PRACTICE MAKEOVER

Dx: Losing Patience

Rx: Bring Calm Back Into the Practice of Medicine

Remain Independent
Reduce Workload by 25% or more
Increase Earnings by $200K(1)

Interested? We’ll give you a $100 gift card just for learning more(2)

800-419-4625
SignatureMD.com/rsvp0619c

Medical Economics
MedicalEconomics.com JUNE 10, 2019 VOL. 96 NO. 11
What Makes SignatureMD Different?

- No patient termination; all patients and associated revenue remain in practice
- We deliver concierge-level service to concierge physicians

(1) Affiliates typically increase revenue by $300,000 and earnings by $200,000 annually
(2) Only qualified physicians will be invited to participate in webinar and eligible to receive $100 gift card
Integrate SignatureMD’s Concierge Program Into Your Practice

- Increase net income by $200,000 annually\(^{(1)}\)
- Retain complete control over your practice
- Reduce working hours by 25% or more

RSVP for a 20-minute webinar
To verify eligibility call 800-419-4625
or visit SignatureMD.com/rsvp0619C

Receive a $100 Gift Card for Completing the Webinar\(^{(2)}\)
PRACTICE MAKEOVER

- Reasons for an office remodel
- Tips to make your project happen
- How to pay for it

The CBD oil trend
What should you tell your patients?

Treating Gen Z
What young patients want

MedicalEconomics.com
Five-minute reads. Lasting advice.

Physicians Practice is a fully digital publication for real-world business challenges: billing, coding, collections, tech, workflow, marketing, law and malpractice.

Daily updates feature insights from the same experts in Medical Economics, including Ericka Adler, Ike Devji and Jennifer Frank, MD. You’ll find quick takeaways with solutions that work for your entire staff.

head to physicianspractice.com & plug in.
Physicians must address social determinants of health

“Like all hard things, we can either stay passive ... or we can learn more about what we can do, and then do it.”

The list of questions is extensive. While I adhere to the bio-psycho-social concept of medicine, I also have a laundry list of things to accomplish in a visit. I tend to stick to the things I have some knowledge or expertise in: antibiotics, interpreting lab tests, managing insulin, targeting high blood pressure. However, I am missing a bigger picture. Consider the following:

- Are you lonely?
- Do you have any concerns about whether your water is safe to drink?
- Are you concerned about safety in your neighborhood because of crime or violence?
- Can you read?
- Are you able to afford food?
- Are you able to afford housing?
- Do you have transportation to your job? The grocery store? The clinic?
- Have you been the victim of discrimination?

All of these scenarios profoundly impact my patients’ ability to engage in lifestyle improvements, follow a healthy diet, take prescribed medications, and afford the care I provide. Even though I recognize that, I do not know about literacy classes in my community or what assistance is available to protect someone who claims discrimination in the workplace. We are fortunate enough to have care managers and social workers, but the need is greater than they can meet.

Like all hard things, we can either stay passive because being active is difficult and time-consuming. Or we can learn more about what we can do, and then do it.

We cannot fix or address all social disparities, but we can address some. What if tomorrow you asked three patients about some aspect of SDOH? What if you found out what resources were available in your community to address those needs? What if you did the same thing the next day and the next?

As physicians, we have a unique window into our patients’ lives. They tell us things that they will not tell anyone else. Many factors of SDOH may be uncomfortable for people to discuss. We should use our privilege to ask those questions and find those answers.

Jennifer Frank, MD, is a family physician and physician leader in Northeastern Wisconsin.
Practice makeover
How to make your remodel happen

7 A solution to prior auths?
Why some experts think an automated process is coming

14 EHR errors
Could your system put you at legal risk?

25 Get paid for telehealth
How to code for and get reimbursed for virtual care

26 Treating younger patients
What Millennial and Generation Z patients want from doctors

30 Negotiate with payers
Six steps to take on payers and get a better contract

31 Home healthcare
An older form of medicine is coming back with modern twists

34 Legal advice
Can physicians charge uninsured patients more for care?

35 Stop claim denials
The top reasons for denials and how to prevent them

36 CBD oil
Patients consider it a panacea. How should you talk about it?

Cover Story
ALSO INSIDE

7 14 25 26 30 31 34 35 36

LAST WORD
Why terminology matters
Physicians should fear the dumbing down of medical terminology, writes Eric Postal, MD.

Page 41

IN EVERY ISSUE

4 Interactive
5 Your voice
6 Vitals
42 Our adviser
45 Funny Bone

Medical Economics
does not verify any claims or other information appearing in any of the advertisements contained in the publication and cannot take responsibility for any losses or other damages incurred by readers in reliance of such content.

Medical Economics
cannot be held responsible for the safekeeping or return of unsolicited articles, manuscripts, photographs, illustrations, or other materials.

Library Access
Libraries offer online access to current and back issues of Medical Economics through the EBSCO host databases.

To subscribe, call toll-free 888-527-7008. Outside the U.S., call 218-740-6477.

Cover Maksym Dykha/Stock.Adobe.com

JUNE 10, 2019
VOLUME 96 ISSUE 11
SMARTER BUSINESS. BETTER PATIENT CARE.

MedicalEconomics.com
The gentle power of MiraLAX® (PEG 3350) is prized by both doctors and patients.¹⁻³

**AGA** recommends PEG laxatives as a first-line treatment⁴

#1 GI-recommended laxative

96% patient satisfaction rate³

---

AGA=American Gastroenterological Association.


The Bayer Cross, MiraLAX, and the MiraLAX Pink Cap are registered trademarks of Bayer.

Physicians are misapplying the opioid prescribing guidelines, CDC says

Physicians may be over-correcting their prescribing practices as a result of the opioid addiction crisis by cutting off patients that still need the drugs, according to the authors of the 2016 guidelines.

In a commentary published in April in the New England Journal of Medicine, Deborah Dowell, MD, MPH, Tamara Haegerich, Ph.D., and Roger Chou, MD, wrote that the guidelines are intended for primary care physicians treating chronic pain in adults, but that physicians have been misapplying the guidelines by limiting or cutting off opioid prescriptions for patients who need them.

"Efforts to implement prescribing recommendations to reduce opioid-related harms are laudable," they wrote. "Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations."

A physician over-correction on opioid prescribing is not surprising, given the scale of the problem. More than 130 people die daily in the United States from opioid overdoses, and more than 11.4 million people have misused prescription opioids, according to U.S. government data.

Primary care physicians treating chronic pain in adults should apply the guidelines by working with patients receiving long-term opioid treatment at high dosages by reviewing the risks with patients in an empathetic way, collaborate with patients who agree to taper their dose and taper slowly enough to minimize withdrawal symptoms.

The CDC is evaluating the consequences of the guidelines, and the Agency of Healthcare Research and Quality is conducting a "systematic review" on the effectiveness of various pain treatments.

"Why was I retiring? I liked my interactions with my patients, my long-term relationships, and the mental and psychological challenges, but the overwhelming pressure of productivity, documentation, recording data, and "meeting metrics" had worn me down."

—Max Burger, MD, on his last patient visit before retirement.

"While this is not a world in which the person with the most years of schooling wins, something is amiss when our nation's most highly educated individuals make one seventh of someone with half the education. These top hospital executives make multiples more despite never having touched a patient, ordered a test, made an incision, or shouldered the responsibility—and liability—of signing a patient chart."

—Marni Jameson Carey, on the pay gap between hospital executives and physicians
Medical malpractice is a major policy issue; doctors should pay attention

“Healthcare’s future: Four policy debates doctors must follow”. (March 25, 2019 issue) you mentioned the Affordable Care Act, expanding healthcare insurance, prescription drug prices, and changes to accountable care organizations (ACOs) as four areas of healthcare policy that physicians must keep their eyes on.

But, to these four should be added a fifth because it leads to inefficiency and rising costs: the medical liability system. It is deplorable that even though the personal injury lawyers are permitted to hit doctors with unmerited suits, they receive little or no criticism from policymakers.

Malpractice suits are doctors’ worst nightmares. To ward them off, they order extra tests and consultations. It is impossible to estimate how much these extra tests and consultations raise the cost of care, but doubtless it is considerable.

Even if doctors have acted competently and even if they have trusting relationships with their patients, bad things happen and some patients will sue.

An American Medical Association report in 2017 mentioned that 68 percent of closed claims in 2015 were dismissed or withdrawn, and that of the 7 percent of claims that went to trial, 88 percent were decided in favor of the doctor.

Clearly, there are way too many brought against physicians.

Health courts that operate like workers compensation are a good alternative. Overseen by judges with special training medical liability, they would resolve cases quickly and get compensation to patients in months, not years.

And knowing that there would be fewer unmerited suits, physicians would have peace of mind and be less inclined to order unneeded tests and consultations.

Edward Volpintesta, MD
Bethel, Conn.

Empowered patients: Are they just misinformed?

Regarding your article about empowered patients (April 10, 2019 issue), I think you should change the title to over/misinformed patients.

Just because someone has access to all the medical information they can read does not mean they are qualified to interpret it. I would argue that patients are not even close to being qualified to interpret the glut of information and misinformation on the internet.

Just because someone has access to all the medical information they can read does not mean they are qualified to interpret it.”

Even though I’m a family practice doctor I could very easily research airplane repair on the internet. Will you fly in my jet? I doubt it. The only thing I can say possibly about the “empowered patient” is that they are good for business. All their research always leads to a self-diagnosis of cancer—which brings them into my office for an accurate diagnosis. Long live the internet.

Lee Morgentaler, DO
Tappan, N.Y.
Study: Employed physicians now outnumber independent doctors

For the first time ever, more U.S. physicians are now employed by a hospital or a hospital-owned practice than own their own practice, according to a new employment study released by the American Medical Association (AMA). Here are some key takeaways of the data:

“This change has been predominantly driven by the shift away from very small practices, especially solo practices, in favor of very large practices of 50 or more physicians.” —AMA Physician Practice Benchmark Survey, 2019

**Takeaway** Physicians shifted toward employment since 2012

<table>
<thead>
<tr>
<th>Physicians worked as:</th>
<th>Employees</th>
<th>Practice owners</th>
<th>Independent contractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>47.4%</td>
<td>45.9%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

**Takeaway** Primary care split between owners and employees

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Employees</th>
<th>Practice owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL INTERNISTS</td>
<td>46.8%</td>
<td>46.9%</td>
</tr>
<tr>
<td>FAMILY PHYSICIANS</td>
<td>57.4%</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

**Takeaway** Younger physicians and female physicians are more likely to be employed

- Nearly 70 percent of physicians under age 40 were employees, compared to 38.2 percent of physicians age 55 and over.
- Nearly 58 percent of female physicians were employed, while 52 percent of male physicians were practice owners.
Tech Talk

Are automated prior authorizations on the way?

Prior authorizations are not going away anytime soon, but dramatic changes to how they are handled may finally be on the horizon.

An April 2018 study from the Government Accountability Office found that Medicare prior authorization programs had saved Medicare between $1.1 and $1.9 billion since 2012 through a reduction in unnecessary utilization and improper payments. However, the American Medical Association (AMA) did some research of its own, estimating in a 2017 report that clinicians spent 14.6 per week on prior authorizations.

Not only does this process take time away from patients, but 78 percent of clinicians reported in the AMA survey that the delay can result in patients abandoning a particular course of treatment.

How tech can help

Technology can move the process along, says Robert M. Tennant, MA, director of health information technology policy for the Medical Group Management Association. Work is currently under way to automate the prior authorization process, and these efforts are being headed up by the Council for Affordable Quality Healthcare (CAQH).

According to CAQH, 90 percent of communications between payers and providers is still done by phone or fax, which really adds up considering that there are around 77 million prior authorizations done manually each year.

Automating the prior authorization process could cut the cost of performing these transactions, with CAQH estimating it could result in a nearly $7 per transaction savings between payers and providers.

Tennant says part of the process of automating these communications depends on when CMS will release a standard for the mandated 278 transaction. CMS has promised these standards for some time but they have yet to be released.

When they are, Tennant says the prior authorization process could be automated between providers and payers using data pulled from electronic health records.

“The future of prior authorization is real-time—prior authorization should be a discussion, not a transaction,” Tennant says.

“If we can automate that discussion, it can really save time for physicians and improve patient care.”

One way technology may help speed along the prior authorization process is through the Fast Healthcare Interoperability Resources (FHIR), a draft standard for electronic health information exchange created by Health Level Seven International. Tennant says HL7 is working with a number of major stakeholders in healthcare to launch the DaVinci Project.

“They are using this new standard to move clinical data, and some of the use cases are administrative. One is prior authorization,” Tennant says. “We are going to create a new workflow for prior authorization.”

Interfacing with EHRs

The process would work directly with EHRs. Currently, when a provider orders an intervention, there is a long back-and-forth process, Tennant says. The new approach would involve an automatic trigger in the EHR when a physician places an order that would send a transaction to CMS to find out if a prior authorization is required. The system would offer a clinical documentation template sent by CMS outlining what is needed to justify the ordered intervention and prove medical necessity.

“So there’s no more guessing about what information is necessary,” Tennant says. “The goal is really to get all payers to agree to and support this standard. This will be a game-changer. It could be real-time, if not near real-time.”

Rachael Zimlich, RN, is a contributing author. Send your tech questions to medec@ubm.com
When Gary LeRoy, MD, FAAFP, signed on as medical director of a community health center in Dayton, Ohio, it consisted of a single physician and dentist, a nurse practitioner and a handful of other employees housed in a 5,000-square-foot former grocery store.

Today, the center—now known as the East Dayton Community Health Center—bears little resemblance to the facility LeRoy joined 16 years ago, despite being in the same location. For starters, it’s doubled its size by expanding into formerly vacant space in the rear of the building. It now employs two physicians, two nurse practitioners, and nine staff members.

Equally important, the building’s retail-like ambiance has been replaced by a welcoming environment, due in part to the abundant natural lighting provided by skylights. The waiting room has plenty of comfortable furniture for adults and a play area for children.

In addition, LeRoy says, the center improved its efficiency by changing the way patients flow through the building, and created work pods where physicians and support staff can talk without being overheard by patients.

“One basically redesigned the building from the ground up,” recalls LeRoy, now a board member of the American Academy of Family Physicians. “Everybody drew up their wish list of what they wanted to see in the facility. Then we sat with the architect and said, ‘how can we realistically create the components everyone is asking for?’”

As a result of its makeover and expansion, East Dayton now serves about 15,000 patients annually and has been designated a Federally Qualified Health Center. It also hosts community classes on health and stress reduction. “We decided that since we’re a part of the community we should provide services of use to the community,” LeRoy explains.

While East Dayton’s overhaul may have been more extreme than most, it was far from alone in undertaking it. In a 2016 survey by the Medical Group Management Association (MGMA), just over half of respondents said they either remodeled, added space, moved, or made some other change to their practice space in the past two years.

Ken Hertz, FACMPE, principal consultant with the MGMA, says those numbers don’t come as a surprise. “Given the rapidly
changing healthcare landscape, practices and physicians are coming to see it’s vital that they continually reinvest in the business by updating their space, changing the aesthetics, introducing new technology and so forth,” Hertz says.

**REASONS FOR PRACTICE MAKEOVERS**

So what are some of the tell-tale signs that a practice may need a makeover? They fall into three broad categories, experts say: space, appearance, and productivity. Of these, space—or the lack of it—is usually the most obvious, since it’s readily apparent when a practice can no longer accommodate the needs of its patients and providers.

David Zetter, CHBC, founder and lead consultant of Zetter HealthCare in Mechanicsburg, Penn., cites the example of a client, an urgent care center in an Orlando, Fla., strip mall just outside Disney World. “Every time I’ve walked in there, the place is packed,” Zetter says. “They’ve got patients standing outside or sitting in their car waiting to be called because there isn’t enough room in the reception area.”

Fortunately, Zetter adds, an adjoining storefront came available that the client plans to buy, even though it’s more room than the center currently requires. “There’s a perfect example where somebody realized, ‘I’ve got to do something about this situation,’ and he’s going to spend a lot of money on it to do it right. But he’s confident, given how busy he is, that he’ll get a return on his investment.”

The need to freshen its appearance, especially in the patient waiting area, is another frequent catalyst of practice makeovers. That’s especially the case, experts note, given that the waiting area is where patients form their first impression of a practice. Worn-out carpeting, lack of comfortable seating, outmoded decor, absence of Wi-Fi, and use of fluorescent lighting are all indicators that some serious remodeling is in order for that space—and likely the rest of the practice as well.

**“PUT YOURSELF IN THE PATIENT’S SHOES”**

Sometimes doctors, even if they own the practice, may not be aware of problems with the waiting room simply because they rarely see it. That’s because in many practices clinicians and staff members use a separate entrance that takes them directly into the work area.

The way to overcome that disconnect, Zetter advises, is to “put yourself in the patient’s shoes. Walk into your reception area, sit in the chairs for a little while and ask yourself, ‘is this where I would want to spend time waiting to see the doctor?’”

Hertz says that in some client practices he holds weekend strategic planning sessions in the waiting room. “I make the docs spend a day or two where their patients sit every day, and I see them walking around going, ‘holy cow,’” he says. “Usually on Monday morning they’re saying to the practice administrator, ‘please get us some new furniture and have the walls painted as soon as possible.’”

Sometimes the signs that changes are needed show up in a practice’s processes and workflow. “If a practice starts seeing its doctors consistently running behind schedule, or patients aren’t ready for them to see in the exam room, that’s a pretty clear indicator that something’s going on,” says Larry Brooks, AIA, principal of Practice Flow Solutions, a medical space planning and consulting firm in Roswell, Ga. “A lot of times it stems from just not having the space to check people in or do a pre-exam workup.”
IDENTIFYING NEEDED CHANGES

Once a practice has decided it needs a makeover, the next step is deciding on the specific changes it wants to make. For a small practice, the process is similar to remodeling a home, Hertz says; the physician-owner and office manager should inspect the practice’s rooms, equipment, and furnishings and make a list of everything they want to see fixed, changed, or disposed of.

For larger practices, experts recommend convening clinicians and staff members by department and soliciting their input. "Ask them, ‘if you could have a new space, what would it look like? What are the things that aren’t working now and what changes would make our patient care better and help support the work that you do?’” Hertz says.

Patient suggestions for improvements can also be helpful, he adds. Some practices he’s worked with survey their patients via phone, e-mail, or regular mail, while others will invite patients to come in person during an evening or weekend to make recommendations.

Regardless of its size, often a practice can get useful ideas just from looking around to see what others are doing, Hertz says. "If the administrator or docs or staff have been to offices they think are fabulous, or have seen pictures in magazines or newspapers, bring them in, put them in a book and keep them as a resource,” he advises.

Advice and suggestions from other practices who’ve undergone the process is also helpful. "Ask colleagues, when they got through with their makeover what were the things where they went, ‘Oh my God, how could I have forgotten about this?’”

While practices will differ in the look they want to achieve depending on their financial constraints and the tastes and desires of owners and staff, experts agree that the goal is to create an ambiance that is up-to-date, comfortable, and inviting. "Nowadays, nobody wants to be in a sterile office environment,” Zetter notes.

Lighting, wall colors, and fixtures are important parts of a makeover, so Zetter advises practices to consult interior design specialists on how to use these to create the look and feel the practice wants.

Reception area amenities and furnishings are similarly crucial in creating a hospitable, patient-friendly atmosphere. For Brooks, the most important element of a good waiting room is having plenty of chairs with armrests, particularly if the practice serves a large number of elderly patients.

“A lot of times you’ll see practices with nice couches and sofas, but it’s hard for an elderly person with back or knee problems to get out of those,” he notes. “Individual chairs with arms allow them to get up and sit down much easier.”

Other conveniences practices should consider include coffee, snacks, carrels for patients to work in while waiting, charging stations for electronic devices, and Wi-Fi. "Even the grandmas and grandpas are texting and e-mailing with their phones these days, so Wi-Fi has almost become a given,” Brooks says.

Experts note that updating a practice’s appearance need not be expensive. Sometimes, Hertz says, putting down new flooring and carpeting, repainting walls, and re-covering furniture can achieve the desired look without spending a great deal of money. He recalls working with a practice in need of a new paint job but whose physician-owner didn’t want to spend money for professional painters.

"I pulled together some of their staff and we got painting equipment and brought in pizza and soda and painted the place ourselves, and it looked like new,” he says.

IMPROVING PRODUCTIVITY

When it comes to redesigning for improved productivity, experts say practices should focus on eliminating bottlenecks that slow the movement of patients through the office. A common one, according to Brooks, occurs when receptionists are required to both field phone calls and check in patients, causing backups in the latter process. Another is when doctors have to leave the exam room to get something they need or communicate with another provider or staff person, thereby extending the patient visit.

That issue ties into what Fields calls the "number-one time waster" in a medical practice; walking. During his three decades of time studies, he says, "the amount of time doctors spend walking between exam rooms, or for tasks like taking a chart to a ready rack or finding a staff member to verbally deliver orders is mind-boggling, when you consider the doctor is the highest-paid member of the practice.”

Brooks says practices can alleviate this problem during remodels by "podding"
exam rooms—putting them across the corridor from each other rather than stringing them out along a corridor, which causes doctors to have to walk further between them.

Another helpful technique is to place mini work stations near the doctors’ examining rooms. “That way if they want to make some notes or take a phone call between patients they can do it close to their rooms, versus going to their office, which might be far away,” he says.

An important issue practices need to consider when planning a makeover is the exam room: designing it to ensure that doctors can maintain patient eye contact while typing in their EHR, and if possible show the patient the information they are entering. “You want to avoid the situation where the patient is talking to the back of the doctor’s

---

Paying for it

Independent medical practices sometimes are reluctant to undertake a needed makeover, either because they think they won’t be able to get financing at all, or the terms of a loan will be too onerous to repay. But such fears are usually misplaced, experts say. Indeed, among the challenges associated with such a project, obtaining a loan often is one of the easiest to meet.

The reason? Most banks see medical practices as stable, profitable enterprises and thus unlikely to default on a loan. “In almost all cases I’ve seen, a practice can get financing unless their credit is already bad for some reason or it’s underwater financially,” says David Zetter, CHBC, founder and lead consultant of Zetter HealthCare in Mechanicsburg, Penn. “You need to go in with a game plan, showing them what you’re planning to do, how long it’s going to take, and what it’s going to do for your practice.”

When applying for a loan, Zetter advises bringing current pictures of the practice along with renderings of what it will look like after the makeover. “Show them the difference their loan will make,” he says.

Ken Hertz, FACMPE, principal consultant with the Medical Group Management Association, suggests shopping for lenders with medical practice lending experience, since borrowing from them can sometimes expedite the process. Such lenders can be found at https://www.doctorloanprograms.com/list-of-physician-lenders-2/ and https://www.whitecoatinvestor.com/physician-mortgages/

“I also recommend networking as a great resource regarding lenders,” he adds. “Talk to administrators and other physicians in your region. They can often point you to strong lenders.”

Practices who lease their space, as opposed to owning it, face a somewhat different situation. They usually need to get their landlord’s approval before making any major changes to their practice space. But if the property owner does give their OK, it may be possible to have them to pay for the work and build the repayments into the practice’s lease.

“You need to go in with a game plan, showing them what you’re planning to do, how long it’s going to take, and what it’s going to do for your practice.”

— DAVID ZETTER, CHBC, FOUNDER AND LEAD CONSULTANT, ZETTER HEALTHCARE, MECHANICSBURG, PENN.

“Under that scenario your monthly payment goes up, but you may not have to make any out-of-pocket payments upfront,” Hertz says.

If moving is an option, the practice is in a stronger position to get a bargain from the landlord, notes Larry Brooks, AIA, principal of medical space planning and consulting firm Practice Flow Solutions. That’s because it can be costly to property owners to find a new tenant, both in terms of lost rent while the space is vacant and the “tenant improvement allowance” landlords customarily offer new tenants so they can adapt the space to their needs.

“If I’m a landlord, my choice is to give the next guy something, or I can give the current tenant something and keep them without the hassle of changing,” he says.
head while they’re typing on the other side of the room,” LeRoy says.

Hertz says some practices initially addressed this problem by mounting computer monitors on the walls of exam rooms, thereby allowing doctors to face patients and patients to see what the doctor is typing.

In recent years practices have begun using laptop computers and tablets, which afford much greater flexibility than desktop computers. Some are also providing mobile tables, enabling doctors to wheel the EHR from room to room and position it to accommodate the patient.

An additional exam room feature to keep in mind, Brooks says, is standardization. Designing and supplying them identically means providers don’t have to spend time looking for items they need. “A doctor or staff member should be able to walk into any room, close their eyes and know where everything is, even to the point where they know each drawer has certain things in it,” he says.

**AN ARCHITECT’S PERSPECTIVE**

**The physical space is a key component of patient care**

**By George A. Ewart, AIA**

In recent years, the effects of the physical environment on the healing process and well-being have proven to be increasingly relevant for patients, their families, and clinicians. An examination of more than 400 studies on the impact of design on clinical outcomes has proven that design significantly impacts the overall physician-patient experience. Improved physical settings can be an important tool in making hospitals, clinics and physician-related spaces safer, more healing, and better places to work.

Architectural design is also an important component of marketability for physician practices and related endeavors. As the saying goes, “perception is reality.” People use tangible cues to form opinions about intangible products like healthcare. As such, if your practice area is outdated and visually unappealing, there is a good chance that current and potential patients will have a poorer perception of your services.

My team and I recently completed the design for a 15,000-square-foot medical office building for Tennessee Cancer Specialists. Our goal was to develop a space that was not only aesthetically pleasing, but that was also functional, efficient, and safe. We learned that the most important aspect of the design needed to be the overall patient and visitor experience. We needed to extend this concept throughout the entire design, not just in the waiting room.

Cancer patients and their family members go through significant emotional anxiety during treatment. Our goal was to minimize this as much as possible. Warm woods and natural materials are used to create a comfortable aesthetic for patients as they await their appointment/procedure. We wanted patients and their guests to feel as comfortable as possible, while surrounded by a warm, welcoming environment.

In addition to overall esthetic, we looked at the entire build-out from the patient perspective. Instead of creating a single waiting room for pre-treatment and post-treatment

**EXECUTING THE PROJECT**

With a practice’s makeover wish list in hand, it’s time to execute the project. If it involves reconfiguring or adding space, an architect is essential. The best way to find one, experts agree, is through old-fashioned word-of-mouth and networking.

“This is where you reach out to colleagues in your community who’ve redone their practice and ask who they used for the project and what their experience was,” Hertz says. After developing a list of candidates, check references and, if possible, visit other practices to view a candidate’s work firsthand.

Once the architect is on board, he or she will price out the practice’s wish list and work with administrators and doctors to determine which of them are financially and/or technically feasible. The architect will also draw up the plans and assemble the other members of the project team, such as the construction contractor and interior designer.
For a makeover that’s only cosmetic—a new paint job or flooring, for example—an interior designer alone will usually suffice. While administrators and/or doctors sometimes want to select colors and fabrics themselves, Hertz advises leaving these decisions to design specialists. “Someone with experience in this area will have a better understanding of the colors, materials and textures needed for the look and feel the practice wants to achieve for its space,” he says.

When work gets underway, practices face the challenge of minimizing any disruption and inconvenience to employees and patients while continuing to function. Here, strategies differ depending on the scope of work involved. If the practice is adding space, Brooks says, the typical approach is to build the new space first and move the practice’s operations into it while work is being done on the existing space.

If the practice is just renovating or recon-figuring its existing space, Zetter says, the choices are to work on one section of the office at a time, or have the work done during evenings and weekends.

The latter is usually the best approach when it comes to the waiting room, Brooks says. “I’ve seen a lot of groups close early on Friday and give the contractors over the weekend to do the stuff they just couldn’t get to with patients in the office. That seems to work pretty well,” he says.

Regardless of how the work is scheduled, it’s vital to inform patients and staff about what the practice is doing, why, and how long it’s expected to take. Zetter advises posting floor plans and artist’s renderings in the waiting room and around the practice so everyone can see what the result of the work will be.

“When you’re letting patients and staff know what’s going on, it gets everyone kind of hyped up and creates an atmosphere of excitement,” he says. “That makes noise and disruption easier to take.”

Based on our research, we found that pre-treatment patients experienced higher levels of anxiety when they were seated waiting for treatment while post-treatment patients were recovering next to them.

A secondary consideration for the design was that the building sits within view of a cemetery. We spent time designing the space so that the idea of death was not visible during visits. This was done in order to further reduce patient anxiety. The building also faces a church adjacent to the property, therefore, we designed the property so that patients would see this instead.

The result of our work on behalf of Tennessee Cancer Specialists was a space that not only looked great, but that was a practical, safe, and healing space—designed to soothe and care for its patients and visitors.

When it comes to evaluating an overhaul of a practice’s physical space, the hard part often is figuring out where to begin. It can help to have early conversations with an architect about needs, such as whether the scope is the renovation of an aging facility or a new structure designed to house physicians practicing the most current medicine with state-of-the-art devices.

When architects get involved in the early planning stages of a new facility, they can see opportunities for spatial re-configurations that will improve patient care and staff interaction. This helps clients meet current requirements, while remaining flexible enough to anticipate future models of practice.

Here are some additional things to consider when looking to work with an architect to make your space as patient-friendly as possible.

- Make certain the architect you choose utilizes evidence-based design strategies. This will help your practice provide patients with better outcomes, so the people you treat can feel better faster.
- Make flexible design choices. With an ever-evolving array of technologies entering the practice, it can be hard to know if the direction you are headed is the right one. That's why flexibility—both as a mindset and in terms of physical space—is so important. You don't want to design a space today that will be obsolete in five years.
- Focus on the overall experience your patients will have in your space. Take a holistic approach to the design.
- Think of your space as the ultimate “experiential marketing” opportunity. Experience is second only to quality of care and cost, but sometimes it can even one-up those.

George A. Ewart is principal in charge at George Armour Ewart, Architect, based in Knoxville, Tenn.
Is your EHR a malpractice risk?

Take steps to ensure technology doesn’t lead to liability

by KAYT SUKEL  Contributing author

In his 2004 State of the Union address, former President George W. Bush introduced a plan to roll out EHRs across the country, stating, “By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”

Certainly, the desire to avoid medical errors, a major basis of medical malpractice claims, was one of the driving forces behind EHR adoption. But with the implementation of these systems, the country has seen a rise in what used to be a relatively rare malpractice situation: medical liability claims with an EHR as a contributing factor.

EHRs have evolved but variability remains in what different systems offer, says Mark Graber, MD, FACP, chief medical officer of the Society to Improve Diagnosis in Medicine, who has investigated EHR-related events in medical malpractice claims.

“When you introduce any new technology, you are going to see bugs,” he says. “But you also introduce the possibility of users making errors. Doctors who aren’t trained well on the system may make unintentional mistakes.”

RISING CLAIMS, RISING CONCERNS

A 2017 research report by The Doctors Company, a medical malpractice insurer, revealed that the number of medical malpractice claims among their approximately 80,000 plan members involving EHRs in some way has risen in lockstep with EHR adoption.

The report found two closed EHR-related claims between 2007 and 2010. Between 2011 and 2013, the number jumped to an average of about 23 claims each year. The upward trend continued in 2014, 2015, and 2016: where a total of 92 EHR-related malpractice claims over the three years, or an average of about 30 per year, were closed.

Such medical errors can have profound consequences for patients. In a 2015 study published in the Journal of Public Safety, Graber and his colleagues discovered most EHR-related errors involved medications, diagnoses, or a complication of treatment in the ambulatory care setting.

Perhaps most strikingly, 80 percent of such claims involved moderate or severe harm to the patient. Daryl Zaslow, JD, an attorney specializing in medical malpractice law, says there are many ways that malpractice could arise from an error in a patient’s EHR.

“What typically happens is that there’s a failure to input or access information that is vital to a patient’s health,” he explains. “Therefore, that information is not communicated to another medical care provider who is also involved with the patient’s care and something bad happens.”

IT’S NOT JUST THE TECHNOLOGY

While it would be easy to blame technology for critical information slipping through the
cracks, Hardeep Singh, MD, MPH, chief of health policy, quality, and informatics at the Veteran’s Administration and professor at the Baylor College of Medicine, says a physician could have the best EHR system in the world and still be a victim of “unintended consequences.”

“There are instances where, thanks to a technical glitch, there have been medical issues,” he says. “Sometimes, the technology is not safe, it’s got a bug or a virus or it’s down because you don’t have the right updates.”

The Doctors Company study found system errors like fragmented EHRs (i.e., a system where key sections of a patient’s record aren’t located together), technology failures, and electronic data routing issues did contribute to some claims. But Zaslow says true technology-related cases are uncommon.

“Unfortunately, because these systems aren’t as user-friendly as they often claim to be, and because medical providers have a lot of responsibility keeping track of a lot of things for a lot of different patients, important information just isn’t being inputted in the right way,” he says.

That’s why it’s important to look at where, when, and how users are making those sorts of errors, Singh says. He argues that a lack of standard interfaces for EHR systems makes it more likely that clinicians may incorrectly enter—or fail to enter—patient data into the system.

In addition, since many physicians use multiple systems across different facilities, it can be difficult to know where information should be entered or accessed. He adds that it’s also important to consider how clinicians are using EHR systems—because errors still occur even in the most user-friendly platforms.

There is now a well-established link between EHR usage and increased physician burnout with studies showing that primary care physicians can spend more than half of their work day on the EHR due to billing and regulatory requirements. These increased demands often result in a more demanding workload and amplified feelings of frustration—and, too often, a physician’s attention being drawn away from what should be their top priority: documenting and assessing important patient data.

To address the issue, many healthcare organizations have tried to find ways to ease those documentation requirements. They may select EHR systems that offer auto-population features, or the ability to automatically fill in different data fields when a user opens or completes the record. They may also appreciate the idea of customized templates for different portions of the patient record, which help automate entry of what is often redundant patient data.

Furthermore, physicians may develop their own short-cuts and workarounds, skipping certain fields in the record or using the copy and paste function to quickly move information from one part of the record to another. Ironically, Singh argues, in doing so they may be inadvertently triggering more EHR-related errors.

“People don’t realize, in their haste to get their work done, just how much extra stuff can be auto-populated, resulting in a doctor missing an abnormal lab result they need to address or a patient getting an unnecessary medication,” he says. “And the next thing you know, you are looking at a malpractice claim.”

**MINDING THE GAP**

In general, Graber says, well-designed and well-maintained EHRs can easily integrate into a physician’s workflow to save time...
and help reduce errors. But healthcare organizations need to do their part and adopt strategies to reduce the risk of EHR-related malpractice.

One of the most obvious techniques, and one that EHR vendors often recommend, is regular system audits—relevant reviews of the system to document who has accessed and edited different records as well as what content has changed. Such audits can often identify users who are not meeting organizational policies regarding documentation, and provide insights into how workflows might be modified to better support those efforts.

In addition, those audits should help to ensure platforms are regularly updated and patched to deal with any system or security bugs. But while audits can offer valuable information to the information technology (IT) department, Zaslow says physicians may not find the results as enlightening.

“If you don’t have a work environment that supports clinicians, that doesn’t have the policies and procedures in place to support them, technology won’t help no matter how good it is,” he says. “Organizations should look at their systems and their users to see where they can make changes to help reduce errors across the board.”

Singh says that physicians also have a vital role to play in decreasing these kinds of malpractice claims. He suggests that physicians take steps to avoid the most common pitfalls that can lead to EHR-related errors. To start, don’t disable or override alerts or reminders built into the system. If physicians feel they are experiencing “alert fatigue,” or that such alerts are interfering with care, they should inform the organization’s IT department. In addition, if physicians use copy/paste functions or auto-population features, they should be sure to double- or triple-check any notes before signing off on them.

“Having better awareness of the danger of copy/paste, autopopulation, and templates is important—these short-cuts can lead to a lot of problems,” Singh says. “But the other thing I’d say is, don’t skip on your EHR training. No one wants to do this training. But the EHR is a tool that clinicians have to use, it’s not going away—so get the training necessary so you can effectively use it.”

Avoiding EHR-related malpractice truly is a team effort, adds Graber. As these systems become an increasingly integral part of the care process, he says, it’s important to understand that they can affect the quality of care in a variety of direct and indirect ways. And the first step to mitigating those risks is awareness.

“It’s increasingly important for clinicians to understand how some of these common errors happen, and how to better mitigate them,” says Graber. “And that’s whether there is a malpractice claim on the table or not.”

— DARYL ZASLOW, JD, MEDICAL MALPRACTICE SPECIALIST

If you don’t have a work environment that supports clinicians, that doesn’t have the policies and procedures in place to support them, technology won’t help no matter how good it is.”
I have several colleagues who are getting paid for telehealth services. Is this something that is being reimbursed? If so, how do we bill?

A: Reimbursement varies between payers, so be sure and check with those in your area to ensure they reimburse for telehealth services prior to performing and billing. There are several requirements that must be met in order to bill telehealth services.

**Originating site**
An originating site is the location of an eligible Medicare patient at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A county outside of a Metropolitan Statistical Area (MSA) or
- A rural Health Professional Shortage Area (HPSA) located in a rural census tract

Authorized originating sites include physician practices, hospitals, rural health clinics.

**Distant site practitioners**
Another requirement for telehealth services is the type of practitioners at the distant site who can perform and be reimbursed for covered telehealth services, and those include: Physicians, nurse practitioners, physician assistants, and others.

**Requirements for billing**
You must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.

In order to indicate that services were performed as telehealth services at a distant site, you need to list Place of Service (POS) 02: Telehealth on the claim. This is where the services are provided or received, through telehealth telecommunications technology.

**Use the correct modifier**
Simply using the appropriate CPT and POS codes sometimes is not enough. Since Medicare and payers are tracking the number of telehealth visits, they require these modifiers for specific situations:

- A GT modifier is used for interactive audio and telecommunications system on institutional claims billed under CAH Method II only.
- A GQ modifier is used for asynchronous telecommunication

**Originating site payment**
Originating sites are paid a facility fee for telehealth services, per HCPCS code Q3014. Bill for the originating site facility fee, which is separately billable, and append the GQ modifier.

**CODES TO USE**
Medicare’s list of telehealth services that can be reimbursed include:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Diabetes self-management training</td>
<td>G0108, G0109</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>G0438, G0437, 99406, 99407</td>
</tr>
<tr>
<td>Annual depression screening</td>
<td>G0444</td>
</tr>
<tr>
<td>Annual wellness visit</td>
<td>G0438, G0439</td>
</tr>
</tbody>
</table>

**System visits**
(only for Federal telemedicine demonstration programs in Alaska or Hawaii).

Renee Dowling is billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your questions to medec@ubm.com.
How to build a practice for younger patients

Millennial and Generation Z patients demand convenience and quicker access, experts say

by LISA A. ERAMO, MA contributing author

Millennials (born 1981 to 1996) and Generation Zers (born 1997 to 2012) represent 7 percent of patients in the practice of James Legan, MD, and they also tend to come in for an appointment only once every couple of years. However, this hasn’t deterred the Montana-based internist from devising a strategy to attract and retain these individuals that he hopes will, over time, comprise more of his patient base.

In January, he started using secure texting so patients could ask for prescription refills and request copies of reports, lab results, and office visit summaries. Texting doesn’t require any additional work on his part. His nurse signs patients up for text messages after she takes vital signs, and responds to the messages as they come in.

Legan says patients of all ages—and especially younger generations—tend to prefer texting over phone and email communication. He has seen this in his own practice as well as in his personal life with his 18-year-old son and 16-year-old daughter, both of whom are in Generation Z. “Their phone is their connection to the outside world,” he says. “I hate to say it, but I think email is old technology now. We need to make communication more immediate.”

Nearly 70 percent of Legan’s patients actively use the patient portal that’s tied to his EHR, though he anticipates texting will eventually replace it entirely. He’s also exploring providing secure video chatting to address common medical problems such as a rash or sinus infection. He predicts younger generations will increasingly demand this type of technology as part of their healthcare experience.

According to Accenture’s 2019 digital health consumer survey, convenience is a major factor for younger generations when choosing a provider. For example, 84 percent said they want easy access to test results, and 80 percent want the ability to request prescription refills electronically. This is in addition to the majority of respondents who demand short wait times, responsive providers, and cost-conscious care.

GIVING YOUNGER GENERATIONS WHAT THEY WANT

Experts say physicians who want to attract and retain younger patients need to rethink how they interact with them and create a technology-driven strategy for engagement.

To do this, physicians must shift their mindset, says Mike Morgan, chief executive officer at Updox, a patient engagement con-
Younger patients consult in Dublin, Ohio. “Your practice is a business, and your patients are customers,” he says. “A typical business segments its customers because everyone has different priorities.”

Millennials and Generation Z expect their healthcare experience to mimic that of other industries, says Morgan. Most importantly, they want convenience. They’ll compare healthcare, for example, with the ease of ordering takeout meals online, requesting an Uber or Lyft, or chatting with a company’s customer service rep, he adds. If their healthcare experience isn’t similar in terms of booking appointments, paying bills, and communicating with providers, they’ll simply move on to find a different practice that can provide the type of experience they want.

“Many physicians have built their business based on word of mouth,” says Kaveh Safavi, MD, JD, senior managing director at Accenture, a healthcare consulting and IT company in Chicago. “Now, that’s not enough when convenience is three times more compelling.”

Younger consumers also want the ability to make appointments easily. Legan, for example, tries to accommodate these patients who have acute problems with same-day appointments, when possible. “These patients are hard to capture otherwise,” he says. “If you can’t fit them in, they’ll go to an urgent care.”

Three-quarters (76 percent) of participants in the Accenture study said they want the ability to book, change, or cancel appointments online. “These generations, in general, don’t want to pick up the phone and call,” says Norm Schrager, senior content marketer and strategist at PatientPop, a practice growth technology provider in Santa Monica, Calif.

However, some physicians believe that by offering online booking, they’ll lose control over their schedule. This isn’t true, says Schrager. Many products allow practices to limit scheduling options online. They also fully integrate with EHR scheduling systems, offering a seamless experience for practices, he adds.

BOOSTING ONLINE PRESENCE
Standing out among competitors is perhaps the biggest challenge in terms of attracting millennials and Generation Z to a physician’s practice, says Morgan. Having a website is a good first step, but the site must include updated information and provide a decent user experience with high-quality photos of your staff and office. Otherwise, it could actually harm your ability to attract these patients. “Some patients look at the website as a proxy for the experience they will receive at the practice,” he says.

Physicians also need to work with a web designer or marketing company to create a
The operations plan for search engine optimization (SEO), the process of ensuring search engines can find a website, says Carrie Liken, head of industry for healthcare at Yext, a digital knowledge management provider in New York City. A savvy web designer or marketing company should also be able to add relevant schema tags to the HTML code on each page of the site. These tags help search engine algorithms prioritize the content for patients searching key terms, she explains.

A practice website should also include a page for frequently asked questions, about various diagnoses and procedures says Schrager. Ask—and then answer—these questions on the site. “This starts to build up the idea that you have a level of authority and relevance,” he says.

Claiming and optimizing a Google business profile is also important, says Schrager. Physicians should go to https://www.google.com/business/, claim their identity, and add specific information about the services they perform. “Not only does this help with search results, it also lets prospective customers know who you are,” he adds.

**PAYING ATTENTION TO ONLINE REVIEWS**

As important as a practice website are the myriad healthcare- and consumer-related websites (e.g., Healthgrades, Vitals, and Yelp) that include reviews and ratings provided by patients, says Liken. Over half (59 percent) of patients say online patient reviews are the most critical online resource they consider when choosing a provider, according to the 2019 patient perspective online reputation survey conducted by PatientPop.

In some cases, these third-party websites are the only ones that prospective patients see, either because the practice doesn’t have a website or the practice website isn’t SEO-optimized and thus doesn’t appear in search results. Another reason is that the patient searches the physician’s name not the practice name. If the website only mentions the practice name, it won’t come up in a search for the physician’s name.

The most important step physicians can take regarding these reviews is to simply acknowledge them, says Liken. However, they should be careful not to confirm or disclose protected health information (PHI) during these interactions. Instead, thank patients for their feedback and ask them to call the practice directly to discuss their concerns, she explains.

Schrager agrees. “Let the patient know you heard them and that you want to address the issue they had,” he says. “That will help you not only retain that patient, but it...

---

**5 things you need to know about millennials and Generation Z**

1. **They won’t tolerate a poor customer experience.** Convenience is key. Will you offer technologies such as online booking, secure texting, paperless intakes, online bill pay, and more?

2. **They won’t necessarily be loyal to your practice.** What will you offer that your peers do not, and how will you make patients feel welcomed and appreciated?

3. **They’re concerned about costs.** Will you be able to inform them of whether treatment is covered by insurance, why that treatment is necessary, and what their out-of-pocket costs will be?

4. **They care about what other people say.** Do you monitor your online ratings and strive to keep patients happy?

5. **They don’t want to wait.** Wait time and speed of appointment are critical. What will you do to stay on schedule and keep patients informed of delays?

---

“*Their phone is their connection to the outside world. I hate to say it, but I think email is old technology now. We need to make communication more immediate.*”

—James Legan, MD, Internist, Montana
shows a level of care and professionalism that will help attract prospective patients.”

Physicians should feel comfortable asking patients to share their experiences online because these reviews are highly influential in terms of choosing a provider, says Schrager. The more recent the review, the more relevant it is for younger patients—many of whom ignore reviews older than three months, he adds.

Many of these third-party sites also include basic information about a practice, such as the address and phone number. Nearly 70 percent of the time, this information is either inaccurate or missing, says Liken. “This leads to a really bad patient experience,” she adds. “When younger generations find information that’s not accurate, or they can’t find the right number, they just go ahead and search for another doctor altogether.” She says physicians should claim and update their profiles on these sites.

RETHINKING THE PATIENT EXPERIENCE

Once they arrive for an appointment, millennials and Generation Z expect to be treated as customers of your business. As such, they’ll appreciate a warm greeting upon check-in, says Schrager. Practices should also offer amenities such as Wi-Fi, coffee, water, TVs, comfortable chairs, and updated magazines. If the physician is behind schedule, staff should let them know they’ll experience a delay and by how long. “This level of open communication makes such an impression,” he adds.

Younger generations definitely don’t want to be inundated with paperwork once they arrive, says Schrager. Paperless intakes that patients can complete in advance using their mobile device are preferred, he adds.

Once patients are in the exam room, Legan projects the EHR onto a 40-inch screen so people can view their health data trends over time. “These generations are very visual, and they like that effect,” he says.

Upon checkout, they’ll want to know what specific costs they’ve incurred as well as instructions for next steps (e.g., tests or referrals), says Morgan. They also want the ability to communicate with physicians asynchronously through texting. The only caveat with texting is that physicians and staff must use secure texts if they intend to exchange PHI, he adds. In addition to encryption, secure text messaging offers other safeguards, such as accessing a conversation through a link that’s only active for 48 hours. If a patient wants to reactivate the conversation after 48 hours, they must verify their identity using their date of birth or a personal identification number.

THINKING ABOUT LONG-TERM RETURN ON INVESTMENT

Engaging millennials and Generation Z isn’t necessarily about generating revenue—at least not initially, says Safavi. It’s about building relationships and being accessible so patients automatically reach out when needs do arise. “Your goal is to think about having these patients think of you as their doctor,” he adds. The idea is that over time, their healthcare needs will evolve and increase as they age.

On the other hand, embracing health-care consumerism undoubtedly improves patient satisfaction and retention across the board for all generations, says Safavi. “It’s about realizing this is what patients expect now,” he adds.
Financial Strategies

6 steps to renegotiate payer contracts

Do your homework
Gather all your contracts, review the terms, and know the effective dates of your contracts. Study your payer mix and learn who is your largest payer. Create a database where you can track the terms of every contract and when each is up for renewal. Keep copies or detailed notes of all interactions with your payers, including the last time you renegotiated the contract.

Payers are hoping you have so many payer contracts and too little time to review all the agreements, especially at small practices that don’t have a dedicated team to review them. They are counting on you to not be diligent. That gives them the opportunity to skimp here and there. Don’t let your payers cheat or hoodwink you.

Know your fee schedule
Anticipate that each payer will establish speed bumps to slow down your claims process. Some payers might require different procedures to submit claims, such as the use of a web portal, special emails, and the like. They will use vague language to give them wiggle room—and the opportunity to deny claims. Beat them at their own game.

Create another database for your most common codes separated by each provider. Note how each code should be submitted. Make sure you capture all of them.

Building this central repository will require time upfront, but it should ultimately speed up the daily claims process, reduce the number of days bills are in accounts receivable/accounts payable, lower the volume of denied claims, and make it easier should you to resubmit.

Let the games begin
Once you have assembled all of your data, you can compare each payer to one another. Now you have the information you need to begin the process of renegotiating your contract with a specific payer.

Initiate the process according to the terms of your agreement but do so with a formal notice. Pick a payer that you think you’ll be able to get the desired changes from. It might be based upon the fee schedule, the time to the end of the contract, or the volume of business you do with them.

I would recommend starting with payers that offer the lowest rates and those with the least amount of time left on the contract.

Research who you should send the notice to and ask for confirmation of receipt. I would recommend sending your notice to as many people at the payer’s organization as possible.

Remember: These payers aren’t your friends and being friendly won’t yield the desired results. You must approach this process without fear.

Hold the line
Remember, negotiations start with a “no.” Payers will push back and even refuse to open up talks. Press on, and don’t give up.

Stay focused on your mission and purpose. The key to any successful negotiation is knowing what you want. Be specific with your desires. Don’t let their fear tactics intimidate you, and always be comfortable exercising your right to veto.

Keep goals in mind
Know what you want—and the outcome you seek—even before you start the renegotiation process. You’re renegotiating these contracts so that you have capital to continue to provide excellent care to their beneficiaries. If the payer isn’t moving the needle enough, don’t be afraid of walking away.

Remember, the payer sold a contract to the patient or their employer, and they must fulfill the terms of that contract. Their contract with you helps them meet their contractual obligations to the other party.

Prepare to adapt
Plan your negotiation steps carefully and accept that you might need to change things as the talks progress. However, you should understand what you want from a specific negotiation event, meeting, or email. It might be another meeting with someone else, an acknowledgment of your proposal, or acceptance of your offer, but you must be explicit on this issue.

David J. Norris, MD, MBA, is an anesthesiologist and author of The Financially Intelligent Physician: What They Didn’t Teach You in Medical School. Send your financial questions to medec@ubm.com.
Home healthcare makes a comeback

How innovative care solutions bring the health system and primary care to patients’ homes

by AINE CRYTS contributing author

There are myriad factors driving interest in home health. For one, there are 46 million people who are 65 years of age and older in the United States. That number will jump to more than 98 million in 2060 when this age group will represent 24% of people in the United States.

Add to that the soaring cost of treating chronic conditions—Diabetes alone cost $327 billion in 2017. The CDC projects the cost to treat COPD will reach $50 million each year by 2020.

Preventing hospital-acquired conditions such as sepsis is also on the mind of healthcare executives. For example, severe sepsis impacts more than 1 million Americans each year—and 15% to 30% of those people die.

And all of this is taking place in a country where as much of one-third of healthcare spending may be wasteful.

Approximately 5% of patients drive 40% of a provider’s costs, says Michael Le, MD, co-founder and chief medical officer at Huntington Beach, California-based Landmark Health, which contracts with payers to provide home health services.

Who’s helping to drive that spend? It’s older patients with mobility challenges who can’t travel to their physician’s office for follow-up appointments. These are patients, says Le, who stay home and “tough it out.” Then it gets so bad that they call 911 and get admitted to the emergency room, instead of getting care from their primary-care provider.

Repeated visits by very sick and frail patients to the emergency room are bad for continuity of care. That’s why it’s valuable to determine those patients who are frailest and in the most need of support at home, he adds.

BRINGING CARE TO THE SICKEST

Landmark Health employs a variety of clinicians, including nurse practitioners, physician assistants, and behavioral health specialists (such as psychiatrists and social workers), to provide around-the-clock home-based care to 26,000 patients on an urgent or scheduled basis. Landmark Health contracts with payers to provide this care to members.

The majority of its patients are aged 80 years or older, but Landmark Health also serves very sick patients in their 20s and 30s, says Le. On average, patients have eight chronic conditions, such as congestive heart failure, COPD, and chronic kidney disease. Many of its patients are considered frail.

Most patients receive a home visit once a month and three phone calls per month; the
**Policy**

Home healthcare

“*Our [primary care providers] are relieved to have patients seen and chronic conditions are now being managed in the home. Our patients are extremely grateful.*”

—LOUIS JENIS, MD, CHIEF MEDICAL AND INNOVATION OFFICER, NEWTON-WELLESLEY HOSPITAL.

“Initial visit lasts an hour and follow-up visits run about 45 minutes. That’s in addition to visits by care team members to respond to urgent medical events around the clock.

Landmark Health provides coverage—and is 100% at risk for—82,000 patients across 13 states. In some of its more established markets, the organization is engaging with 55% to 60% of covered patients. Since the company was started in 2013, it has worked with more than 30,000 patients.

Here’s how their care approach works: Care providers can test patients’ blood-glucose levels, do an inventory of their medicine cabinets, measure blood pressure, draw blood, check labs, and administer antibiotics and steroids in the home. Landmark Health partners with local imaging providers for X-rays and ultrasounds to provide imaging services within patients’ homes.

These are patients who have a medical-loss ratio of more than 100%, adds Lee. That means payers are losing money on them, largely because they’re going to the hospital so often. The patients served by Landmark Health typically have a 20% to 30% medical-loss ratio, and they have a 50% lower mortality rate than patients who aren’t engaged.

**PILOTING HOME HEALTH DELIVERY**

One of the biggest challenges with home health is getting paid for that care. But that doesn’t mean providers aren’t working hard to figure it out.

Case in point: Newton-Wellesley Hospital, a suburban hospital that’s part of Boston’s Partners HealthCare. It’s piloting a program that brings clinicians into patients’ homes. The pilot is financed by the hospital.

“*Proof of concept is our current goal [and] focusing on providing high-quality care while the patient is at home ... as well as progress in improving total medical expense as a system,*” says Louis Jenis, MD, chief medical and innovation officer.

Patients are selected for home health for two reasons: they’re “super utilizers” of the emergency room or they don’t show up for follow-up appointments with their primary care providers regularly.

The pilot, which began in April, serves 60 patients—some of whom are on their third scheduled home visit. The average patient is aged 85 years and most patients are women. It involves sending a nurse practitioner into the patient’s home. The patient’s primary care physician refers the patient to the practice’s nurse practitioner for home visits.

Its home health program is still in a pilot phase, which means cost and quality measurements are currently unavailable. But Jenis says the home care program is a fundamental part of the hospital’s primary care strategy. “*Our [primary care providers] are relieved to have patients seen and chronic conditions are now being managed in the home. Our patients are extremely grateful.*”

**TECHNOLOGY CAN HELP**

Many older patients, in particular, prefer to be home and surrounded by their families, says David Levine, MD, MPH, a physician and researcher in the division of general internal medicine at Boston’s Brigham and Women’s Hospital, which is also part of Partners HealthCare. Thus, providing home health can translate to a better patient experience.

It also helps patients avoid adverse events such as falls or hospital acquired infections. Levine adds that there’s a finite number of beds for sick patients, and that’s why sending clinicians into patients’ homes—aided by technology—can help. In this program, a care team travel to the patient’s home.

When a patient is stabilized in Brigham and Women’s Hospital’s emergency room, their care team then decides—based on the patient’s needs and proximity to the hospital—that they’re a candidate for home-based visits. That entails regular monitoring and home visits between two and five times a week. Supplementing that care is VitalPatch, a patch that monitors patients’ vital signs, such as heart rate, skin temperature, fall detection, and respiratory rate. That data is shared with Brigham and Women’s Hospital’s care team.

Here’s how that works: There’s an 85-year-old patient with the flu, who requires oxygen and antibiotics, in addition to regular monitoring. If the patient experiences a faster heart rate, it would trigger the team to adjust their treatment plan, says Levine.

His team has used this device and conducted home visits with 300 patients since 2016. A pilot study including 20 patients—nine of whom were treated at home and the remainder were treated in the hospital—was published in *Journal of General Internal Medicine*. The result was a 52% reduction in direct care costs while maintaining quality and patient experience.
EXTENDING BEST PRACTICES

Increasingly, providers are reworking pre-operative education and post-surgical recovery for joint replacement patients. Oakland, California-based Kaiser Permanente has created a playbook that allows providers in each of its different markets to select from one of three post-surgical recovery paths, based on the individual patient’s needs.

Leading Kaiser Permanente’s National Total Joint Replacement Initiative is Kate Koplan, MD, MPH, associate medical director for quality and patient safety. One of the key drivers behind getting patients home after their surgeries is patient satisfaction, she says. Other drivers are patient safety and infection risk, both of which are inherent with being in the hospital. Affordability is also important, since care provided in patients’ homes costs less.

Still, Koplan acknowledges that falls, in particular, can be an issue in patients’ homes. That’s why a safety care plan is done in patients’ homes before the surgery, to assess uneven floor surfaces that could cause falls.

Her work to provide best practices for orthopedic teams for total joint surgery started about three years ago. And the different approaches, which range from no nights in the hospital to one night to two or more nights after the surgery came from the health network’s orthopedic surgeons.

The number of nights a patient stays in the hospital after their surgery depends on a variety of factors, which include number of comorbidities, support within the home, and the home safety evaluation. The decision is ultimately the result of shared decision-making between the patient and their surgeon and the rest of the clinical team.

Koplan adds that care planning is an integral part of each of the three paths. For example, patients will need access to follow-up appointments and some patients will receive that follow-up care in their homes.

Because Kaiser Permanente operates in seven markets—each of which has access to different resources—these steps may happen differently, she says. For example, a home safety assessment may be done in person or by phone by a nursing care coordinator, who also assesses the family and social support the patient will have in the home environment.

Still, the variables that help orthopedic surgeons and their patients to choose the appropriate post-surgery path are laid out in a playbook that’s shared throughout the network. The playbook was created by a multidisciplinary team that includes orthopedic surgeons, anesthesiologists, nurses, care coordinators, physical therapists, and home health service providers, in addition to patient input.

Practices outlined in the playbook range from pre-operative care (such as patient and family health education), to perioperative care (such as blood management protocols), to post-operative care, which can include home physical therapy visits.

Koplan says her role is to extend best practices throughout Kaiser Permanente. As a result of this work, the average length of stay in the hospital for patients is trending downward, while quality and safety have been maintained. The feedback from clinicians has been “fantastic,” she says.

PAYMENT CHALLENGES

Getting paid for care provided in the home is a challenge. That’s why Newton-Wellesley Hospital is financing its pilot and Brigham and Women’s Hospital is sharing the payment burden with a payer.

The difficulty stems from providers getting paid less for care when it’s delivered outside the hospital. That’s according to Michael Brookshire, a Dallas-based partner at consulting firm Bain. Thus, there are “odd incentives” for providers to not offer home health services to patients. Provider organizations that are successful with home health have been making investments in value-based care for a long time, he says.

Levine acknowledges that lack of payer support for home health makes this work difficult. But he believes payers will receptive once more research is done on the cost and quality impacts of home health. For example, if an emergency room visit costs a payer $10,000 and care in the home costs $9,500, the payer may be willing to share the savings with the provider. Levine hopes to see more payers embrace home health within the next five years—or even sooner.

Editor’s note: This article was first published in our partner publication, Managed Healthcare Executive.
Can I charge uninsured patients more?

Dr. Fees has a large practice that has seen an increased number of people without health insurance. In fact, these patients have presented him with a unique economic advantage. He charges his uninsured patients double what he bills to contracted managed care insured patients.

Not only does he charge these patients more, but he also aggressively pursues them with collection agencies if they fail to pay. He thinks of himself as a quality physician. Much to his surprise, he is sued by an uninsured patient over his dual pricing.

Can Dr. Fees charge uninsured patients more?

In Morrell v. Wellstar Health System, a patient argued the hospital violated the Georgia Uniform Deceptive Trade Practices Act because it charged unreasonable rates and charged the uninsured higher rates than insured patients. The Georgia statute at issue prohibited fraudulent misrepresentation, false advertising, or false and misleading statements.

The court found nothing illegal about the hospital’s policies, because the hospital made patients aware of its fees.

When patients win

Despite this, and similar decisions, some uninsured patients have been successful in their claims.

In Servedio v. Our Lady of the Resurrection Medical Center, a lawsuit was brought by several uninsured patients who owed the hospital more than $60,000. The patients were unable to pay for their medical services and the hospital vigorously tried to collect the debt. The patients claimed they were charged inflated rates compared with insured patients, they were not considered for charity care, and excessive collection methods were used. In fact, Resurrection Medical Center had the highest charge-to-cost ratio of any Chicago hospital. The Illinois court ruled that medical services sold by a hospital were a form of trade or commerce, and that the hospital’s conduct was immoral, unethical, oppressive, and clearly against public policy.

Litigation entitled In re. Sutter Health Uninsured Pricing Cases, a group of uninsured patients of a California hospital alleged they were charged unreasonable rates compared to those charged to insured patients. The California Supreme Court noted that under the California Unfair Competition Law, any “unlawful, unfair, or fraudulent business act or practice” was a violation.

Sutter agreed to a policy that provided discounts to uninsured patients.

These patients pay more

In recent years, the United States has seen countless similar stories with regard to physician and hospital charges.

Although patients with private or governmental insurances receive huge discounts for medical care, uninsured patients, who make up an ever increasing number of lower and middle income classes of Americans, pay higher prices for the same medical care. Apparently this pricing disparity has gone on for years, but over the last decade has been highlighted through stories in the Wall Street Journal and on CBS’s 60 Minutes.

In one report, it was estimated that uninsured patients were charged two-and-a-half times more than a patient covered by one or more of the major insurance companies. The disparity is further accentuated by the fact that these inflated charges are not a voluntarily assumed debt, but rather, one that often cannot be avoided.

It is common knowledge that both not-for-profit and for-profit hospitals across the United States have policies of charging uninsured patients more. Some physicians have done the same.

Lawsuits result

However, over the last decade, uninsured patients have increasingly sued hospitals for such policies.

The claims have been based on several theories, one being that such differential billing policies violate state consumer protection statutes. Such lawsuits are based on the theory that uninsured patients have been subject to discrimination. The success of these claims depends on the state statutes where the litigation has been filed.
The top reasons for claim denials—and how to prevent them

Each new denial is essentially a revenue leak. Even when claims are recovered, the costs associated with that recovery must be subtracted from patient revenue. Recent data put that recovery cost at roughly $118 per denial. Factor in the lost revenue from your unrecovered claims and it’s clear why denials are a painful financial drain on practices.

What makes denials so frustrating is that many are avoidable. The key is having processes in place to identify and correct errors and omissions before a problematic claim is ever submitted.

The number one cause for a denial is that a patient isn’t eligible for care under the terms of the insurance plan. In the research cited above, nearly one in five respondents said “registration/eligibility” was the leading reason for denials. The simple step of doing eligibility checks before a patient is seen by medical staff can prevent this.

Other common reasons for denials are:

Insufficient information. A simple omission, such as date of birth, can lead to a costly denial.

Duplicate billing. This happens when a similar or equivalent claim is sent because of a clerical error or overlap in office duties.

Improper or outdated CPT or ICD-10 codes. The codes, which determine what is paid, change quarterly, and your practice—or your RCM vendor—is responsible for capturing and operationalizing all updates.

Untimely filing. You only have so many days to file the claim.

Service is not covered. A patient’s coverage may have been terminated or their maximum benefit has been met (often in the case of physical therapy).

Out of network. Some plans require doctors and practitioners to be “in-network” for coverage.

Problems with modifiers. Errors can result from submitting invalid modifier combinations. Many invalid modifier combinations can be avoided with better training for coding personnel or by using a qualified medical billing service.

Prior authorization required. Some payers want authorization or a referral from another physician before services can be performed.

Claim denial tips

1. Audit your practice to see if you’re at risk for any of the most common reasons for denial.

2. Train and retrain staff to recognize and be vigilant around the key error points that lead to denials.

3. Consider revenue cycle management technology, which, when properly integrated with your EHR and/or practice management system, can automate critical aspects of the billing process.

4. Start benchmarking your progress; see how much profit you recoup by stopping leakage that is caused by denials.

Focus on “denial rate,” which the American Academy of Family Physicians says should be between 5 to 10 percent on average. Less than 5 percent is more desirable.

Tom Romeo is general manager of HIT and Quanum solutions at Quest Diagnostics. Send your questions to medec@ubm.com.
The CBD oil trend
What should physicians say to their patients?

by JORDAN ROSENFELD contributing author

Depending on who’s talking about CBD—short for cannabidiol, the nonpsychoactive compound found in marijuana and hemp plants—it’s either a cure-all for every ailment, or little better than a placebo. Since 33 states (and the District of Columbia) have legalized medical marijuana, and the 2018 Farm Bill legalized hemp, physicians may be seeing more requests from patients to try these products. What do physicians need to know to best inform their patients? The answers lie somewhere in the middle of the two extremes.

WHAT IS CBD?

CBD is one of hundreds of cannabinoids found in the cannabis sativa plant (marijuana and hemp) that does not cause the euphoria or intoxication of its cousin compound, THC.

“CBD binds to different receptors than THC,” says Jack Springer, MD, Fellow at the American College of Emergency Medicine and assistant professor of Emergency Medicine at the Zucker School of Medicine at Hofstra Northwell in San Diego, Calif.

Researchers are only just beginning to understand the endocannabinoid system in the human body, he says, which were only discovered around the 1990s. “Since that time this system has been found to have numerous important functions on the body relating to appetite and energy balance, immune function and nervous system function,” Springer says.

CBD, a phytocannabinoid—deriving from plants—is frequently touted as relieving such conditions as chronic pain and inflammation, anxiety, and sleep issues.

WHAT IS CBD?

CBD is one of hundreds of cannabinoids found in the cannabis sativa plant (marijuana and hemp) that does not cause the euphoria or intoxication of its cousin compound, THC.

“CBD binds to different receptors than THC,” says Jack Springer, MD, Fellow at the American College of Emergency Medicine and assistant professor of Emergency Medicine at the Zucker School of Medicine at Hofstra Northwell in San Diego, Calif.

Researchers are only just beginning to understand the endocannabinoid system in the human body, he says, which were only discovered around the 1990s. “Since that time this system has been found to have numerous important functions on the body relating to appetite and energy balance, immune function and nervous system function,” Springer says.

CBD, a phytocannabinoid—deriving from plants—is frequently touted as relieving such conditions as chronic pain and inflammation, anxiety, and sleep issues, says Rosemary Mazanet, MD, PhD, an oncologist and Chief Scientist at Columbia Care, a provider of medical cannabis products in 13 states.

However, when it comes to the evidence, most claims are only anecdotal. Research studies in the U.S. on CBD are still limited. Mazanet says that many of CBD’s positive effects on these conditions may be placebo, but she does not consider that a bad thing, particularly for issues such as anxiety. “Even if it’s placebo, if people think it’s working for them, that’s good because people take so many benzodiazepenes, which can be addictive over periods of time,” Mazanet says.

Other physicians believe that taking CBD alone is missing the effectiveness of the whole cannabis (marijuana) plant, which includes THC and numerous other cannabinoids, which work together in what is known as an “entourage effect.”

Jordan Tishler, MD, an inter-

HIGHLIGHT

CBD, a phytocannabinoid—deriving from plants—is frequently touted as relieving such conditions as chronic pain and inflammation, anxiety, and sleep issues.
Don’t miss an issue—renew your subscription now!

✔ Coding tips for better reimbursements
✔ Malpractice advice from the experts
✔ Practice management Q&As
✔ Strategies for optimal patient flow
✔ Practice makeovers to improve operational efficiency

Renew today!
Online subscription renewal only takes a minute

Visit bit.ly/ME-subscribe
nist and professor at Harvard Medical School in Brookline, Massachusetts, and president of the Association of Cannabis Specialists, also believes that the benefits the average person is getting from CBD are likely placebo, and that it’s THC that can really treat symptoms. “If you think about the general things cannabis is used for—pain control, nausea suppression, appetite stimulation, treatment of anxiety—that’s all THC... in proper dosing and in proper timing that’s actually working.”

However, any of the compounds of cannabis in isolation have their downsides, even THC, Tishler says. This is evidenced by the failure of a drug called Marinol, released in the 1980s, which was essentially pure THC. “It didn’t work well because most people got so intoxicated that they never achieved the therapeutic value,” Tishler says.

Because both hemp and marijuana were considered illicit substances for so long, research on CBD in the United States has been limited. Thus, there simply isn’t enough convincing scientific evidence yet to back up any specific usage of CBD with one exception. The only FDA approved use for CBD in the U.S., Tishler says, is the FDA approved drug Epidiolex, used to treat seizures associated with Lennox-Gastaut syndrome (LGS) or Dravet syndrome (DS) in patients 2 years of age and older. Even then, it does not work for every patient who takes it.

Tishler says that the dosage of CBD required to bring benefit to the average person is so high—between 600 and 1200 mg of CBD per day—it is also cost prohibitive for many. He estimates CBD costs approximately five cents per milligram, which would make a therapeutic dose of CBD about $80 per person per day. “You need so much CBD to make a dent,” Tishler says.

In an attempt to provide some concrete evidence on effectiveness of CBD and THC, The National Academy of Science Engineering and Medicine released a report in 2017 that found the following:

- “Conclusive or substantial evidence” that cannabinoids (not specifically CBD) are effective as antiemetics in the treatment of chemotherapy-induced nausea and vomiting (with oral cannabinoids); and improving patient-reported multiple sclerosis spasticity symptoms (with oral cannabinoids).
- "Moderate evidence” that cannabinoids improve short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (primarily nabiximols).
- For everything else, evidence is “limited or inconclusive.”

“The important thing to get across is that nothing is a panacea. Until we dial in the mechanism of action and can pick apart which cannabinoid is most beneficial for what and can isolate it, we’re not going to know.”

—JACK SPRINGER, MD, ASSISTANT PROFESSOR OF EMERGENCY MEDICINE, ZUCKER SCHOOL OF MEDICINE AT HOFSTRA NORTHWELL

THE LEGAL QUESTION

In addition to questions about CBD’s curative
“Less than half of the products had in them what they said they had in them. There’s really no oversight in what people buy.”

—ROSEMARY MAZANET, MD, PHD, ONCOLOGIST AND CHIEF SCIENTIST, COLUMBIA CARE

Trends

claims, there’s some gray area around its legality. There’s an erroneous assumption that marijuana is illegal and hemp is legal, therefore, CBD derived from hemp is assumed to be legal as well. William Garvin, JD, shareholder for the law firm Buchanan, Ingersoll, and Rooney in Washington D.C., and co-head of its cannabis group, which handles issues related to the regulation and sale of cannabis, says, “The problem is that marijuana and hemp have the same genus species of plant.” Thus, he says, hemp has long been lumped in with marijuana, legally speaking, and treated as illegal even though hemp does not contain enough THC to create intoxication. That muddied the legal waters in states where local authorities don’t know the difference between the plants, and has kept even hemp-derived CBD from being legal to buy and sell in every state.

The passage of the 2018 Farm Bill has legalized hemp, and thus hemp-derived CBD, so long as the producer is licensed and in compliance with federal or state agricultural standards.

However, no such federal agricultural program exists yet, Tishler says. The legalization of hemp may change who is allowed to produce and sell CBD, by requiring more stringent standards, but Garvin thinks that might be a benefit to the consumer by creating more consistent and standardized products.

All of that said, there is often lag time between legislation and law enforcement, so Garvin urges CBD users, “Don’t take [CBD] through airports. Treat it as a product that could have difficult with authorities because you never know which authorities are going to be on board with it and which ones aren’t.”

CAVEAT EMPTOR

Mazanet also cautions that not all CBD products are created equally, or with any consistent manufacturing standards. “When patients buy CBD products over the counter or from the gas station, they have no idea what they’re getting,” she says.

She points to a 2017 study in JAMA where researchers tested 84 CBD products they purchased over the internet from 31 different companies—40 oil products, 20 tinctures, and 20 vaporizations. “Less than half of the products had in them what they said they had in them,” Mazanet says. “There’s really no oversight in what people buy.”

Springer says even dispensaries in states with medical marijuana are not always the most reliable source.

That being said, Mazanet accepts that patients who want CBD products are going to get them, and feels that physicians should try to work with these patients. “The thing that’s most important is that physicians don’t send their patients elsewhere,” she says.

Springer urges physicians to encourage their patients to do their research before purchasing products and to acquaint themselves with quality brands for those patients who are determined to buy them.

Like Mazanet, in the service of keeping rapport with his patients, Springer doesn’t write CBD off entirely because his patients are interested in it. He’s hopeful about research that shows cannabinoids may help to reduce dependence on other drugs, particularly opioids and benzodiazepenes, which can become addictive.

“For people who are opiate dependent or on a medication that has side effects, it’s a no brainer. If they’re willing, they should try...”
**Trends**

CBD oil

“If you think about the general things cannabis is used for—pain control, nausea suppression, appetite stimulation, treatment of anxiety—that’s all THC.”

— JORDAN TISHLER, MD, INTERNIST AND PROFESSOR, HARVARD MEDICAL SCHOOL; PRESIDENT, ASSOCIATION OF CANNABIS SPECIALISTS

CVS’ rollout of hemp-based cannabidiol (CBD) products at stores in select states is expected to open the CBD door for other pharmacy chains.

At the same time, growth of the category could be hindered by complex regulations on CBD and similar products that differ from state to state, along with consumer confusion.

CVS recently began selling topical CBD-containing products such as creams, sprays, lotions, and salves in seven states: California, Colorado, Illinois, Indiana, Kentucky, Maryland, and Tennessee. Rival Walgreens announced in March that it will sell CBD products in 1,500 locations across the U.S., including Colorado, New Mexico, Kentucky, Tennessee, Vermont, South Carolina, and Indiana.

“CBD is gaining popularity among consumers, particularly those looking for alternative care products,” says Joseph Goode, senior director of corporate communications at CVS. “Anecdotally, we’ve heard from our customers that these products have helped with pain relief for arthritis and other ailments, and we believe consumers will be looking for these products as part of their health offering.”

Goode was quick to clarify that the topical products are based on hemp, not on marijuana, and that CVS is not selling any supplements or food additives that contain CBD. Hemp is a form of cannabis plant that contains very low quantities of tetrahydrocannabinol (THC).

The 2018 U.S. Farm Bill redefined “marijuana,” a controlled substance, to exclude hemp containing less than 0.3 percent THC. As a result, hemp and hemp-derived CBD are no longer controlled substances under federal law, Goode says.

The FDA has not as yet issued regulations on the marketing and sale of CBD-containing foods and topicals. In April, the FDA issued a press release saying questions remain regarding the safety of widespread CBD use. Gottlieb has also expressed concern regarding the decision to sell CBD products.

The regulation of hemp-derived CBD varies by state and is often regulated by multiple agencies.

BDS Analytics estimates that the total U.S. CBD market, which includes products sold at cannabis dispensaries and via e-commerce, will reach $20 billion by 2024. Around 40% of U.S. consumers said they would explore CBD products under the right conditions, a separate new study says.

Editor’s note: This article was first published in our partner publication, Drug Topics.
Why medical language matters

It’s very helpful, if not a necessity, that when you say something, others know what you mean. There’s a reason so much of education and training boils down to the learning of vocabulary. Specialized fields such as medicine particularly depend upon having well-defined concepts. One might therefore think they’re relatively protected from such dumbing-down of their terminology.

The terminology that we depend on to precisely and accurately communicate our expertise is allowed to drift, and sometimes such drift is even formally accepted into the professional lexicon. That is, the field determines that enough of its denizens are using the wrong words, so it’s better to officially declare that what was once wrong is now right, or at least acceptable.

Except it seems that a lot of healthcare folks didn’t remember their anatomy (or didn’t learn it well enough in the first place), and weren’t properly considering the superficial femoral veins as part of the deep-venous system. Hardly a capital crime; a layman could certainly be forgiven for thinking that “superficial” means superficial, and “deep” means deep.

Still, these healthcare-folks weren’t laymen. Presumably, they had gone through adequate education and training, and maintained their knowledge-base with ongoing reading, CME, etc. Kind of a paradoxical thing, then, that when they failed to remember that the superficial femoral vein was actually part of the deep-venous system, the Powers That Be decided to throw in the towel and just rename the vessel.

The evident philosophy, and dangerous precedent being set: If enough people can’t be bothered to get something right, change the answer so they’re not wrong anymore.

And if you think about it, there’s still plenty of room left for confusion. If someone refers to “the femoral vein,” the same clueless individuals who couldn’t remember that this vessel was part of the deep venous system might just as easily fail to recognize the distinction between the various veins that have the word “femoral” in their names (common, deep, circumflex).

There are a whole lot of specific, useful terms that got developed in medicine to describe signs and symptoms that patients might have. ( Heck, the waters between “signs” and “symptoms” have gotten muddied.) Every time these terms get blenderized to the point where we really can’t be sure of which meaning is intended by their usage, we lose another increment of definition, and things get dumbed down that much more.

Eric Postal, MD, is a board certified radiologist.
<table>
<thead>
<tr>
<th>Name</th>
<th>Role Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maria Young Chandler, MD, MBA</td>
<td>“My father, who is a child psychiatrist and the most patient person I know.”</td>
</tr>
<tr>
<td>George G. Ellis, Jr., MD</td>
<td>“My family doctor growing up.”</td>
</tr>
<tr>
<td>Antonio Gamboa, MD, MBA</td>
<td>“Steve Jobs, Elon Musk, Warren Buffet, and [University of Texas-El Paso President] Diana Natalicio.”</td>
</tr>
<tr>
<td>Melissa E. Lucarelli MD, FAAFP</td>
<td>“Mrs. Kobida (my 8th grade math teacher), Marie Curie, and my mom.”</td>
</tr>
<tr>
<td>Joseph E. Scherger, MD</td>
<td>“[Neurologist] David Perlmutter, MD.”</td>
</tr>
<tr>
<td>Salvatore Volpe, MD</td>
<td>“My parents.”</td>
</tr>
</tbody>
</table>

The board members that contribute expertise and analysis to help shape content of *Medical Economics*. 
“You want to avoid the situation where the patient is talking to the back of the doctor’s head while they’re typing.”

GARY LEROY, MD, MEDICAL DIRECTOR, EAST DAYTON COMMUNITY HEALTH CENTER

PAGE 8

“Many physicians have built their business based on word of mouth. Now, that’s not enough when convenience is three times more compelling.”

KAVEH SAFAVI, MD, SENIOR MANAGING DIRECTOR, ACCENTURE

PAGE 26

The number of EHR-related malpractice claims in 2014-2016, according to the Doctors Company

PAGE 14
Advertising in Medical Economics has accelerated the growth of our program and business by putting me in contact with Health Care Professionals around the country who are the creators and innovators in their field. It has allowed me to help both my colleagues and their patients.

Mark J. Nelson MD
FACC, MPH
E-mail: mjnelsonmd7@gmail.com

Reach your target audience.
Our audience.

Contact me today to place your ad.

Tod McCloskey, Sales Manager
440-891-2739
COMING NEXT ISSUE

The rise of patient consumerism

There's a growing consumer force making its presence known in medicine: convenience. Patients are now demanding the same expectations from practices that they do from restaurants or retailers, and if they don’t get them, they find another doctor. Our coverage details this trend and explains how practices can keep patients satisfied in an age of consumerism.

“They give great care here but they don’t update their magazines very often.”
Concerned about changes coming from Washington, D.C.? Want strategies to boost your bottom line? Curious as to what your peers across the nation are thinking?

Sign up for our free weekly e-newsletters and discover effective strategies to run a successful practice. Each Monday, Wednesday and Saturday, we provide up-to-date coverage of the industry and issues that affect physicians’ everyday lives.

Get the latest on:

- Technology solutions
- Financial strategies for you and your practice
- Viewpoints from fellow physicians
- Legal issues
- Coding tips and insight
- National policy issues
- And much more

SIGN UP TODAY! Visit https://www.medicateconomics.com/user/register