with a level 5, it could create a disparity in reimbursement for those with multiple chronic conditions,” says Anders Gilberg, MGA, senior vice president, government affairs, for the Medical Group Management Association. Part of the reason behind the delay was the short timeline between the final rule announcement and when it would have to be implemented.

“It would be nearly impossible for all the software systems and EHR and payment vendors to get this up and running,” says Gilberg. So for now, E/M reimbursement levels remain unchanged, but expect to see further debate on what collapsing levels 2-4 would mean to physicians, says Gilberg.

Another significant PFS change for this year is the addition of codes for virtual check-ins, allowing physicians to bill for some evaluations done over the internet or phone. “It’s a little wonky in the sense that they don’t call it telehealth, but it is telehealth,” says Gilberg. “If physicians can now bill for the time spent talking to patients on the phone or internet, that will help alleviate the time taken away from other patients.”

From a financial standpoint, it allows reimbursement for common communications with patients.”

Nancy Enos, FACMPE, a professional coder, says physicians need to find out if their private payers will reimburse for these new codes. “Having the codes added to Medicare is a good first step, but it remains to be seen what private payers will cover them,” says Enos. □

—Todd Shryock
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THE GROWING CYBER THREAT

Practices are increasingly coming under attack by cyber criminals
Right now, medical practices are being attacked by cybercriminals.

Emails are being sent in the hope a practice employee will click on a link that will install ransomware, hackers are exploiting security flaws in medical equipment with internet connections, and information is being gathered from social media to trick staffers into revealing patient or financial records.

The sophistication and volume of attacks is increasing, according to cybersecurity experts, and practices have to be more vigilant than ever to protect themselves, even if at times it seems fruitless. “A doctor running a small practice might say, ‘If Blue Cross of Tennessee can’t protect itself, how can I?’” says Rob Tennant, director, health information technology policy for the Medical Group Management Association. “But you can’t just throw your arms up and say there’s nothing that can be done. If at the minimum you take some low-impact security steps, that should be sufficient, but always have a contingency plan so that if you run into a hack, a fire, or flood, you have a way out that ensures your practice continues.”

Cybercriminals have many resources and are highly knowledgeable about how technology works and its vulnerabilities, experts say. But they also tend to take the path of least resistance, meaning the harder they have to work to hack a practice, the more likely they are to move on to an easier target. As the bad guys refine their tactics, practices must continue to be vigilant, especially against the most common threats.

“Malware is still big and they are learning to be more effective with the messaging they use to get people to click on ransomware links,” says Kevin Johnson, CEO of Secure Ideas, a Jacksonville, Fla.-based security consulting firm. “The threats compared to last year are very much the same, but that’s good, because organizations that took the time to enhance their security are still running down the right path. However, people that said they weren’t worried about it are just as far behind as they were last year.”

EVERY PRACTICE IS A TARGET

One of the biggest mistakes a practice can make is to assume it won’t be a target because it is too small or has nothing of value. “Hackers are not going after you specifically, they are going after everybody,” says Johnson. “They target large numbers of victims, because it doesn’t take much more effort to send out millions of attacks versus a hundred, because it is all automated.”

The idea that a hacker is someone living in their mom’s basement is almost always wrong. In fact, most cyberattacks are coming from complex organizations.

“A lot of these groups would be considered mid-sized businesses,” says Elliott Frantz, CEO of Virtue Security, a New York City-based firm that identifies vulnerabilities in applications and networks. “They have full-time staff, their own R&D teams, and in some ways are on par with many tech companies.”

Broad attacks are the most common, but practices can still be singled out by hackers. Elliott says that there are huge markets for stolen information, including specific markets with established prices for healthcare records. Because cybercriminals know the potential return, they can calculate whether targeting a specific practice is a good invest-
“You can’t just throw your arms up and say there’s nothing that can be done. If at the minimum you take some low-impact security steps, that should be sufficient, but always have a contingency plan so that if you run into a hack.”

— ROB TENNANT, DIRECTOR, HEALTH INFORMATION TECHNOLOGY POLICY, MGMA

“Threat Types

Practices need to defend against several threat types as part of a comprehensive cybersecurity plan, but ransomware is still the leading one. "Ransomware in particular works from a cybercrime perspective because its straightforward and uses malware to infect the system," says Snell, who adds that medical organizations are particularly vulnerable because of their immediate need for access to patient information.

Because some healthcare organizations pay the ransoms, it leads to more ransomware attacks across the industry, because cybercriminals see they can profit from it. But paying a ransom doesn’t always work, says Snell. The ransomware code is sometimes poorly written, so even when the victim pays the ransom, they still are not able to recover their data using the key.

Phishing attacks, where a cybercriminal uses an email pretending to come from someone the recipient knows, are also common, says Elliott. The sophistication of attacks has evolved well beyond the old ruse of the Nigerian prince who requires a little money upfront to secure a much bigger payout later.

"Attackers are realizing they need to put in more effort to create a realistic scenario," he says. "It’s much more common now for malicious emails to look legit and be relevant to the victim. Emails targeting medical practices are now more likely to contain names of doctors or accounts payable staff, with requests for modest money transfers or patient records.

When cybercriminals want to attack a specific organization, they’ll do the research required to get as many details as possible. "They are looking up identities on social media like LinkedIn and Facebook," says Elliott. "They are using these sources to target people not traditionally targeted five or 10 years ago."

A rising threat to practice cybersecurity is through devices connected to the internet, collectively known as the "internet of things" (IoT). This can include everything from medical equipment to thermostats. As medical technology advanced, many of these devices began collecting and storing patient data like a computer, but without the same level of built-in security, says David Finn, MA, executive vice president, strategic innovation for CynergisTek, an Austin, Texas-based cybersecurity consulting firm. These devices are often connected to a practice’s network and offer a gateway for hackers to get in.

While computers might get changed out every three to four years, medical devices are typically kept for a decade or longer, meaning many older devices weren’t designed with security features to deal with today’s hacking threats, says Finn.

"There are literally millions of devices deployed across the country in hospitals and practices, and nothing can be done in terms of protecting the device," he adds.

More troubling is that some hackers have attacked devices not to steal or ransom data, but simply to..."
Connecting practices to

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“A lot of these [hacker] groups would be considered mid-sized businesses. They have full-time staff, their own R&D teams, and in some ways are on par with many tech companies.”

—ELLIOTT FRANTZ, CEO, VIRTUE SECURITY, NEW YORK CITY

PLAYING DEFENSE

With the rising number of threats and the growing sophistication of attackers, trying to defend a practice may seem impossible. However, experts agree that a careful review of cyber vulnerabilities can greatly reduce the odds of a breach.

“Before ever looking for a specific technology or solution, I think generally speaking, small practices should understand what their exposure is and where the risk really lies,” says Elliott. Too often, people look for one “silver bullet” product that will protect their data. Elliott adds that the most important thing is to understand what the potential problems are before trying to solve them.

For example, a practice sending lots of emails or receiving files from outside sources needs to invest in making sure those systems are secure and that it is taking extra precautions when accepting files or getting requests for information, such as some sort of secure email delivery service, says Elliott.

Basic security hygiene is also important. “Make sure your passwords are different for your work email and personal email,” says Elliott. “Make sure your desktops and laptops are secured at the system level, and ensure you have anti-virus or endpoint detection of threats.”

Snell says that every log-in for every computer and device should have a different password and should not be common words. If it’s too complicated to manage, he suggests using a password tool such as LastPass or 1Password.

Johnson recommends working with the practice’s IT expert or vendor to reduce the number of ways an attacker can potentially gain access to the network or its data. “Too many organizations buy computers that are way more powerful than they need that run lots of applications,” says Johnson. “Evaluate using something like a Chromebook.”

Because of the device’s simplicity, there are fewer ways for hackers to exploit them. He compares using Chromebooks, which are stripped down computers, to removing half the windows and the back door to the garage on a house—fewer points for an intruder to get in.

Similarly, using as many cloud-based services as possible can help a small practice with security because the application provider—with its superior resources—will be responsible for securing its platform, says Snell.

An often overlooked security measure is training staff members to recognize potential risky links and to not click on them. “Users have to understand they are the first line of defense,” says Johnson. “They have to think through what they are doing and ask themselves if it makes any sense.”

“Often these [hacker] groups would be considered mid-sized businesses. They have full-time staff, their own R&D teams, and in some ways are on par with many tech companies.”

—ELLIOTT FRANTZ, CEO, VIRTUE SECURITY, NEW YORK CITY
Snell says education can be one of the most effective defensive tactics a practice can use. “Make sure everyone in the organization is part of the overall security program,” he says. “Make sure everyone is aware of the risks they may see on a daily basis.”

For example, Johnson says, an office manager received what looked like a request from a supervisor for all the employee W-2 forms. The office manager was a little suspicious and so encrypted the data and sent it with a message that the encryption key was texted to his phone.

The attacker, still posing as the supervisor, emailed back that he lost his phone and requested the key by email—and the office manager complied, thus giving the attacker the data and the key because of a compromised email account.

“People think computers are different,” says Johnson. “If you got a letter in the mail asking for everyone’s sensitive data, would you comply? They need to think about what they are doing.”

When purchasing new medical devices with internet connections, always ask about the security standards on the device, says Finn. “Ask if it can be upgraded if a vulnerability is found and if it can run some sort of anti-virus program on its system,” he says.

One other caution with connected medical devices is to know whether they store patient data, and if so, to make sure the data is purged on a regular basis, says Finn. “When you scan a document, some of what you are putting in is stored and retained by the device and most people don’t even think about that,” he says.

If cost is an issue to securing a practice’s data, Tennant says to look at free resources first, then bringing in outside help to deal with the unresolved vulnerabilities. He recommends starting with the Office of the National Coordinator for Health IT website (www.healthit.gov), which has guidance on how to do a security analysis and other tools. Another option is to team up with other practices and share the cost of a security consultant.

Attacks, with the exception of ransomware, are rarely obvious. Experts say a practice most likely wouldn’t even know if it’s systems are compromised, because there are few tell-tale signs from today’s hackers. Only a security expert examining a practice’s systems will be able to tell if a breach has occurred, and if it has, can take steps to remove the intruder. The best approach is to be proactive and assume an attack is coming, if it hasn’t already happened.

“Security 101 is making sure you have all your data backed up,” says Snell. “Cloud-based backup is inexpensive, and it will give you secure and remote backups so you can recover quickly.”

Tennant says not investing in a backup system to protect the integrity of patient data is irresponsible, and puts the viability of the practice at risk. “It is not a question of if a practice will be attacked, it’s a matter of when,” he says. “You have to assume you are going to be hit with something eventually. If it happens, what is your solution to that?”

Cybersecurity terms to know

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**Malware**
Malicious software designed to disrupt computer operations or steal information.

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**Ransomware**
A type of malware that locks users out of their data and encrypts it until a ransom is paid.

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**Virus**
A type of malware that can corrupt or erase information on a computer before spreading to other computers.

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**Worm**
Malware than can replicate itself to spread to other computers.

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**Phishing/spear phishing**
A scheme using an email to trick someone into divulging personal information or passwords. A spear phishing attack uses more detailed personal information to make an email appear to be coming from a known employee, business associate or family member.
When employees walk away from the job

My practice has had a fairly stable staff for the last several years, but I’ve had my share of unpleasant employee exits.

There was one who gave notice but one day up and left without saying a word.

There was another who quit but claimed I fired her. We were on the phone with unemployment, and it was her turn to tell her side of the story. She started with, “Well, Dr. Young was in another one of her moods…” I listened in angry silence. When it was my turn, I was honestly confused and asked, “I just want to clarify, she gets to collect unemployment even if she has a new job?” I knew she did since she wrote “start new job” on her desk calendar and told another employee all about it. Needless to say, she was ineligible to collect.

And then there was the one who was technically employed for about a month but was only physically present for a week. Someone was always sick, had to go to the doctor, or the car broke down.

But even when employees don’t give you troubles like these, they can still cause headaches.

An acquaintance of mine recently had a long-time employee who just disappeared one day, along with hundreds of dollars in cash and a few items from the office. There was proof she wished to prosecute, but it’s more than the theft. She feels betrayed and violated. Now that former employee wants her last paycheck. It is our understanding that, by law, she cannot withhold this from the employee.

“No one person in the practice should be solely responsible for all the financial transactions.”

Some people are telling her to send the check and let it all go. That it isn’t worth the hassle for a few hundred dollars. Then there are others who feel she should fight this on principle because the employee committed a crime and should be held accountable. That a police report should be filed. Some have suggested deducting the losses from her paycheck but as far as us non-lawyers can tell, that’s not legal.

Regardless of what is legal or what a lawyer might advise, she has still been hurt by this employee’s actions. Those actions are likely to cause a ripple effect throughout the physician’s existing and future relationships with co-workers and staff. The theft is more than a monetary loss. It’s a violation of trust.

What can physicians do to protect themselves from theft in the office? A good background check and references are helpful prior to hiring. Establishing a system of checks and balances for cash transactions at the front desk is also important. No one person in the practice should be solely responsible for all the financial transactions.

Physicians may also consider investing in security cameras. If there are any valuables or controlled medications, a good inventory must be kept.

Most physicians in solo practices are so busy seeing patients and running the practice that they don’t have time to serve as human resource managers and security officers. But we must find time to take steps to prevent such events when we can. Otherwise, we will pay the price.

Melissa Young, MD, FACE, FACP, is owner at Mid Atlantic Diabetes and Endocrinology Associates, LLC. As such, she is both actively involved in patient care and practice management while also raising two kids and a dog in suburban New Jersey.
AMA Announces Evaluation and Management coding changes

Are there any updates on the Evaluation and Management (E/M) code requirements?

A: The American Medical Association (AMA) has now weighed in with their E/M requirement modifications, which means that all payers will be affected in 2021. If you remember, Medicare announced plans to revamp the E/M coding structure in 2018 and was met with a quick response from the medical community. As a result, the Medicare changes implemented in 2019 were mostly documentation-related changes that generally benefited providers but were not necessarily accepted and implemented by all payers.

In March, the AMA posted the CPT Editorial Summary of Panel Actions for February 2019, which lists specific changes that they intend to make. Additionally, as the CPT Editorial Committee met earlier this month and will also meet in September, we may see even more E/M changes following the summary from those meetings (May 9-11 and September 26-28).

What does this mean for those documenting E/M services, assigning the code levels, and auditing them?

The AMA has joined Medicare and has published the 2021 E/M changes that they intend to make. We’ve all seen that when Medicare and Current Procedural Terminology (CPT) do not agree on how to report a specific service, or group of services, Medicare may produce Healthcare Common Procedure Coding System (HCPCS) code(s) with specific guidance for Medicare-contracted providers to follow.

As coders know, when a provider contracts with a payer, they must follow the guidelines and policies specific to the contract they have signed, whether or not it matches the CPT guidelines.

Now that the AMA has published these changes, we will need to wait and see how Medicare responds to them. Will we end up with significant differences in E/M code assignment among multiple payers or will they all adopt the same changes? And what are the new AMA E/M changes?

E/M codes affected

The new AMA CPT E/M changes are specific only to Office or Other Outpatient Services (99201-99205 and 99211-99215) codes. To date, we don’t have any changes to the inpatient or observation codes.

Unless the AMA makes further modifications, these changes will be included in the 2021 CPT codebook, so payers, including Medicare, will need to decide whether or not they will adopt them. They include:

- Deletion of 99201
- New guidelines specific to 99202-99215
- Changes in component scoring for both new and established patient codes (99202-99215)
- Changes to the medical decision-making table
- Changes to the typical times associated with each E/M code (99202-99215)

Say goodbye to 99201

The AMA is planning to delete 99201 from the E/M code set. That is an official code deletion, meaning it will no longer appear in the codebook after 2020. There are some situations in which you may still need to report 99201, such as those entities that will not immediately adopt the 2021 CPT code changes (e.g., workers compensation payers).

Changes in determining E/M code levels

Although documentation of history and physical examination will still need to be medically appropriate, the amount of history...
Coding Insights

or number of elements examined and documented will not factor into the scoring used to determine the overall E/M level of service.

Instead, the basis for code selection will be the level of MDM performed or the total time spent performing the service on the day of the encounter.

To this end, the AMA will be changing the definition of the time element associated with codes 99202-99215 from typical face-to-face time to total time spent on the day of the encounter, and changing the amount of time associated with each code.

What hasn’t changed is that medical necessity for the level of service must be identifiable within the documentation.

The changes to the titles of the subcategories and time in the MDM table on this page.

Again, these are the CPT changes; however, any payer contracts (e.g., Medicare or payers that follow Medicare guidelines) may require another way to calculate the E/M code levels, so confirm how your payers are implementing E/M changes in 2021.

<table>
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<th>CPT Year</th>
<th>Medical Decision Making (MDM)</th>
<th>Typical Time</th>
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<td>Number of diagnoses or management options</td>
<td>Amount and/or complexity of data to be reviewed</td>
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<tr>
<td>2021</td>
<td>Number and complexity of problem(s) addressed</td>
<td>Amount and/or complexity of data to be reviewed and analyzed</td>
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### Q: Can an ICD-10-CM body mass index (BMI) code be used as a standalone code? If not, what does the documentation need to include to justify the use of a BMI code?

**A:** The 2019 ICD-10-CM Official Guidelines state that you cannot use a BMI code (found in ICD-10-CM code category Z68.____) alone. BMI codes should only be assigned when the associated diagnosis (such as overweight or obesity) meets the definition of a reportable diagnosis.

Keep in mind BMI codes were never intended to be used as standalone codes; they were always meant to be accompanied by a corresponding diagnosis code.

In previous years, the guidelines read, “As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable diagnosis.” However, there was a long-standing issue of Coding Clinic (Third Quarter 2011, pg. 3-4) that stated:

“Individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the body mass index (BMI) code meets the requirement for clinical significance when obesity is documented.”

This 2011 direction apparently is no longer valid. The Coding Clinic, Fourth Quarter, 2018, specifically states that the provider must provide documentation of a clinical condition such as obesity to justify the reporting of a code for BMI. So this begs the question of what diagnosis, such as sleep apnea, diabetes, or hypertension, could make the use of a BMI code relevant. The same Coding Clinic article does not identify the conditions that can be considered associated with a BMI.

So my best advice to show that BMI is clinically relevant is to ensure that the documentation clearly links the condition to BMI.

For patients with provider documentation identifying “morbid” obesity, the code E66.01 (morbid [severe] obesity due to excess calories) can be assigned even if the BMI is not greater than 40, per the Coding Clinic.

This guidance is important since there are some situations where a patient can have severe or morbid obesity with a BMI of 35-39.9 due to co-existing comorbid conditions.

As noted in the 2019 ICD-10-CM Official Guidelines, Section I.A.19, “The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

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Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your billing and coding questions to medec@ubm.com.
Carmela Mancini, DO, worked long days as a hospitalist for almost three years after residency. She became frustrated early on, feeling that the doctor and patient were not the most important factors to the hospital and healthcare system. "I became disheartened," she says. "I did not go to medical school to do billing and write notes the majority of the day."

Mancini thought she was going to have to quit practicing medicine, but began talking with one of her hospital’s admitting physicians, Jeffrey Gold, MD, who ran a direct primary care (DPC) practice in Marblehead, Mass. His practice accepts no insurance plans; instead, his patients pay a monthly fee for their primary care needs. They get an annual physical, wellness and sick visits, same or next-day appointments. Other minor in-office procedures are included, like wart removals, skin biopsies and osteopathic manipulative treatments.

Mancini rented space in Gold’s office in 2015, and hasn’t looked back. With insurance billing and insurance documentation requirements considered some one of the most frustrating parts of practicing medicine, physicians like Mancini are finding ways to practice off of the insurance treadmill. Besides DPC, a number of alternative payment models exist, including concierge medicine and fee-for-service self-payment. But transforming to an alternate model can be a challenging endeavor.

WHO IS A GOOD FIT FOR DPC?

While practices like Mancini’s started with no patients, it’s easier to make the leap if the physician already has a full practice of patients to draw from. Physicians can run a hybrid practice, accepting insurance and DPC payments from different patients, during the transition.

This model can increase the practice complexity. The physician may want to consult legal with counsel to ensure that the business structure is appropriate to accept both kinds of payments, and that the billing staff is clear on what patients can be billed. The scheduler also needs to track which patients are in which model, to schedule the right amount of time for each visit, and to leave time in the schedule for same day or next day appointments for the DPC patients.

Patient panels in traditional insurance settings generally include about 2,500 patients, according to the American Academy of Family Physicians (AAFP); DPC panels are smaller, often with 600-800 patients, according to the AAFP.

There are financial risks with alternative payment models, and one of the keys is convincing your existing patients to stay on with the practice.
**Direct primary care**

It’s also easier for independently employed physicians to start a DPC practice. If employed, the physician would have to break away and start a separate practice, or the whole group needs to move to the model. The physician also must ensure there is no non-compete or non-solicitation agreement.

There are financial risks with alternative payment models. “There’s no guarantee that you’ll hang up your shingle and people will come,” says Jennifer Pollard, MD, an internist in Austin, TX. “People are spending money out of pocket.”

Pollard, runs an integrative medicine practice, using a fee-for-service model, but paid directly by patients. She wants to spend a lot of time with her patients, but not the same level of patient commitment as DPC physicians. “I don’t want to make myself available 24/7 for patients. I don’t want to manage every aspect of their primary care,” she says.

**STAFFING AND FINANCIALS**

Monthly membership prices are often based on what the local market will bear. A study in the *Journal of the American Board of Family Medicine*, notes a $77 average monthly DPC membership payment. Mancini’s practice charges $40-$135 a month, depending on patient age. Some practices have a family rate.

Physicians in DPC models find that their overhead decreases, compared to the insurance reimbursement-based model, and the study found a 40 percent overhead reduction for DPC practices. The main reason is they need fewer staff members because they don’t bill insurance. But they also use fewer to no mid-level professionals, as the physician takes on the entire clinical role.

Mancini shares a receptionist with Gold, and handles her own billing. She has no nurse, does her own triaging and calls patients directly with lab or imaging results.

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**8 ways to transform your practice to a concierge model**

By Matt Jacobson

Are you considering integrating a Concierge Medicine service offering into your practice in the next few years? If so, here are a few things you can do today, to pave the way for a successful conversion tomorrow.

**Decide which model of concierge medicine is right for you.**

If you value work life balance over all else, then perhaps you should explore a full conversion model. If you have a small practice that cannot support a full conversion or “segmented model,” you may want to consider a hybrid practice. If you already employ extenders and want to improve lifestyle and maximize earnings, then a segmented model is right for you.

**Full Conversion Model:** The full conversion model provides the best work-life balance, as full conversion practices typically yield 300 to 400 concierge members and terminate all non-member patients from the practice. Physicians operating full conversion concierge practices realize very little, if any, economic improvement from converting to a concierge practice, but are able to cut their work hours in half. There is, however, one downside to the full conversion: If a physician does not attract enough members to the program to break even, he/she will earn less and may even need to find alternative sources of income.

**Hybrid Model:** The hybrid model is appropriate for smaller practices that do not have the requisite patient volume to support a full conversion model. Physicians operating hybrid concierge practices deliver two levels of service to their concierge members and standard fee for service patients. Because patients can continue to see their physician, conversion yields tend to be low—typically below 100 concierge members. Furthermore, hybrid models actually increase, rather than decrease, physician workload.

**Segmented Model:** The segmented model is the most financially rewarding of all concierge models because it enables physicians to maintain their entire patient panel, while adding a new revenue stream from 200 to 600 concierge program members. In a segmented model, physicians focus their time and attention on the care of program members and oversee...
She spends 20-25 percent of her time on administrative work, including writing notes, billing patients, and getting prior authorizations for imaging tests, which in most practices is handled by a staff member. She says that in an insurance-based practice, about 50 percent of the physician’s time is spent documenting what she says is extraneous information on the history and physical, so that insurance would pay for the visit.

Pollard has lower overhead than when she was in a traditional practice, but also finds that the insurance-free model simplifies the office infrastructure. She takes the patient’s vital signs and asks about their medications, allergies, and complaints, which elsewhere is done by a nurse or medical assistant. Not all physicians want to do that, Pollard says.

When starting any practice from scratch, there may be additional costs to rent, buy or outfit the office. Pollard says she doesn’t have a lot of equipment, which decreased her start-up cost.

It can take time for physicians in DPC practices to earn a salary equivalent to their traditional practice days, though. Pollard says she broke even her first year.

Much depends on how many patients the practice can recruit, and the amount charged per month. Before starting a practice, it’s a good idea to think about the eventual patient panel size, how much time to allocate per visit, how many days and hours providers will spend seeing patients in the office, and then anticipate overhead expenses including office space, insurance, office supplies, and programs such as EHRs.

Running some cost scenarios on a spreadsheet should give an idea of the anticipated salary with a full patient panel, and the amounts brought in for various numbers of patients.

Identify options to maintain your existing patient base (assuming you are not doing a full-conversion model)

Physician Extenders

- If you already have a physician extender, this is the most straightforward option.
- If you do not currently have a physician extender, consider hiring one and introducing them to the practice on a part-time basis.

Young Primary Care Physician

- An Internist or Family Practice Physician with an existing practice could join your practice and be available to absorb your non-concierge patients.

Capitation

- Review your payor mix and focus on the highest quality programs. For example, capitated Medicare programs are far more financially remunerative than the average collections from a non-capitated Medicare patient. Many Medicare Advantage programs compensate the physician with up to $100 per patient per month.

Make small but meaningful upgrades to your office environment

Look at your office - would you be happy paying $1800 per year to visit this environment? If the answer is “no,” consider making small changes that can enhance the comfort of the waiting and exam rooms. Provide free Wifi, up-to-date magazines, spring water, etc.

Invest in your employees

Your employees are the face of your practice. You need to hire quality employees, train them in customer service, and pay them well. A bad front office can destroy a concierge program integration, and a good front office can help a doctor build up from 300 to 400 members. Once you hire good talent, develop systems to monitor customer service and patient communication. Remember, you get what you pay for.

“Your employees are the face of your practice. You need to hire quality employees, train them in customer service, and pay them well.”

Continued on page 34
“You have to really train whoever is answering the phone to explain what the practice is about and the benefits you may get.” —JENNIFER POLLARD, MD, INTERNIST, AUSTIN, TEXAS

“As a hospitalist, I made much more money,” says Mancini, who has recruited about 250 patients to her practice. She doesn’t want to go above 300, as she has chosen to keep her panel small in order to enjoy more family time and decrease her stress level. “Most direct primary care physicians make at least as much money as in their prior practice. My wellbeing was more important to me than how much I was making.”

MANAGE THE TRANSITION
Some doctors launch a DPC program while continuing to see patients with insurance, a hybrid model. A 2018 survey of AAFP physicians using a DPC model showed that those who achieved their ideal practice size did so in an average of 20 months. However only 17 percent of those practices had reached their target panel numbers. That concurrent period allows revenue from the new model to kick in.

“You have to really train whoever is answering the phone to explain what the practice is about and the benefits you may get.” —JENNIFER POLLARD, MD, INTERNIST, AUSTIN, TEXAS

Consider your influence in the community
As a concierge physician, you want to ensure that subspecialists and imaging centers will accommodate your patients in a timely manner. Your influence in the community is dependent on the number of referrals you make and your rapport with your colleagues. It is imperative that you cultivate and nurture your relationships.

Evaluate your current service offerings
Consider adding services such as cryosurgery, skin biopsies, trigger point and joint injections. In addition to being financially rewarding, providing these services will save your future concierge members from the inefficiency and the additional expense of seeing subspecialists for minor problems. Instead, your patients will have their minor problems addressed by their trusted physician in a comfortable environment.

Start delivering concierge-level care today
This is very important. If you are not already delivering high-quality service to your patients, they will not join your concierge program. Most patients who value their health and their relationship with their physician can afford $5 per day for a concierge program, and they will join your program if you have been doing your job correctly.

Explore concierge medicine service providers and find the right fit for you.
Once you have decided which concierge model is right for you, you will need to select a partner to help you integrate your program. You should focus on the following items during your selection process:

Company stability: How long has the company been in business?

Company expertise: How many concierge integrations has the company executed?

Conversion resources: How experienced is the company’s conversion staff?

Post-conversion marketing: What marketing does the company provide after conversion?

Practice growth: Can the company provide statistics demonstrating that affiliated practices grow over time?

Programs to enhance patient experience: Does the company provide programs to enhance the patient experience and/or enhance the financial well-being of the practice beyond the basic concierge program?

Service Agreement: Is the concierge service provider agreement fair? Does it handcuff you to the service provider with post-contract term non-competes?

Cultural fit: Do you like and trust the company representatives with whom you have interacted? You are getting into a long-term relationship, make sure it feels “right.”

Matt Jacobson is chief executive officer and founder of SignatureMD, a company that helps physicians convert to concierge medicine.
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"Patients have to know what they’re signing up for."

—ASHLEY MALTZ, MD, DIRECT-PAY PHYSICIAN

34 in, while the traditional practice winds down. Physicians should be prepared financially if coming from a salaried position, as salary is not guaranteed with this model. Physicians often supplement their income by working at other practices or hospitals as they continue to market and build their practice.

“When you have zero patients, it’s risky and scary,” Mancini says, and it can take a few years to reach the enrollment goal.

Ashley Maltz, MD, is still ramping up her self-pay practice, with more than three years in business. The internist and preventive medicine physician shares space with Pollard, and works part time for another clinic. She is considering converting to the DPC model, as it offers a continual stream of revenue, versus fee-for-service patient payments. To transition, she’ll need to rework her forms, website and payment system.

“Patients have to know what they’re signing up for,” she says.

Before talking with patients, the physician must set up the infrastructure and work out all logistics, with a business plan and timeline in place. The physician should have all the legal and financial paperwork drawn up, including brochures and patient contracts. The physician needs a website and other electronic programs, including electronic health records, membership management software, a secure patient communication portal, and possibly telehealth access if offered. Some physicians broker discount agreements with labs and imaging centers, and dispense discounted medication from their office as well.

It can be time consuming to tell patients about the new model, and physicians who are transitioning their practice will want to spend several months before it begins, explaining it to each patient at the beginning of the visit.

MARKETING TO FIND PATIENTS

Whether starting from scratch or with a full patient base in a traditional practice, the physician and office staff must have a clear elevator speech about the new model, including the benefits to the patients, says Pollard. In a DPC practice, the office staff may just include a receptionist, which may be shared with other physicians in the office. If transitioning a practice, all office staff members should understand the new model well enough to explain its benefits clearly.

“You have to really train whoever is answering the phone to explain what the practice is about and the benefits you may get,” she says.

Physicians need to network and market, and that may put them outside their comfort zone, says Mancini. Since transitioning her practice, she has attended chamber of commerce meetings, held open houses, gave healthcare speeches at senior centers, and joined a networking organization. Once she had 100 patients, word of mouth referrals increased, and she did not need to network as vigorously.

“You have to be willing to be a business person,” Mancini says.

Maltz also started with in-person networking, and now concentrates more on social media. She formed a group called the Austin Wellness Collaborative, which she says has been a great source of patient referrals. The Collaborative includes a variety of wellness professionals who network with each other.

Physicians can also network with employee benefits companies, insurance brokers, local banks, and financial planners, to incorporate DPC into a financial or benefits plans. Patients may find it worthwhile financially to change to a less expensive high deductible plan, and join a DPC practice. Some DPC physicians work with employers to enroll employees as well.

GO IT ALONE OR WITH HELP

With growing interest in DPC, many physicians are willing to help other physicians for free. “I wouldn’t recommend someone paying a company to help them get started. There’s so much free advice out there,” says Mancini. “Doctors who do this type of practice want to help this movement grow and are happy to talk to doctors thinking about going this route.”

Those who want high-touch professional help can consult with companies like Paragon, though these companies focus mostly on concierge practices. The AAFP publishes information on its website, and sells a toolkit to get started with DCP, as well.

“I’ve never been happier in a job,” says Mancini. “I’ll never go back to working for a hospital-based system.”
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.

Physicians who want to adequately fund their retirement should consider a cash balance plan. It 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. The cash balance plan also allows the participant to roll over the balance into another qualified plan, such as an Individual Retirement Account (IRA).

Participants are promised a quantified benefit at retirement 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.

A cash balance plan allows practice owners to contribute money annually to participant accounts on top of the money that has been contributed to a 401(k)/Profit Sharing plan. Participant accounts are guaranteed an annual interest crediting rate from the invested money. This rate may be fixed or variable and is typically tied to an index. These plans are designed to be in operation for five to 10 years.

Seven major benefits of cash balance plans are:

- **Multiply retirement savings**: Doubled or even quadrupled annual retirement plan savings are possible. A 401(k) plan allows contributions of up to $19,000 per year plus an extra $6,000 per year “catch up” for individuals 50 years old and over. Profit sharing allows up to an additional $37,000 for a total of $62,000 per year. A cash balance plan allows an extra $55,000 to $336,000 of deductible savings.

- **Tax deduction**: A medical practice can deduct all contributions made for employees. As individuals, medical practice owners and partners may deduct dollar for dollar the money invested into a cash balance plan. Typically, this can be much larger than even the homeowner’s mortgage interest payments deduction.

- **Tax deferral**: Money is invested tax deferred and may ultimately be rolled into an IRA account where it will continue to grow tax deferred.

- **Attract & retain employees**: Cash balance plans are very attractive to current and future partners and employees. When a cash balance plan is implemented, retirement plan participation improves.

- **Protection from creditors**: As a qualified retirement plan, the cash balance plan assets are protected from creditors. This includes protection from bankruptcy proceedings and civil lawsuits.

- **Comfortable retirement**: Cash balance plans allow significant annual contributions from $55,000 to $340,000, depending on variables including age and income. They allow physicians to catch up and save an adequate amount for a comfortable retirement.

<table>
<thead>
<tr>
<th>Age</th>
<th>401(k) w/ Profit Sharing*</th>
<th>Cash Balance**</th>
<th>Total</th>
<th>Taxes Saved 40%</th>
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</tbody>
</table>

**Seth Swenson, MBA**, is President of Orchid Wealth Management in Palo Alto, CA. Send your financial questions to medec@ubm.com.
Practical Matters

Physician partnership agreements: It’s time to review yours

When was the last time you reviewed your partnership agreement? Even if you aren’t looking for shareholders or partners, if you haven’t looked at your agreement recently, now is the time.

Market forces have changed significantly over the last several years, and the partnership agreement you signed in the past may not cover issues like reduced responsibilities to accommodate work-life balance, retiring partners, or how to manage to value- or performance-based contracting in which one partner’s performance can determine if the group receives any performance payments at all.

Here are some of the key questions that you should consider in every partnership agreement:

Addition of partners: Does the current agreement outline how you will add new partners or shareholders? Is there a buy-in? If so, will that be in the form of financial or sweat equity? Will the buy-in amount or term change (e.g., if it is practice value)? Has a method been determined for assessing that value and has it been incorporated into the agreement?

Division of duties: Will all partners carry equal responsibility and be expected to dedicate equal time to administrative and clinical duties? Or is there one ‘managing partner,’ or even a Board of Directors? If so, how are those partners compensated differently?

Reductions in responsibility: How will you address one partner stepping back from their obligations for reasons such as health or family issues or upcoming retirement? Are there terms clearly defined to accommodate that, either in the form of reduced compensation or even the ability to maintain partnership status?

General compensation: How will profits be shared? Will they be distributed equally or will there be a productivity component involved? What model will you use to determine that? (e.g., relative value units, revenues brought in, etc.) How might that model change over time?

Performance-based pay: More and more often, we see payer contracts that have ‘value- or performance-based’ components attached to compensation. How will these group-based payments be distributed? Are there penalties for individuals that fail to meet targets, since that could put substantial sums at risk for the group as a whole?

Individual risk: Is each partner responsible for their coding and documentation? In the event of an insurance audit that results in take-backs, is the group liable for an individual’s errors?

Dispute resolution: How will disputes be resolved? For example, if one partner wants to expand or invest but the other does not, how will that be decided? What happens if you simply can’t get along with a partner any longer—do you have the right to force them out? If so, is there a premium allocation to be paid to that partner in the event of this situation?

Withdrawal from partnership: Does the agreement designate how far in advance a partner wishing to leave the group must notify the other members? For example, retirement notice should be given at least 18-36 months ahead of time, and it may be prudent to consider that shorter notification periods could result in forfeiture of part of the buyout.

Different classes of shares: Do the senior partners retain voting rights while more junior owners remain non-voting shareholders? Addressing your agreements from these angles will not only help you cover your bases in the event of unforeseen circumstances, it also ensures that you are providing the best ongoing governance of your practice for many years to come.

Susanne Madden, MBA, is founder and CEO of the Verden Group, a consulting firm. Send your financial questions to medec@ubm.com

MedicalEconomics.com
Loneliness: It is a growing societal challenge that can dramatically influence patient and physician health.

In a keynote presentation at the American College of Physicians (ACP) Internal Medicine Meeting 2019, former Surgeon General Vivek H. Murthy, MD, MBA, told about 4,000 attendees that the country’s state of emotional health remains an important driver of health.

“If you told me five years ago that I would be talking to physicians about the subject of loneliness, I would have been surprised,” Murthy said. As he travelled the country as the 19th Surgeon General of the United States, he began to hear more patient stories related to addiction, violence, mental illness and other behavioral-based health conditions. There was an undercurrent, Murthy says, that connected many of these prevalent social issues to loneliness. “Many patients are struggling with it,” he adds.

Healthcare professionals are starting to recognize its impact on adherence to physician treatments and recommendations, lack of exercise, smoking, and other unhealthy lifestyle behaviors and other social determinants.

It is estimated that as much as 20 percent of the population struggles with loneliness, and additional research in this area is starting to offer stronger linkages to health consequences associated with loneliness including depression, dementia, cardiovascular disease, and anxiety.

“It affects physicians too. We talk about burnout in our profession,” Murthy says, but healthcare is not a profession that often promotes self-care.

Physicians work long hours, which can definitely contribute to feelings of isolation and a kind of physical and emotional barrier to making stronger connections with friends and family.

When your professional lives take over, Murthy says, you need to adopt strategies that can help you stay connected with your love of medicine and maintain a healthy balance outside of busy schedules.

During long shifts, try to add a micro-dose of self-appreciation, Murthy says. For example: Take five extra seconds when you are washing your hands to reflect on the ways you have helped patients that day. Do that three times a day.

“We are not designed to work alone,” he says. “We need each other, and we need to support each other.”

Murthy called on attendees to imagine a time in healthcare where physicians have built a culture that supports each other. “The lives of the people in this room matters.”

“Our country is in this struggle between love and fear,” he says. “People are worried about the kind of environment their children are growing up in. They see the polarization of politics. They look at the meanness on social media. People are worried. How are we going to create a better world for ourselves? Where will that leadership come from? Our profession has to lead.”
As more physicians become employed, learning how to successfully negotiate an employment contract becomes a crucial skill to learn. A common issue is that many physicians simply don’t negotiate, and just sign what’s put in front of them, says Michael S. Sinha, MD, JD, a Regulatory Science Fellow at the Harvard-MIT Center for Regulatory Science.

Sinha talked with Medical Economics to discuss some of the key aspects of negotiation vital for physicians to learn.

Medical Economics: What is a common mistake physicians make when negotiating contracts?

Sinha: Often, physicians will eagerly sign a binding letter of intent or agree to terms of a contract with little or no negotiation—in some cases, they aren’t even aware of what can be negotiated!

The key is to consult a healthcare lawyer early in the process. Find someone who specializes in physician employment contracts in that state. They will have a lot more insight as to what can, and should, be negotiated.

Ultimately, if you don’t negotiate, you’re only cheating yourself.

Medical Economics: What areas in an employment contract are most important to focus on?

Sinha: The first thing to do, before any financial compensation is discussed, is to clearly define the duties and responsibilities in the contract. Get any promises that are important to you in writing. Only when those details have been hammered out can you get an estimate of your true market value.

It will also affect the salary structure that works best for you. Perhaps you have a lot of administrative responsibilities that would cut into meeting pre-defined relative value unit (RVU) thresholds—this may mean you’ll miss out on bonuses under an incentive-based contract, and a fixed salary would make more sense.

Flexibility and vacation time may also be up for negotiation, but at the expense of your base pay. Here, an incentive-based contract may mean that, as long as you’ve hit appropriate metrics, you’ll have more time off with no salary repercussions.

That said, be sure that you have access to the performance reviews or quality metrics that are being used to determine bonuses. Get it in writing!

Medical Economics: One area we regularly hear about from physicians is restrictive covenants/non-compete clauses. What do physicians need to know before signing a contract containing one of these? Is there anything they can do to protect their post-employment career opportunities if they sign a contract containing a restrictive covenant?

Sinha: State-level legal expertise is particularly important here. Some states, like Massachusetts, ban restrictive covenants in physician contracts. Others have limits on what these clauses can entail. The lawyer you hire should know the standard for a particular area and can push for compromises in duration and geographic distance.

That distance can be very important. For instance, a 20-mile restrictive covenant may be reasonable in rural Tennessee but would be unreasonable in New York City. Negotiate favorable terms for a restrictive covenant prior to signing the contract; if you don’t, disputes over restrictive covenants could take a few years and several thousand dollars in litigation fees to resolve.

Don’t ignore the clauses just because you think you’ve found your “dream job.” And don’t be afraid to ask around. Other physicians in your practice group may have a covenant of shorter duration or distance—or may not have one in their contract at all.

Medical Economics: What are some items physicians can/should negotiate for that many physicians tend to overlook?

Sinha: I would start with student loan repayment. Some newly-minted physicians are coming out of residency with $200,000 to $300,000 in student loan debt. There are usually ways to get the hospital to pay some of it off. They may be reluctant to pay a lump sum directly to you, but may be happy to write a check straight to the lender. They’re also less likely to pay any of it up front, but may agree to annual installments, payable after each year of service.

Conference Review continued on page 42
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As the prevalence of physician burnout rises, so too might the occurrence of medical errors. A recent study by researchers at Stanford University School of Medicine found that physicians with burnout were more than twice as likely to commit medical errors, even after adjusting for specialty, work hours, fatigue, and workplace safety. But the relationship between physician burnout and medical errors may be more cyclical than linear. “We value our relationships [with patients], so when someone dies or an error occurs … not only does it hurt the patient and the family, but we are upset as well,” says Tracey L. Henry, MD, MPH, FACP, assistant professor of medicine at Emory University in Atlanta. When left unaddressed, this emotional or psychological stress can further contribute to burnout. Despite this issue, Henry says most institutions do not have a system in place to support physicians and other healthcare professionals in the event of a medical error or adverse patient outcome. As a result, many physicians avoid disclosing errors and end up internalizing their emotions because “there’s this machismo culture in medicine, and so a lot of times we are ashamed to ask for help,” she explains, noting that early career physicians tend to struggle the most with error-related stress because their clinical self-confidence is still developing.

Specifically, leaders should create awareness that medical errors happen and can happen to any physician, and then ensure that physicians are able to process their emotions in a healthy way. Henry recommends developing a protocol that includes nonpunitive teams debriefs following an error or adverse event and a peer-to-peer support network. She notes that it’s important for the individuals leading the debriefs and peer support groups to receive training in order to ensure they understand how to discuss the error without pointing blame or re-traumatizing the physician. “We’re all human. Everyone makes medical errors at some point in their career,” Henry says. “This is how you deal with it. This is how you move forward.”

Patients with chronic conditions such as diabetes, COPD, and congestive heart failure are some of the most challenging for physicians to treat. The good news is that there are proven strategies for physicians to help patients improve their management of these difficult conditions, said Edward Wagner, MD, MPH, an internist and director emeritus for MacColl Center for Healthcare Innovation, Kaiser Permanente Washington Health Research Institute, Seattle, Wash.

Wagner said that there are key functions that practices must provide to patients to better manage chronic conditions. These include:

**Population management:** Staff uses data to identify and close care gaps by reaching out to patients with conditions judged by performance metrics.

**Clinical skills center**

**Caring for the caregiver**

**What chronic care patients need to get better**

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**Population management:** Staff uses data to identify and close care gaps by reaching out to patients with conditions judged by performance metrics.
Doctors know that growing numbers of their patients are having difficulty paying for their healthcare. Even so, many doctors are reluctant to bring up the question of care costs, due in part to concerns that they won’t have any solutions for patients who can’t afford the care they need.

Helping doctors become more comfortable holding cost-of-care discussions was the goal of the session, “How to Talk to Your Patients about the Cost of Their Care” at the 2019 ACP Internal Medicine Meeting. And it’s increasingly important that they raise the subject with patients, says C. Jessica Dine, MD, FACP, associate professor of medicine in the division of pulmonary and critical care at the University of Pennsylvania’s Perelman School of Medicine and one of the session’s speakers.

“Out-of-pocket costs are increasing to the point where it’s affecting patient care, which means it has a direct impact on outcomes,” Dine said. For example, some of her pulmonology patients use their inhalers less often than prescribed so as to make the medication last longer, with adverse long-term health consequences.

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In addition, cost considerations need to include indirect expenses associated with receiving care, such as taking transportation to the physician’s office and taking time off from work. For example, her patients often require chest imaging or other tests before seeing her, so they have to miss two work days if those can’t be scheduled on the same day as their appointment with her.

Doctors don’t have to have all the solutions for their patients’ cost concerns. But it is important to know that cost could be a problem, so the physician and patient together can figure out alternatives. One possibility is to develop a care plan that, while perhaps not optimal from a medical perspective, is one the patient can afford.

“Most of my patients are actually relieved when I bring it up,” she says.

While some physicians fear that cost discussions will reduce the time they have to address patients’ medical issues, Dine says most studies show that most such discussions average only one to three minutes. “These conversations have such a huge potential impact on patient outcomes that we have to do it,” she says. “The healthcare costs patients have to shoulder nowadays is just too big for us as physicians to ignore.”
ACP calls for public insurance option; will research viability of Medicare For All

A new position paper by the American College of Physicians says Congress must strengthen the Affordable Care Act (ACA) by creating a public insurance option and expanding Medicaid coverage in all 50 states.

In addition, the ACP’s leaders said last week they plan to embark on a wide-ranging project to recommend a way forward on healthcare in the United States. They will include a viability study on Medicare for All, which has gained popularity among voters and Democratic presidential candidates as the ACA continues to face political and legal challenges nine years after it became law.

“The ACP is committed to universal coverage,” said Bob Dougherty, the ACP’s senior vice president of governmental affairs and public policy. “For too long, we feel we have been playing defense and reacting. We decided it’s time to look at if we could reinvent the healthcare system, what would it look like?”

In the shorter term, Dougherty and ACP leaders are concerned about a legal challenge to the ACA in Texas. In that case, the U.S. Department of Justice is seeking to challenge the legitimacy of the entire law. “There would be no replacement plan,” Dougherty said. “It would create absolute chaos. We are really worried and concerned about what would happen.”

The position paper, which was published in the *Annals of Internal Medicine*, makes a case of bulwarking the ACA. The paper, authored by Sue S. Bornstein, MD, and Ryan A. Crowley, calls to:

- Expand Medicaid in all 50 states.
- Create a public insurance option to “ensure enrollees have access to a variety of coverage options in their area.”
- Have federal or state government ensure all patients are enrolled in coverage, either by creating an auto-enrollment program, instituting a penalty for failing to enroll and/or some form of individual mandate.
- Increase tax credits to help patients better afford ACA marketplace coverage.
- Limit the sale of individual market plans that do not comply with ACA regulations.
- Increase and provide sustained funding for marketing, outreach, and patient enrollment assistance.

“Adopting these policies will be a step toward realizing what has been an unachievable goal: affordable, comprehensive insurance for all,” the authors write.
How we can defeat burnout

his past September, my organization sponsored a screening of “Do No Harm,” a documentary that profiles medical student and physician suicide. This issue is being increasingly discussed, and awareness is growing. The documentary showed how medical training can be dehumanizing and demoralizing. I have to admit my first reaction was typical: I did it, so why can’t they? This is likely why we’ve allowed an unhealthy system to perpetuate itself for generations.

More recently, I read the excellent book Why We Sleep, which I found both intriguing and alarming. Intriguing because it taught me much I didn’t know about sleep and cognitive and physical functioning. Alarming because the medical profession not only tolerates but promotes sleep deprivation as a necessary element of training physicians.

When I was on my obstetrics rotation as a family medicine resident, I remember falling asleep once on the desk at the nurse’s station. I would commonly work 110-hour weeks, and I just couldn’t stay awake that day.

Do you know what I felt? Shame. I was ashamed that I wasn’t tough enough to work 100 plus hours week after week. After all, everyone else did it, right? No one was concerned that the physician who was responsible for the next newborn resuscitation or precipitous delivery was so exhausted. How can a system like this possibly produce healthy professionals who recognize limitations and support each other’s well-being?

Burnout is such a loaded word now. Being burned out can be a badge of honor and a shroud of shame. Medicine loves to push physicians to the brink of burnout. And we honor those seemingly superhuman individuals who are able to operate, diagnose, treat, and function without tending to their own basic needs of rest, nutrition, and social connection. It has been aptly stated that resiliency training is not the answer because physicians have already been trained to bounce back from crippling exhaustion, stress, and even depression. We are resilient.

Burnout is not about broken doctors and nurses. It is about a broken system.

Every practicing physician knows what is broken. We have ceded the practice of medicine to government, insurers, and health systems. I think we did this because we care about our patients and not about the business of medicine and government regulations. In order to focus on what is most important to us, we have ignored the looming threats to our ability to practice medicine with integrity.

Fortunately, things are changing, albeit slowly. Medical practice has become so burdensome and far from what we dreamed it would be that we, as physicians, are forced to turn our attention away from our patients and look internally into our profession and externally to the factors that threaten its integrity. I believe we are moving from the shame of not being able to tolerate a malevolent system and feeling outrage at what the system has created.

The challenge, of course, is that the system is us. I am a physician leader and have been an academic physician teaching students and residents the way I was taught. This is not victim-blaming. It is a challenge to my smart, capable, and talented colleagues to take the passion and strength that made them physicians and fix this for the generations who will follow us.

The fight is not against burnout; it is against the multitude of factors that drive us to burnout. The list is long and challenging—work hours and compensation, RVUs and quality metrics, EHRs, and tort law. But I believe we are capable of changing the system to promote not only healthy patients but healthy caregivers.

Jennifer Frank, MD, is a family physician and physician leader in Northeastern Wisconsin.
Who are your role models?

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

“My father, who is a child psychiatrist and the most patient person I know.”

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

“My family doctor growing up.”

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

“Steve Jobs, Elon Musk, Warren Buffet, and [University of Texas-El Paso President] Diana Natalicio.”

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

“[Fellow physician] John C. Tapp, MD.”

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

“Mrs. Kobida (my 8th grade math teacher), Marie Curie, and my mom.”

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

“[Neurologist] David Perlmutter, MD.”

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

“My parents.”

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“Ultimately, if you don’t negotiate, you’re only cheating yourself.”

MICHAEL S. SINHA, MD, JD, HARVARD-MIT CENTER FOR REGULATORY SCIENCE

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COMING NEXT ISSUE

Medical practice makeover

Everyone knows what the stereotypical physician’s practice looks like: drab rooms, outdated furniture and motel room style artwork. In this article we will envision what the 21st century medical practice can and should look like. How can physicians improve their physical spaces to better attract and retain patients and make their practices more inviting places for patients and staff? How should physicians approach a remodel? How do they pay for it, who should they hire to help, and what other advice can be learned from experts?
Je m'appelle Ivy.

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