CONSUMER MEDICINE

Patients demand convenience.
Here’s how to provide it.
Online physician reviews: What do they actually measure?

Roughly half of adults under the age of 50 routinely check online reviews before buying a product for the first time, and nearly three out of four patients will use online reviews as the first step in finding a new doctor.

Yet, a 2019 study of more than 180,000 physician reviews, conducted through the University of Maryland, found that 8% were completely fake. Meanwhile, the remaining genuine ratings have been shown more to reflect a patient’s general experience, physician friendliness, and overall atmosphere, while failing to provide any objective measure of quality of care. With these statistics in mind, it is easy to see how the patient attempting to make an informed decision could be easily misguided.

On the opposite side of the equation are the physicians being rated. Much has been written from the physician perspective on the frustration with such anonymous patient reviewers, often riddled with tales of vengeful pain medication seekers or unrealistic expectations. The current system leaves physicians and patients alike questioning the trustworthiness and value of unchecked ratings and rankings.

Little has been discussed about the accountability and reliability of the institution and the reviewer. With consumer attention a scare resource, health systems are increasingly leveraging the importance of marketing, through billboards highlighting short wait times and television ads touting high national rankings. Even my small hometown health system, a single-county not-for-profit organization, maintains a staff of 11 in marketing and public relations alone.

To reinforce trust, our systems must support reviewer and reviewee platforms that provide reliable comparison between providers, offices and systems and ensure authenticity. A simple five-star rating system may work for a toaster on Amazon, but is wholly inadequate to offer meaningful impression of a 45-minute complex care management visit.

The questions should be vetted, and related to either the specialty or service environment. While in medicine it would be unimaginable to not use a validated set of questions when performing academic study, the healthcare system at large has passively accepted these unscientific and biased ranking systems.

While conquering the myriad rating systems in existence would be impossible, the profession of medicine could take a giant step forward by agreeing upon and promoting a single reliable platform that could become the primary trusted source. This would include all of the rigors of truthful interaction, patient satisfaction, the physician-patient relationship, appropriate medical decision making, and more.

To inspire trust from patients, this platform should not be embedded with or influenced by monetarily incentivized industry, while for provider trust, it would be essential to minimize biased or fake reviews.

While this seems a massive task, both patients and providers could learn to embrace the use of technology in their search for medical care, and the ever-present specter of “online reviews” could morph into a positive tool for all.

Aaron George, DO, is a family physician practicing in his hometown of Chambersburg, Penn. He was an Andlinger fellow in health policy with the Center for Public Health, and was recently named one of the “40 under 40” physicians by the Pennsylvania Medical Society.
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Physicians must discuss nutrition
Healthy food is a prescription for better health, writes Colin Zhu, DO.

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Despite a blip at the start of the year, U.S. unemployment remains at historic lows. Things are looking great for workers.

And that can be problematic for employers.

Employee turnover is always a concern, but in flush economic times like these it often jumps. Indeed, according to the 2018 North America Mercer Turnover Survey, U.S. companies reported an average 22 percent turnover rate in 2018, up from less than 16 percent in 2014. Personal and family reason drove the majority of these moves, but base salary complaints and overall job satisfaction each drove 24 percent as well, indicative of employees’ new power in the workplace.

If they aren’t happy, they’ll leave.

Nowhere is this more apparent than in the medical office, where support staff are often under intense pressure to perform and face a daily onslaught of incoming calls, patient visits, and other tasks. The typical primary care front desk employee fields 30 inbound calls per day, and handles more than 1,500 patients and 4,300 total encounters per year, according to the MGMA Data-Dive Cost and Operations datasets.

It’s a difficult job, and the turnover numbers reflect that. Annual turnover among front office support staff in primary care offices exceeds 18 percent, and in surgical practices it’s above 20. For clinical support staff, these figures are 16 percent in primary care and 25 percent in surgical.

This constant upheaval can be draining on the staff that does stay, as they are often forced to pick up the slack as well as train new employees year after year. But it’s also a financial drag on the practice overall. Hiring over and over again for the same positions is an expensive proposition, not to mention the fact that, without effective support staff around them, clinicians can’t do their best work.

Faced with these challenges, many employers turn to employee appreciation programs—handing out performance bonuses, awarding extra vacation time, and even providing premium parking options—in hopes of improving the situation.

But it turns out that these programs can often have the opposite of their intended effect.

To read more, visit bit.ly/appreciation-for-support-staff

“Patients are looking for actionable pricing information, but most providers shroud their pricing in secrecy (and U.S. averages and crowdsourced data points are not actionable). So if you or your practice could give patients pricing information, you would quickly realize two things: 1) you’ll be one of the few offering that information and 2) that level of customer service would separate you from the competition.”

—Jonathan Kaplan, MD, MPH, on why price transparency is a customer service opportunity.

“Rather than simply introducing technology with no consideration of its impact on clinicians—as happened with many EHR rollouts—we must establish a way to measure whether a new solution actually improves the lives of clinicians and their ability to provide compassionate, high-quality care.”

—M. Bridget Duffy, MD, on reducing clinician burnout with a fresh look at healthcare technology.

For more, visit bit.ly/MEC-sexual-health

To view, visit bit.ly/13-reasons-for-claim-denials
I appreciate Dr. Alisha Scott taking the time from her busy practice to write her letter “Stop selling primary care physicians short” (Your Voice, May 10, 2019 issue) for my comments about the future of primary care.

Seeing patients “in the clinic, hospital, nursing home, and emergency room... [and doing]...operative vaginal deliveries, cesarean deliveries, postpartum tubal ligations, versions... [and] EGDs and colonoscopies” must leave her exhausted.

I notice that she and many of her supporters are from the western United States. I suspect that many of them practice in communities where specialty care is hard to come by. If that is so, I can understand why she and they are proficient in so many areas of medicine.

In my state of Connecticut, we have many specialists and I have many colleagues in primary care but none of them have practices as diverse as Dr. Scott. Many primary care doctors that I know are discouraged with the intrusions of insurers and the time-consuming distraction of electronic health records.

They also worry about the constant threat of malpractice suits (real or unmerited) which forces them to practice defensive medicine. Maybe these are not issues that affect primary care doctors in the Western United States.

But with the rapid advances of medicine and the emotional and social problems that doctors increasingly have to deal with, I stand by my comments which she disagrees with. I have been in practice for over 40 years and it’s all I can do to keep up with treating my diabetic, cardiac and hypertensive patients. I no longer treat hospital patients or those in nursing homes and I don’t see people in the emergency room. I make the occasional house call for an elderly patient.

It is a fact that medical students are turned off by primary care and those that do finish training are becoming employees of hospitals.

I believe that primary care training will be shortened so that a fully trained provider can be turned out in about six or seven years, bypassing the intense concentration on the basic sciences and focusing on training in community health centers. Those who will practice in areas where specialists are not readily available will probably pursue training in OB/GYN, minor surgery, and in doing EGDs and colonoscopies, among other things.

It is a great shortcoming that the leaders of primary care have not convened local meetings to discuss the future of primary care. I don’t think they know how to define primary in the context of modern medicine.

Be this as it may, Dr. Alisha Scott has done a good thing by continuing this conversation. It is far from over.

To its credit Medical Economics is the only national medical publication that provides a forum for practicing physicians to participate in this primary care issue.

Edward Volpintesta, MD
BETHEL, CONN.
Antibiotic resistance
Effort underway to find new treatments

The news
The National Institutes of Health has awarded a five-year, $33.3 million grant to develop new antibiotics to treat deadly bacteria that have become resistant to current treatments. The grant was awarded to David S. Perlin, Ph.D., chief scientific officer of Hackensack Meridian Health’s Center for Discovery and Innovation in Nutley, N.J.

Perlin will use the grant to establish a Center for Excellence for Translational Research, a public-private partnership that brings together prominent scientists from Hackensack Meridian as well as other institutions and industry.

Who are the researchers?
Senior researchers assembled by Perlin include:
- **Sean Brady**, a chemical biologist at The Rockefeller University in New York City
- **David Alland**, an infectious disease expert at Rutgers New Jersey Medical School
- **Thomas Dick**, drug discovery expert at Meridian
- **Richard Ebright**, a biochemist at Rutgers’ Waksman Institute of Microbiology
- **Terry Roemer**, founder of Prokaryotics Inc., a biopharmaceutical company focused on discovering and developing antibiotics that target multi-drug-resistant bacterial infections.

Who is David S. Perlin, Ph.D.?
Perlin has played a major role in advancing the national research agenda to overcome drug resistant infections. His expertise is in drug discovery, rapid diagnosis of drug resistant bacterial and fungal pathogens in cancer, transplant, and other high-risk patients. He has published more than 250 papers and book chapters and co-authored two books.

The problem
2 million
Number of U.S. patients who are sickened every year from antibiotic-resistant infections.

“We are embarking on a new era for antimicrobial discovery.”
—David S. Perlin, Ph.D., Hackensack Meridian

Number of U.S. patients who are sickened every year from antibiotic-resistant infections.
Monitoring INR levels
Don’t miss out on revenue by LISA A. ERAMO, MA Contributing author

Prior to 2018, payers considered international normalized ratio (INR) monitoring (i.e., the testing and dosage adjustments required to manage warfarin therapy) part of the routine work associated with an office visit. This meant payment was bundled into the evaluation and management (E/M) code when physicians performed these services.

Now, two new CPT codes allow payment when physicians order, review, and interpret new INR test results—even when patients self-test at home: 93792 (patient/caregiver training for home INR monitoring) and 93793 (anticoagulation management for a patient taking warfarin).

This is good news for physicians who frequently treat patients on warfarin, because it means they’ll be paid separately for work they’re already doing, says Rhonda Granja, CPC-I, CPC, lead instructor at the Medical Management Institute in Atlanta. Many physicians still don’t know about these codes even though they’ve been active for more than a year, which means doctors are probably leaving money on the table, she adds.

Consider these four questions before billing for INR monitoring:

1/ Do commercial payers reimburse for the service? Ask commercial payers to include CPT codes 93792 and 93793 in their contract if they haven’t done so already. Don’t assume payers will automatically cover these services just because Medicare does, says Granja.

2/ Will patients have the option to monitor their INR levels at home? Home INR monitoring isn’t only convenient for patients—it also frees up the schedule so physicians can focus on face-to-face visits with patients who have acute problems, says Norman Vinn, DO, family medicine home care physician in Laguna Hills, Calif. Home monitoring also has potential clinical benefits. “You can rapidly get answers and provide almost instant turnaround on dosage advice,” he adds.

One caveat is that not every patient will have the physical and mental abilities to perform INR tests at home, says Vinn. “The operator reliability must be reasonably accurate and consistent,” he says.

Vanessa Vinn, DO, internist in Costa Mesa, Calif. adds that younger and more tech-savvy patients may be the best candidates for home INR monitoring.

3/ How will patients receive INR test results? What workflow will the practice use to communicate results and dosing adjustments? For example, will patients come into the office? Will a physician or nonphysician provider call them? Will staff send results through the EHR portal? A combination? These decisions will ultimately drive how the practice will bill for these services, says Granja.

4/ How will the practice capture revenue? There are several ways in which physicians can bill for INR monitoring. The specific scenario and supporting
Money
Monitoring INR

Three CPT codes for INR monitoring

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2018 national payment amount</th>
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<tbody>
<tr>
<td>85610</td>
<td>Prothrombin time</td>
<td>$4.85</td>
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<tr>
<td>93792</td>
<td>Patient/caregiver training for initiation of home INR monitoring under the direction of a physician or other qualified healthcare professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient/caregiver ability to perform testing and report results</td>
<td>$55.08</td>
</tr>
<tr>
<td>93793</td>
<td>Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed</td>
<td>$12.24</td>
</tr>
</tbody>
</table>

Five coding tips for INR monitoring

1. Don’t report INR monitoring on the same day as an E/M service.

2. When applicable, report patient/caregiver training with a significant and separately identifiable E/M service by appending modifier -25 to the E/M service.

3. Report INR monitoring no more than once per day regardless of the number of tests reviewed.

4. Don’t report INR monitoring or patient/caregiver training with non face-to-face telephone or online services provided by a nonphysician provider (CPT codes 98966-98969) when the telephone or online services address home and outpatient INR monitoring. The same is true for non face-to-face telephone or online services provided by a physician (CPT codes 99441-99444).

5. Don’t report INR monitoring or patient/caregiver training during the service period of CCM services (CPT codes 99487, 99489, and 99490) and transitional care management (TCM) (CPT codes 99495-99496). During the service period means during the same calendar month as CCM or during the 30-day post-discharge period when billing TCM.

documentation will dictate the most appropriate and compliant method. Granja provides the following scenario advice:

Patient monitors INR level at home and comes into the office to discuss results. Report CPT code 93793. Don’t forget to bill CPT code 93792 for the initial patient/caregiver training to provide education regarding use and care of the INR monitor, how to obtain a blood sample, and how to report home INR test results.

Patient goes to an external lab for an INR test and comes into the office to discuss results. Report CPT code 93793.

Patient has an INR test at a lab in the office or at the point of care and follows up with a visit to discuss results. Report CPT codes 85610 (prothrombin time) and 93793.

Patient presents for an office visit during which the physician also discusses INR monitoring. Report CPT code 93793 and the appropriate E/M code with modifier -25. Another option is to report the E/M code with a prolonged service code (CPT codes 99354-99357), but only when documentation includes a detailed description of the additional time spent—what the physician did and why.

Patient requiring INR monitoring already receives chronic care management (CCM) services. Include the INR monitoring in your total CCM time, and report the CCM only (CPT codes 99487, 99489, or 99490). Note that INR monitoring alone doesn’t constitute CCM.

Patient monitors INR level at home or goes to an external lab for an INR test, and the physician or a nonphysician practitioner provides results and instructions via telephone or electronic communications (e.g., through the portal). Report a CPT code from the 98966-98969 or 99441-99444 ranges.

Patient has an INR test at the lab in the office, and the physician or a non-physician practitioner provides results and instructions via telephone or electronic communications (e.g., through the portal). Report CPT code 85610 and a CPT code from the 98966-98969 or 99441-99444 ranges.
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We’re taking the mal out of malpractice insurance. However you practice in today’s ever-changing healthcare environment, we’ll be there for you with expert guidance, resources, and coverage. It’s not lip service. It’s in our DNA to continually evolve and support the practice of good medicine in every way. That’s malpractice insurance without the mal. Join us at thedoctors.com

The nation’s largest physician-owned insurer is now expanding in New York.
Secure financing with the three Cs

Whether starting a new practice, expanding an existing one, or relocating to a new permanent space, there may come a time when you need external funding to elevate your career to the next step.

Deciding which loan you will apply for is only half of the battle. Lenders are going to examine you personally and professionally to determine your credit worthiness. You need to make a strong case for why a lender should issue you a loan.

Before you head to the bank, it may be beneficial to complete a personal audit so you can improve any shortcomings and maximize your chances of receiving the needed funding. To begin, review the three C’s to financing: cash, credit, and character.

Cash
To determine your credit worthiness and ability to repay your loan, your lender will first take a look at your complete financial profile. This may include your personal assets, expenses, and financial history.

Most lenders prefer that you have at least a 10 percent down payment, but you should also have an additional 5 to 10 percent available to cover project costs and overages. These expenses are often underestimated and overlooked, but failure to have additional cash on hand could lead to trouble. Whatever the amount, it is important that you do not completely drain your bank account to meet your down payment requirements.

In addition to maintaining your current lifestyle, you need a cash reserve in case of emergencies. Take inventory of all your assets — property, stocks, investments, and anything else you could liquidate quickly. If you aren’t confident that you have enough capital to keep you out of financial trouble, it may be wiser to postpone your purchase.

Credit
Your personal credit rating will have a large influence on your loan. Lenders like to see a FICO score of at least 650, and your credit history will also be thoroughly examined. An excessive number of late payments and multiple charge-offs are bad signs. Delinquent accounts, foreclosures, and outstanding debt are also red flags. Unfavorable information on your credit report does not automatically mean your loan will be denied, but it will affect the interest rate and amount of funds you receive.

To avoid a higher annual percentage rate and stricter loan terms, get a copy of your credit report before approaching a lender and verify that all of the information is accurate. Credit report errors are common. However, failure to resolve an error before applying for a loan could have a negative impact.

Character
While a lender’s primary job is to examine your financial status, most will also take a look at who you are as a person. If possible, establish a relationship with the lender beforehand or reconnect with a lender. If the two of you have worked together in the past, she may be more inclined to do business with you and assist in ways that best suit your needs.

Your reputation can take you very far, and an established relationship of trust could potentially overshadow faults in your financial history. A lender who sees that you have taken action to aggressively pay down your debt may disregard the fact that you do not have $50,000 in assets. Similarly, evidence that you constantly pay your taxes late may overshadow your near-perfect credit score.

Your practice’s reputation and history can also affect a lender’s decision. If you’re a profitable practice with good community standing, you’re an attractive loan candidate. However, frequent employee turnover, poor ratings, and lack of community support may cause a lender to shy away from your practice.

Remain professional and courteous during communications with your lender at all times to reassure her that you are worthy of funding. The loan process could be lengthy, so make sure you are available and willing to provide the additional information your lender requests. Go the extra mile for her, and she will go the extra mile for you.

Jessie Marolis is the senior vice president of United Community Bank’s Healthcare SBA vertical. Send your finance questions to medec@ubm.com.
2019 changes to Medicare’s teaching physician guidelines

We saw that there are changes to the teaching physician documentation guidelines for 2019. But we aren’t sure exactly what to make of them since they read almost the same as they did before. Can you clarify what the changes mean?

A: At first glance, they do seem to read similarly with, at most, very minor changes.

However, when you are a teaching physician supervising resident(s) on a daily basis, this change can save a good amount of documentation time.

According to MLN Matters MM11171 (effective date of January 1, 2019 and implementation date of July 29, 2019, the policy clarification is in two parts. For the purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

1/ That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and

2/ The participation of the teaching physician in the management of the patient.

In addition, the patient medical record must document the extent of the teaching physician’s participation in the review and direction of the services furnished to each beneficiary.

The extent of the teaching physician’s participation may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

The last sentence is where I think we need to focus. This is because the guidelines previously read, “Documentation by the resident of your presence and participation is not sufficient to establish such presence and participation.”

So what this seems to imply is that Medicare is now allowing the resident or nurse to document the teaching physician’s participation in the visit, which aligns with Centers for Medicare and Medicaid’s (CMSs) less-stringent documentation guidelines for E/M services in general.

Also, the change applies to those visits under the primary care exception in the outpatient setting, which includes the E/M codes listed in the box below.

Remember, the teaching physician guidelines only apply to Medicare patients.

Here is more detail from the CMS Teaching Physicians Fact Sheet, which states (emphasis added):

“You must be identified as the teaching physician who involves residents in the care of your patients on claims. Claims must comply with requirements in the General Documentation Guidelines and E/M Documentation Guidelines sections.

“Claims must include the GC modifier, “This service has been performed in part by a resident under the direction of a teaching physician,” for each service, unless the service is furnished under the primary care exception. When the GC modifier is included on a claim, you or another appropriate billing provider are certifying that you complied with these requirements.”

<table>
<thead>
<tr>
<th>New-Patient Visits</th>
<th>Established-Patient Visits</th>
</tr>
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<tbody>
<tr>
<td>99204</td>
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</tr>
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<td>99205</td>
<td>99215</td>
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Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your coding and billing questions to: medect@ubm.com.
You might feel a little uneasy about starting the discussion about selling your medical practice. The thought of letting go can be overwhelming.

However, the truth is that failing to plan is a plan to fail when it comes to your practice exit strategy. Everyone thinks of their future, but they don’t always take active steps in the present to prepare for what they want tomorrow.

But the time will come when you must step away. You need to have a plan to leave your practice — regardless of your age, experience, or long-term career goals — out of respect to your employees, in an effort to prioritize patient care, and to ensure your family’s well-being. Here are several reasons why you should start the succession planning conversation today.

YOU HAVE INCREASING FAMILY OBLIGATIONS

Owners can run medical practices and have families but balancing the two can be difficult. If obligations, such as caring for an ill family member, or your children’s educational or extracurricular commitments are taking time away from your practice, you could experience a negative shift in the dynamic of your practice. If you don’t have a team in place that can run the practice without you for a few days, consider bringing in reinforcements.

Bringing in a physician partner or strategic partners, such as a management services organization or private equity firm, can help free up time for your family while still allowing you to actively contribute to your practice’s growth. These types of partnerships don’t require you to immediately exit from your practice and allow you to discuss future end goals with your new partner(s).

YOU HAVE PERSONAL HEALTH ISSUES

Personal health issues are pulling you way from the practice. When your personal health is in decline, it can be difficult to continue business as usual. As the practice owner, you don’t need the undue stress caused by juggling an illness and the medical practice. Furthermore, your priorities might change if you find your health or the health of a loved one declining.

Your view on where your time needs to be spent might shift from a focus on growing your practice to strengthening your personal relationships. Spending time away from the practice may be best for you personally, but it will have a direct negative effect on your practice’s revenue and daily operations. This makes the goal of achieving maximum value more challenging. Therefore, having a succession plan is essential.

YOU DON’T HAVE A SUCCESSOR

You’re a great leader, and you run your practice like a well-oiled machine. But what happens when you’re gone? If you find your em-
ployed physicians aren’t interested in taking over, or if you don’t have any employed physicians, you need to know what you will do when it’s time to leave your practice.

YOU’RE FEELING BURNT OUT
Running a practice takes a lot of tenacity. Burnout can creep in slowly and take hold in what feels like an instant. It’s important to balance your work life and home life, and that takes commitment and constant fine tuning.

You need to set boundaries to make it effective. If you don’t have a good handle on taking time for yourself, and you are just barely keeping things afloat, exiting partially (such as by bringing on a physician partner, engaging private equity, or joining a management services organization) might be a good option to help you reclaim time to yourself while still maintaining, and hopefully growing, your practice.

YOU AREN’T DOING WHAT YOU LOVE
You had an ambitious view of starting your own practice. You intended to bring outstanding patient care to a community. You were excited and ready to go. Everything started strong and innovative ideas were flowing. Then, you hit a wall or find yourself spending your time on administrative tasks.

If so, it’s time to take a step back and reflect on what you are doing and what you would like to be doing, then see who can help pick up the slack.

YOU’RE HAVING GROWTH PROBLEMS
Your practice has grown a great deal, but now you’ve reached a plateau. You aren’t performing patient outreach like you used to. You don’t have time to research your competitors. You aren’t bringing new ideas to your practice because all your time is tied up in making sure the practice stays afloat and doesn’t fall behind.

How can you continue to experience growth when you can barely keep up with your practice as it is? It might be time to consider bringing in a partner who can develop a synergistic platform to help take your practice to the next level.

We all know that anything can happen at any time. What will you do if something happens that requires you to step down from your practice sooner than anticipated?

As a business owner who is responsible to your employees and patients, it’s important that you consider succession planning before it becomes necessary.

Remember, there are ways to plan so that you can continue doing what you love. Succession planning doesn’t necessarily mean leaving entirely, but it does mean being prepared for the future. Spend some time in thoughtful reflection about your goals, your reality, and any changes that you wish to make. Bring your ideas and concerns to a financial adviser or other trusted expert who can help you find the work-life balance you need, both now and in the future.

“...regardless of your age, experience, or long-term career goals — out of respect to your employees, in an effort to prioritize patient care, and to ensure your family’s well-being.”

Nick Hernandez, MBA, FACHE, is the CEO and founder of ABISA, a consultancy specializing in strategic healthcare initiatives for physician practices. His firm helps devise and implement strategies that will allow practices to remain competitive and solvent.
SELECTED SAFETY INFORMATION

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

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

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

**Acute Kidney Injury and Impairment in Renal Function:** STEGLATRO causes intravascular volume contraction and can cause renal impairment. There have been postmarketing reports of acute kidney injury, some requiring hospitalization and dialysis, in patients receiving SGLT2 inhibitors. Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury. Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake or fluid losses; monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment.

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

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

Discover STEGLATRO™ (ertugliflozin): the 4th SGLT2i to market

**YES, WE’RE #4**

As an adjunct to diet and exercise for appropriate adults with type 2 diabetes. STEGLATRO is not for the treatment of type 1 diabetes or diabetic ketoacidosis.

SGLT2i, sodium glucose co-transporter 2 inhibitor.
SELECTED SAFETY INFORMATION (continued)

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

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

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

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

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

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

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

INDICATION

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

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

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

**INDICATIONS AND USAGE**

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

**Limitations of Use**

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

**DOSAGE AND ADMINISTRATION**

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

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

**CONTRAINDICATIONS**

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

**WARNINGS AND PRECAUTIONS**

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

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

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

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

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

**Acute Kidney Injury and Impairment in Renal Function.** STEGLATRO causes intravascular volume contraction and can cause renal impairment (see Adverse Reactions). There have been postmarketing reports of acute kidney injury some requiring hospitalization and dialysis in patients receiving SGLT2 inhibitors.

Before initiating STEGLATRO, consider factors that may predispose patients to acute kidney injury including hypovolemia, chronic renal insufficiency, congestive heart failure and concomitant medications (diuretics, ACE inhibitors, ARBs, NSAIDs). Consider temporarily discontinuing STEGLATRO in any setting of reduced oral intake (such as acute illness or fasting) or fluid losses (such as gastrointestinal illness or excessive heat exposure); monitor patients for signs and symptoms of acute kidney injury. If acute kidney injury occurs, discontinue STEGLATRO promptly and institute treatment.

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

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

**Lower Limb Amputation.** An increased risk for lower limb amputation (primarily of the toe) has been observed in clinical studies with another SGLT2 inhibitor. Across seven Phase 3 clinical trials in the STEGLATRO development program, non-traumatic lower limb amputations were reported in 1 (0.1%) patient in the comparator group, 3 (0.2%) patients in the STEGLATRO 5 mg group, and 8 (0.5%) patients in the STEGLATRO 15 mg group. A causal association between STEGLATRO and lower limb amputation has not been definitively established.

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

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

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

Patients treated with STEGLATRO presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise, should be assessed for necrotizing fasciitis. If suspected, start treatment immediately with broad-spectrum antibiotics and, if necessary, surgical debridement. Discontinue STEGLATRO, closely monitor blood glucose levels, and provide appropriate alternative therapy for glycemic control.
Genital Mycotic Infections. STEGLATRO increases the risk of genital mycotic infections. Patients who have a history of genital mycotic infections or who are uncurricumised are more likely to develop genital mycotic infections [see Adverse Reactions]. Monitor and treat appropriately.

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

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

ADVERSE REACTIONS

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

Pool of Placebo-Controlled Trials Evaluating STEGLATRO 5 and 15 mg. The data in Table 1 are derived from a pool of three 26-week, placebo-controlled trials. STEGLATRO was used as monotherapy in one trial and as add-on therapy in two trials. These data reflect exposure of 1,029 patients to STEGLATRO with a mean exposure duration of approximately 25 weeks. Patients received STEGLATRO 5 mg (N=519), STEGLATRO 15 mg (N=510), or placebo (N=515) once daily. The mean age of the population was 57 years and 2% were older than 75 years of age. Fifty-three percent (53%) of the population was male and 73% were Caucasian, 15% were Asian, and 7% were Black or African American. At baseline the population had diabetes for an average (53%) of the population was male and 73% were Caucasian, 15% were Asian, and 7% were Black or African American. At baseline the population had diabetes for an average of 7.5 years, had a mean HbA1c of 8.1%, and 19.4% had established microvascular complications of diabetes. Baseline renal function (mean eGFR 88.9 mL/min/1.73 m²) was normal or mildly impaired in 97% of patients and moderately impaired in 3% of patients.

Table 1 shows common adverse reactions associated with the use of STEGLATRO™ (ertugliflozin). These adverse reactions were not present at baseline, occurred more commonly on STEGLATRO than on placebo, and occurred in at least 2% of patients treated with either STEGLATRO 5 mg or STEGLATRO 15 mg.

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

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

* The three placebo controlled studies included one monotherapy trial and two add-on combination trials with metformin or with metformin and sataxitin.

† Includes: candidiasis, genital infection fungal, vaginal infection, vulvitis, vulvovaginal candidiasis, vaginal mycotic infection, and vulvovaginitis. Percentages calculated with the number of female patients in each group as denominator: placebo (N=235), STEGLATRO 5 mg (N=252), STEGLATRO 15 mg (N=245).

‡ Includes: balanitis candida, balanoposthitis, genital infection, and genital infection fungal. Percentages calculated with the number of male patients in each group as denominator: placebo (N=280), STEGLATRO 5 mg (N=267), STEGLATRO 15 mg (N=265).

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

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

<table>
<thead>
<tr>
<th>Study</th>
<th>Placebo N=154</th>
<th>STEGLATRO 5 mg N=158</th>
<th>STEGLATRO 15 mg N=155</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>1.39</td>
<td>1.38</td>
<td>1.37</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>46.0</td>
<td>46.8</td>
<td>46.9</td>
</tr>
<tr>
<td>Week 6 Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>-0.02</td>
<td>0.11</td>
<td>0.12</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>0.6</td>
<td>-3.2</td>
<td>-4.1</td>
</tr>
<tr>
<td>Change from Baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>0.02</td>
<td>0.08</td>
<td>0.10</td>
</tr>
<tr>
<td>eGFR (mL/min/1.73 m²)</td>
<td>0.0</td>
<td>-2.7</td>
<td>-2.6</td>
</tr>
</tbody>
</table>

Renal-related adverse reactions (e.g., acute kidney injury, renal impairment, acute prerenal failure) may occur in patients treated with STEGLATRO, particularly in patients with moderate renal impairment where the incidence of renal-related adverse reactions was 0.6%, 2.5%, and 1.3% in patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively.
Increases in Hemoglobin. In the pool of three placebo-controlled trials, mean changes (percent changes) from baseline to Week 26 in hemoglobin were -0.21 g/dL (-1.4%) with placebo, 0.46 g/dL (3.5%) with STEGLATRO 5 mg, and 0.48 g/dL (3.5%) with STEGLATRO 15 mg. The range of mean baseline hemoglobin was 13.90 to 14.00 g/dL across treatment groups. At the end of treatment, 0.0%, 0.2%, and 0.4% of patients treated with placebo, STEGLATRO 5 mg, and STEGLATRO 15 mg, respectively, had a hemoglobin increase greater than 2 g/dL and above the upper limit of normal.

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

DRUG INTERACTIONS

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

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

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

USE IN SPECIFIC POPULATIONS

Pregnancy.

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

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

The estimated background risk of major birth defects is 6-10% in women with pre-gestational diabetes with an HbA1c >7 and has been reported to be as high as 20-25% in women with HbA1c >10. The estimated background risk of miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Clinical Considerations.

Disease-Associated Maternal and/or Embryo/Fetal Risk. Poorly-controlled diabetes in pregnancy increases the maternal risk for diabetic ketoacidosis, pre-eclampsia, spontaneous abortion, preterm delivery, stillbirth, and delivery complications. Poorly controlled diabetes increases the fetal risk for major birth defects, stillbirth, and macrosomia-related morbidity.
Animal Data. When ertugliflozin was orally administered to juvenile rats from PND 21 to PND 90, increased kidney weight, renal tubule and renal pelvis dilatation, and renal mineralization occurred at doses greater than or equal to 5 mg/kg (13-fold human exposures, based on AUC). These effects occurred with drug exposure during periods of renal development in rats that correspond to the late second and third trimester of human renal development, and did not fully reverse within a 1-month recovery period.

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

Lactation.

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

Data.

Animal Data. The lacteal excretion of radiolabeled ertugliflozin in lactating rats was evaluated 10 to 12 days after parturition. Ertugliflozin derived radioactivity exposure in milk and plasma were similar, with a milk/plasma ratio of 1.07, based on AUC.

Juvenile rats directly exposed to STEGLATRO during a developmental period corresponding to human kidney maturation were associated with a risk to the developing kidney (persistent increased organ weight, renal mineralization, and renal pelvic and tubular dilatations).

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

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

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

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

OVERDOSAGE

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

For more detailed information, please read the Prescribing Information.
Here’s a growing consumer force making its presence known in medicine: convenience.

In the past, a practice could offer a handful of Saturday appointments and that was about the only convenience patients expected. But 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.

“If practices don’t adapt, they will see patients slowly migrate elsewhere,” says Susanne Madden, MBA, president and CEO of The Verden Group, a Nyack, NY-based healthcare consulting firm. Madden has first-hand experience, having recently switched providers herself.

“I was on hold for 12 minutes to book a simple annual physical,” says Madden. “I used that time instead to fill out a transfer medical form and booked an appointment with a larger practice online and picked a new doctor.”

Twelve minutes may not seem like much, but it was enough of an inconvenience for Madden to make the switch. She says if practices want to survive, they need to cater to consumer behaviors in medicine, even if there are no other doctors in town. “Some rural doctors might get patients not because they are amazing doctors, but because there aren’t many options,” she says. “But the day a competitor moves into town with a higher level of care access and communication, they’ll be out of business. They need to take the time to up their game.”

Competition is coming from urgent care facilities as much as other medical practices, experts say, and often have the funds and expertise to give consumers exactly what they want and redefine what an appointment with a doctor looks like.

Take GoHealth Urgent Care. Backed by private equity, its mission is to “redefine the
Money

Patient consumerism

“Understand this is happening whether or not you want it to. You can’t stop it, and you can’t opt out from consumerism. All patients have been consumers in other parts of their life, and now it’s coming to medicine.”

— KEN HERTZ, FACMPE, CHIEF CONSULTANT, MGMA

healthcare experience.” It has 125 centers and is opening 30 more in the next year.

GoHealth partners with local health systems and builds facilities with convenience at their core. Patients can compare wait times for GoHealth facilities online, make an appointment at the one with the shortest wait, and upon arrival, check-in via kiosk. Office designs are bright and open, and patients enter exam rooms where high-tech electrostatic glass walls change from clear to frosted for privacy. All equipment is either in the room or brought to the patient, so no moving about the office if, say, an x-ray is needed. Wall-mounted screens show the patient what the doctor is looking at and entering into the health record, and there is no checkout when the patient is finished—they just leave.

“We compare ourselves to a restaurant, where consumers will not return after one or two poor experiences,” Dev Ashish, CIO of GoHealth, said at HIMSS19, an annual health IT convention. “The same rules apply to healthcare.”

He said that instead of relying on the long patient satisfaction questionnaire with a low response rate that many in the healthcare industry use, GoHealth relies on a simple Net Promoter Score, which asks how likely someone is to recommend their services to a friend on a one-to-10 scale. Their response rate is between 40 and 50 percent, providing GoHealth with lots of data and is the same method used by the nation’s largest retailers. The company follows up with anyone offering specific feedback, good or bad.

The transformation toward consumer-focused convenience in healthcare is similar to what he saw in the banking industry, says Mat Kremke, MBA, the vice president of the American Osteopathic Association. “When I started [in banking], we would sit at a desk and people would just come to us,” says Kremke. “Then banks added Saturday hours, then they opened up branches in grocery stores, then extended hours to 9 p.m.—if they didn’t adjust, they would be forced to close down. The medical industry is next on the list for consumers, who expect convenient-to-use digital platforms.”

Consumer expectations are changing in part because they are shouldering more of their healthcare costs through higher premiums, copays and deductibles, says Madden. “I’ve seen patients seeking out everything from price transparency to wanting the same sort of service they can get elsewhere,” she says. “If they can book a hotel or flight at midnight, why do they have to call during the workday to book an appointment and get to spend time on hold for the privilege of doing so? They are looking for the same level of service and access as they would get from a service business.”

ADAPTING TO THE PATIENT AS CONSUMER

The first step to adjusting to the patient-as-consumer is to understand how they view healthcare. “There needs to be an acknowledgement that we are in the service industry,” says Ken Hertz, FACMPE, chief
consultant for the Medical Group Management Association. "We provide a service, just like a restaurant. We have to see ourselves the same way."

The biggest thing consumers want is convenience, even more so than a relationship with their doctor. "They want their interaction to be easy and simple," says Hertz. They are looking for convenient appointment times that fit their schedule and visits that are fast and efficient, he adds. In addition, they want to understand all the costs, including whether any referrals are in or out of their network, and be given online payment options.

While this list may sound daunting to a small practice owner, experts say there are some basic steps that can identify the conveniences most important to their patients. The first step is to ask the patients, says Madden. "Every day as a patient is checking out, hand them a two- or three-question survey, and that will tell you everything you need to know," says Madden. If a practice is looking at extending office hours, ask what days and times are most convenient for them. "Also, don't forget to survey your staff for their ideas," she adds. "They are hearing from patients and observing when the process begins to break down and patients become unhappy."

Kremke says to also look at what conveniences competitors are offering, and leverage technology to help be more efficient and offer a positive experience. This means offering online check-in, easy payment options, and increased communication. "The patient is expecting the experience to be seamless and not time consuming, and wants it to be almost as quick as ordering a drink at Starbucks," says Kremke. "They want to see the physician as quickly as possible and walk out."

Finding the right technology solution is important, but everyone, including the staff, has to buy in to the commitment to customers, experts say. "You can't do things the old way; things have to change," says Hertz. "Every team member in the practice has to be engaged in the vision, mission, and values of the practice and needs to be held accountable for creating an experience for patients that is second to none. One of the most important things anyone can do is just listen to people."

**PRIORITIZING SOLUTIONS**

When survey results are analyzed, certain patterns of what patients are concerned about will start to emerge. Madden says to identify the top three and then do a follow-up survey using open-ended questions to get more information about these areas. This will provide the details to help the practice figure out how to meet patient demand, whether it's a piece of technology or just a different process.

She says it's vital to involve the staff when discussing survey results and potential improvements. "The buy-in piece is important, and without it, you won't be able to implement anything," says Madden. "You will end up with a lot of information about what's wrong, but not have any mechanism to transform the practice." Focus on the first three areas identified in the surveys and implement the solution that fits the culture and budget of the practice. "Once some meaningful changes happen in the practice, the staff will be much more willing to keep going," she adds.

Start small to increase chances of success, experts say. For a primary care practice, the mere thought of taking the time to implement process improvements can be overwhelming. "Pivot slowly and build on your early wins," says Madden. "You want to build a culture of ongoing process improvement."

These changes will ultimately boost the viability of the practice. "What's good for the patient is good for the practice," says Alex Mangrolia, director of product management and digital transformation for Los Angeles-based Practice Builders, a healthcare consulting firm. "The practice is in business to earn money, and making customers happy is vital."

Mangrolia says physicians should check with their EHR vendor to see what tools might be available through the patient portal. For example, if

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“We compare ourselves to a restaurant, where consumers will not return after one or two poor experiences. The same rules apply to healthcare.”

—DEV ASHISH, CIO, GOHEALTH
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“One of the biggest things you want to look at when evaluating technology solutions is how easy does it tie in to the rest of your practice. The last thing you want is the need to sign in to 15 programs for one patient.”

— MAT KREMKE, MBA, VICE PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION
Meeting the demands of younger patients

In many ways, Millennials and Generation Z patients are leading the way on patient consumerism behavior. Here’s a look at seven things young adults want from healthcare and how shifting demographics are shaping the future of our entire healthcare delivery system.

CONVENIENCE
Research reveals that 45 percent of Americans between the ages of 18 and 29 do not have a primary care physician. For 30- to 49-year-olds, that number is around 28 percent, and only 18 percent of Americans between 50 and 64 are without a PCP.

For millennials and younger generations, maintaining a long-term relationship with one family doctor is taking a backseat to cost-cutting and convenience. But how long this trend continues remains something of an open question.

Doctors warn that trading lasting relationships with physicians in return for lower costs and higher convenience could damage quality of care. A JAMA Internal Medicine report revealed that almost half of all patients who visited a walk-in clinic left with an unnecessary prescription or referral.

SAME-DAY APPOINTMENTS
Between 2014 and 2017, the average wait time for a new patient appointment with a doctor rose from 18 days to 24 days. Wait times vary throughout the U.S., but they are relatively lengthy almost everywhere. Dallas patients wait an average of 15 days to see a new physician while Boston residents have an average wait of 52 days.

Healthcare systems and independent practices that want to draw a younger crowd and stay relevant must do everything in their power to see new and existing patients quickly— and offering same-day appointments can help achieve that. Many healthcare companies have ramped up their hiring over the last few years in an attempt to meet this demand.

TRUSTWORTHINESS
There are some things that no amount of technology and well-meaning legislation can create out of thin air—and personal integrity is one of them. Millennials and Gen Z stand out from older generations in that they have a relative, but still statistically significant, lack of trust in physicians. Just 58 percent of young people trust their doctors, compared with 73 percent in the general population.

ONLINE SCHEDULING AND DIGITAL ACCESS TO RECORDS
Appealing to younger patients and growing your practice involves making sure patients can access your availability and schedule an appointment at their convenience. It’s good for your receptionists, too, because they won’t be quite as swamped with calls during your available hours.

Young people grew up with technology at their fingertips, so it informs how they consume just about everything. Having easy digital access to personal health records is a priority for 92 percent of young people today. Among Millennials and Generation Z, according to surveys, 70 percent of patients would prefer dealing with a doctor’s office that has its own app, including scheduling tools and access to their patient health data.

FLEXIBLE HOURS
Even as remote consultations become increasingly popular, there will always be situations that call for an in-person visit. But for busy young professionals, fitting their appointments into the standard nine-to-five workday often comes at the expense of their professional and personal obligations.

For cases like those, physicians need to be flexible and accessible, and that means emulating the business model of urgent care facilities as much as is feasible—including making your practice available during “non-standard hours” in the evenings and on the weekends.

TRANSPARENT AND UPFRONT PRICING
With young adults increasingly choosing emergency and walk-in clinics over having a primary care physician, the need for pricing transparency has become something of a priority for healthcare industry customers everywhere and of every age group. Some 77 percent of Americans have experienced “sticker shock” over the cost of a medical procedure after it was too late.

“Understand this is happening whether or not you want it to,” says Hertz. “You can’t stop it, and you can’t opt out from consumerism. All patients have been consumers in other parts of their life, and now it’s coming to medicine.”

“Money

Patient consumerism

main viable, they will need to meet consumer demands for great convenience and access. Not doing so will most likely result in a steady drain of patients to a more convenient urgent care facility or a physician with a greater commitment to their needs.
One topic I counsel my clients on is addiction and misuse of drugs by both patients and employees. For example, many practices run into situations where employees have called in false prescriptions, stolen prescription pads or helped themselves to samples, among other similar scenarios.

Fortunately, we find most practices can avoid these situations by ensuring appropriate safeguards. Despite best efforts, even the most compliant and closely regulated practices can still face challenges, and the culprits can be both physicians and non-physicians. Addiction does not discriminate.

**Theft protocols**
I recently helped a client who was dealing with opioid theft among employees. Employee A rifled through Employee B’s purse to steal prescription pain medications, which were appropriately prescribed for a recent surgery. Employee A noticed a few pills missing from her prescription bottle on more than one occasion that she could not account for. Although the practice suspected who the culprit might be, there was no way to say anything without evidence, which was finally obtained through security cameras. The practice confronted Employee B, who with the practice’s support, went to a treatment program. She was not terminated.

The practice took the opportunity to develop new protocols for surveillance of common areas and created a secure storage locker area for staff. They also updated the security protocols related to drug samples and prescriptions. This situation could happen in any business, not just a medical practice, though access to prescription pads and controlled substances do pose additional challenges.

**Forged prescriptions**
Similarly, a large and sophisticated physician practice with many security protocols in place received a call from a pharmacist questioning some unusual prescriptions. The practice determined that the prescriptions were written for patients who visited the practice once but for whom there was no evidence of a prescription in the medical record. It turned out that a feature of the practice’s EHR allowed prescriptions to be canceled after a prescription had already been printed.

This loophole allowed a practice employee to write a large number of false opioid prescriptions undetected for years. The prescriptions were written to a select few individuals, including the employee, all of whom were in the EHR because of a single (now questionable) patient visit. The practice was able to track the deleted prescriptions in the system and identify the culprit. In this instance, the practice had no choice but to immediately terminate the employee and alert the police as well as the DEA.

The client’s EHR vendor has been working to address this loophole, and they have created alerts as well as a cross-check system. However, it is certainly possible that other practices may have the same issue and are simply unaware.

**Gateway to opioids**
All workplaces face some of these challenges as long as there are individuals looking for opioids for themselves or to provide them to others. However, medical practices serve as an easier gateway to opioids and must be on alert at all times.

Developing a strategy is key to protecting and reducing practices’ liability. This can be done through a combination of safeguards, including video surveillance, EHR review and audit, and random employee drug testing (if appropriate). Discuss with your legal advisors what challenges your practice might face and what legal options are available to avoid misuse.

Ericka L. Adler, JD, has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@ubm.com.
5 ways primary care physicians can make their practices LGBTQ+ friendly

Creating an inclusive practice for the LGBTQ+ community requires time and intention. Here are five ways physicians can make their practices more inclusive immediately:

1. **Use inclusive language.** Historically, most primary care practices have been focused on gender-specific patients, so now they need to adjust their language. Words do matter. From the person who answers the phone, to the billing people, to the clinical providers, everyone in the practice needs to retrain and rephrase all patient interaction out of the male-female vernacular to inclusive language. When a woman is on the phone asking about an appointment or a bill, the inquiry should be about her “partner,” not her husband. This can be accomplished by a practice committing to staff training and ongoing quality improvement in LGBTQ+ cultural competency. There are a few organizations with online programs to complete this education, including the Human Rights Campaign, the Family Equality Council, the Gay Lesbian Medical association, and the National LGBTQ Task Force.

2. **Update your forms and marketing collateral.** Websites, paperwork, and all forms need to be reviewed and oftentimes rewritten to be inclusive. Create forms that allow patients to identify a preferred name, their gender identity, sex assigned at birth, and that of their partner’s. People need to be able to register as non-binary. A complete audit also includes asking for feedback from your LGBTQ+ patients. There are always old forms and web pages lingering in every practice.

3. **Change signage.** All physical signage within a practice needs to be inclusive. This includes the patient bill of rights posted prominently in the waiting room explaining that all are welcome regardless of race, religion, national origin, disability or handicap, gender, sexual orientation, gender identity or expression, age, or military service. Even the bathroom signage needs to be inclusive of all genders. Imagery should be updated across the board to reflect all types of families. Waiting rooms should have a mixture of magazines and literature so everyone in the building recognizes that all are welcome. On the website and on your entrance doors should be a rainbow sticker acknowledging your inclusive practice. Additionally, there should be some recognition of pride month in June.

4. **Embrace a different attitude.** Primary care practitioners need to embrace the differing attitudes of LGBTQ+ individuals. How someone identifies does affect their overall health. As a primary care practitioner, you need to know your patients personally. LGBTQ+ people access the health care system with anxiety and a desire for acceptance. They need to feel safe to trust you, which is why you should increase your cultural competence. These patients are less likely to need birth control, and they are at more risk of depression, substance abuse, and discrimination. Men who identify a sexual preference for men need annual STD screening. Women who identify a sexual preference for women still need cervical cancer screening and should be offered the HPV vaccine. Transgender patients may be on hormonal suppressive therapy that changes their risks for heart disease or breast cancer. Commensurate with the acknowledgement of someone’s sexuality and gender identity will oftentimes come a long-term doctor-patient relationship simply because you took the time to ask.

5. **Recognize many shades of grey.** A practitioner must understand that sexuality is often fluid. Relationships are moving away from the male:female; gay:straight binaries. Simply taking the time to ask “Are you sexually active? With whom do you have sex with—men, women, or both?” will allow your LGBTQ+ patients to feel validated and safe in your office. It will also strengthen your ability to better care for them personally.

Mark Leondires, MD, is the practice director of RMA of Connecticut and founder of Gay Parents To Be. Send your practice management questions to medec@ubm.com.
Patient identification is in desperate need of an overhaul—and biometrics could be the answer.

Most consumers are used to using their fingerprint to unlock their phones. That’s just one of the uses for biometric technology, which includes: fingerprint, iris, and facial recognition, as well as palm-vein readers to reduce the authorization fraud and security breaches common with passwords.

Government, financial, travel/logistics and consumer electronic industries have all ramped up use of biometric technology over the last few years and use in the healthcare industry also continues to increase.

The healthcare biometrics market is estimated to be worth $14.5 billion by 2025, due to the increase in healthcare information exchanges and the demand for technology that decreases data corruption and fraud, according to an analysis by Grand View Research. That represents a growth of 23% from 2017 to 2025, and Grand View predicts the growth of consumerism in healthcare will push many organizations to consider biometrics as it becomes the standard in other industries.

Kerry Pillion, director of corporate communication for Imprivata, says the biometrics technology company works with 1,700 global healthcare customers in 39 countries and has seen an increase for the technology in healthcare settings.

“We have seen an increased investment in biometrics by our healthcare customers as a way to accurately identify people in their ecosystems, including patients and clinicians, maintain secure access to protected health information, and secure high-risk work flows such as electronic prescribing for controlled substances,” Pillion says.

Michael Trader, co-founder of RightPatient, Inc., says that his company has seen an increase in hospitals and clinics who are interested in their biometrics technology. Currently, RightPatient supports six different forms of biometric patient identification—fingerprint, finger vein, palm vein, iris, facial, and voice recognition—at 70 hospitals and hundreds of clinics.

“Compared to manual methods of identification that lead to an 18% average duplicate record, $1.5 million annual losses in claim denials, and a significant impact on patient safety, health systems should not see any limitations in implementing biometrics technology,” Trader says.

HIGHLIGHT

Biometrics are helpful for patient identification, which can help make sure patients receive appropriate care wherever they go.

Are biometrics the future of patient care?

Patient identification is in desperate need of an overhaul—and biometrics could be the answer. by DONNA MARBURY Contributing author
to address these issues,” Trader says.

**HOW TO USE BIOMETRICS**

Generally, healthcare organizations are using biometric solutions for two-factor or multifactor identification and single sign-in for staff and patient identification.

Because electronic prescribing for controlled substances is highly regulated, Pillion says that using biometrics is ideal for the required two-factor authentication. The Drug Enforcement Agency requires biometrics to meet criteria for false match rates. According to Imprivata, fingerprint biometric identification has a false match rate of less than one in 1,000.

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance,” Pillion says. “It is an easy, fast, and highly-secure way for prescribers to complete two-factor authentication.”

Patient identification is also a valuable use case for biometrics throughout the care continuum, including at point of care. One use case is radiation oncology, where healthcare providers want to be certain that they are treating the correct patient, Pillion says.

Keely Aarnes, PMP, assistant vice president of business operations for Northwell Health, says the health system is planning to rollout iris recognition for patient identification across more than 600 practices through the next 18 months. Working with RightPatient, Aarnes says the organization was able to pilot the technology at 11 practices before planning to expand across the organization.

“We strategically went with iris recognition, because it takes a high-resolution photo of the patient’s face, which then uses the iris identification and that pattern to create an identifier,” Aarnes says. “That picture can be used for multiple use cases. One, we take that picture and send it through our EHR, which is a better level of identification for the clinician.”

Second, Aarnes says the health system would like to use facial recognition in the future to identify patients as they enter facilities and create a more concierge patient experience.

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.”

— KERRY PILLION, IMPRIVATA

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Biometrics

experience or warn staff of security risks. Aarnes says high-resolution photos provide multiple use cases. “If we know that a patient has arrived, we can welcome them [and] send them messaging and way finding so that they know where to go. It also has a use case in the hospital where we can identify patients that we know we want to intervene early, such as central fraud or drug seeking.” Aarnes believes the initial rollout of the iris recognition technology will allow the health system to solve security and patient experience challenges in the future.

“We need to really start thinking outside the box so we’re not just solving our immediate registration problems in a silo. We need to start thinking about what healthcare looks like in 10 years from now with telehealth services, online scheduling, filling out documents, and registration intake forms,” Aarnes says. “That process has to start with identification. That’s why we chose something that has the ability to be portable and not something that is tied to our registration station.”

OVERCOMING SKEPTICISM

Though consumers are using biometric technology more often, patients and healthcare staff still need to be educated on how it works and why the organization is using these solutions, says Pillion.

“Healthcare organizations that are implementing biometrics will want to be prepared to overcome any stigma associated with this type of technology,” Pillion says. “Some providers or patients may be concerned that the government will get access to their information. However, the data is never shared outside the health system, and with some forms of biometrics such as palm vein recognition, there is no forensic value.”

According to a 2018 survey of 1,000 people by the Center for Identity at the University of Texas, Austin, 58 percent of respondents feel very comfortable with fingerprint recognition technology and about 33 percent are comfortable with other forms of biometrics.

Trader says that the biggest barrier that health organizations face when implementing biometrics is overcoming a culture that is resistant to innovation.

“Patients are becoming increasingly tech savvy and they expect an experience like hospitality or retail,” Trader says. “If health systems acknowledge and embrace this fact, then moving forward with biometrics should not be a difficult process. There will always be skeptics but they are in the vast minority and many of them are typically won over when they see the technology in action and witness first-hand the impact that it delivers.”

Editor’s note: This article was first published in our partner publication, Managed Healthcare Executive.

Three Things to Consider When Investing in Biometrics

1. Start small with scaling to enterprise-wide deployment.
   It’s okay to start small and learn, says Keely Aarnes, PMP, assistant vice president of business operations for Northwell Health.
   “We initially did a proof of concept in September 2018, and we went live with our first site. Looking back, that was a great way to do it, because what we thought would work as far as workflow was completely different than that works in a live environment,” Aarnes says. The health system deployed across 11 more practices in December 2018, with another 40 practices slated for February 2019.
   “After that we’re going to take off very rapidly. We have 600-plus practices, so we envision this will take about 18 months to roll across our organization,” Aarnes says. “Also, we will be implementing our first hospital acute site in June or July 2019. So that will be a whole new workflow that need to be defined and understood.”

2. Think long-term when choosing biometric capabilities.
   Healthcare organizations should be paying attention to regulations that are coming out around telehealth as well as areas such as interoperability, Pillion says.
   “More and more health systems are offering telehealth options, and to do that successfully, they need to be sure that they are correctly identifying the patient who is not physically in front of them,” Pillion says. “Investing in biometrics may help organizations be ahead of the curve when it comes to positively identifying patients and being able to successful treat them in person and remotely.”

3. Consider more robust technology expansion to complement biometric solutions.
   “Health systems should consider much more than just the biometric technology. While important, it is one part of a much larger value proposition that the right platform and partner can deliver,” says Michael Trader, cofounder of RightPatient, Inc.
Primary care physicians, working in an environment where patients need to be evaluated, monitored, and motivated in short office visits, sometimes struggle to effectively treat patients with diabetes. Almost half of patients with diabetes don’t meet their related goals, including A1C blood glucose levels, blood pressure, and LDL cholesterol levels, according to a study in the New England Journal of Medicine. That’s a problem in the U.S., where more than 30 million people are diagnosed with diabetes, accounting for $237 billion a year in medical costs.

The healthcare ecosystem is shifting to value-based medicine, notably through Medicare’s Merit-based Incentive Payment System (MIPS). That program rewards or punishes physicians financially, depending in part on their ability to meet quality metrics, including for patients with diabetes. Physicians are being measured on how they manage their patients’ A1C, blood pressure, LDL cholesterol, smoking cessation and more.

“In the days of meaningful use, there were only rewards,” says Ashok Balasubramanyam, MD, an endocrinologist and professor of medicine in the Division of Diabetes, Endocrinology and Metabolism at Baylor College of Medicine, Houston. “Now we’re in phase of reward and punishment if not met.”

How can doctors motivate their patients to adhere to treatment plans while meeting national quality metrics and maximizing reimbursement for diabetes care?

GIVING PATIENTS RESPONSIBILITY

Given all the metrics to track, such as A1C, the healthcare system has made diabetes mostly about the numbers, says Randall Stafford, MD, Ph.D., an internist and director of the Program on Prevention Outcomes and Practices at Stanford Preventive Research Center, Palo Alto, Calif. By doing that, it’s removed the patient’s ability to feel they’re contributing to their disease management. “If we continue to push for more attention on the numbers, it could backfire,” he says.

One way Stafford motivates his patients is having them correlate how they’re feeling with what they’re doing with their own care, including diet, exercise, and blood sugar management. “It seems like common sense, but we’ve lost track of that to some degree,” he says. “We drastically undersell behavior as a strategy in diabetes.” Behaviors are important links to what people can do to better manage their diabetes, he says.

Stafford avoids using the word exercise with is patients, instead calling it physical activity. “Many people view exercise as something that needs to be difficult and exhausting,” he says. He defines physical activity as something that can be social, like dancing or walking with a spouse. He encourages patients to increase their activity level for a few weeks, and most will realize they feel better. “If the physical activity can

HIGHLIGHTS

- The shift to value-based medicine means physicians will increasingly be on the hook for outcomes related to patients with diabetes.
- Listen to your patients. It can help you understand their struggle, both with adhering to treatments and affording the cost of medication.
“If we continue to push for more attention on the numbers, it could backfire. It seems like common sense, but we’ve lost track of that to some degree. We drastically undersell behavior as a strategy in diabetes.”

—RANDALL STAFFORD, MD, PH.D., INTERNIST, DIRECTOR, THE PROGRAM ON PREVENTION OUTCOMES AND PRACTICES, STANFORD PREVENTIVE RESEARCH CENTER, PALO ALTO, CALIF.

reinforce that correlation with how they feel, that leads to better engagement and better self-management.”

Marc Price, DO, once used scare tactics with his patients, telling them stories of fictional characters, with downfalls that happened when they didn’t take care of their A1C levels. “That didn’t seem to work,” says Price, a family practitioner in Malta, N.Y. Now he uses motivational interviewing, asking patients questions to find out what internal motivators might encourage them to take better care of their diabetes. A patient’s motivation might be improving mobility, so they can play more actively with their grandchildren, for example.

Price also finds it helpful to listen to patients’ struggles, as some share that they can’t afford to pay for medication and also their living expenses. He’ll work with them to find less expensive medications, if possible, and his office provides information on finding cheaper diabetes supplies like testing strips.

He also explains to patients why they should be taking certain actions, even when they feel well. He may tell them to take their statin even if their cholesterol is normal, as diabetes causes life-long changes in various parts of the body.

Lifestyle changes are the hardest for patients to make, so he encourages small changes. “We ask patients to lose 1 pound, not 50, and then we give a lot of feedback,” he says. He tells patients that even a small weight change will help their blood pressure, and he tells them that weight change is mostly a result of dietary adjustment.

WHat CAN PRIMARY CARE DOCTORS DO DIFFERENTLY?

It takes time to find out what issues patients experience while managing their diabetes, and this is further complicated by how short the typical office visit is. Time is the biggest factor in gaining patient trust so they’ll share this information, Balasubramanyam says. Meeting guideline-based metrics and checking them off in the EHR makes it harder to develop that patient re-
Diabetes isn’t one thing. If you treat everybody the same, you get a mixed bag of results that won’t make a difference.”

—Ashok Balasubramanyam, MD, Endocrinologist, Professor of Medicine, The Division of Diabetes, Endocrinology and Metabolism, Baylor College of Medicine

Using population management to treat diabetes

Treating patients with diabetes or those at risk of developing the chronic condition can be improved with population management techniques. Here are some ways to get started:

**Identify the patient population**
Determine the presence of risk factors in your patients. Identify the number of patients with and without diabetes complications, the severity of complications, the extent of comorbidities, the use of health services, and the delivery of preventative care.

**Organize by intensity**
Stratify your practice’s diabetes population into two groups based on the intensity of care required: Newly diagnosed patients with limited complications and patients with complications and comorbidities during the previous two years.

**Analyze resources**
Identify your practice’s strengths and weaknesses in caring for these patients in terms of support staff, educational materials, follow-up services, and more. Assemble patient-friendly diabetes prevention and management protocols, tools, and educational materials to deliver current and consistent care.

**Monitor data**
Use your EHR or another secure systems to collect and assess patients’ clinical performance measures, including hemoglobin A1C, blood pressure, and lipid target values.

**Provide care based on guidelines**
Use evidence-based guidelines adapted from widely accepted standards or practice guidelines to meet local conditions.

**Assess progress**
Document clinical, behavioral, and financial outcomes to show stakeholders, including payers, the value of the services and return on investment. Gather patient feedback with quality-of-life interviews or questionnaires.

Source: National Diabetes Education Program
Operations

Managing diabetes

“We ask patients to lose 1 pound, not 50, and then we give a lot of feedback.”

—MARC PRICE, DO, FAMILY PHYSICIAN, MALTA, N.Y.

With limited time for office visits, using a team-based approach can provide additional patient education and care, boosting reimbursement as well. "If the goal is an A1C below a certain threshold, it doesn’t matter if the physician, dietician, or community health worker is part of that process," Staff ord says. A team-based approach allows the patient to get more attention to the social and psychological dimensions important to some with diabetes.

Endocrinology centers may be better equipped with healthcare extenders, but small offices can bring in specialists as well. Price has a diabetes educator/dietician come to the office once a month. Insurance is billed for these visits, as many of the patients have benefits that cover it. For those with no insurance benefits, Price’s office covers the cost.

The Oak Forest, Ill., county clinic, Oak Forest Health Center, uses a team-based approach to diabetes care. Almost 25 percent of their patients are diagnosed with type 2 diabetes. The team schedules lab tests before visits, calls patients with pending lab orders, preps the upcoming patient charts with A1C values, and conducts a daily huddle to share expectations and information before the day’s visits. Patients complete self-directed goal sheets at each visit, discussing them with the physician, who logs and monitors goals over time. Newly diagnosed patients and those with A1C levels at nine or above, are referred for diabetes education and care management. The program has been successful in better controlling patients’ diabetes.

Though primary care physicians may be tempted to refer out difficult diabetes cases, Staff ord says that primary care physicians should be able to care for patients with relatively complex care, including those on insulin and oral medications. “The primary care approach really is superior, particularly in the ability to see the whole person and all medical issues,” he says. “In my own experience in referring to endocrine, they do a great job in diabetes, but not necessarily treating the totality of a patient’s medical issues.”
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Care coordination
How to close the gaps

by JORDAN ROSENFELD  Contributing author

As healthcare continues its slow but steady shift to a value-based landscape, good care coordination is becoming crucial for physician practices to thrive and for patients to get the best care. To coordinate optimal care, primary care physicians, who are often defined as “the quarterback of healthcare,” need to address common gaps in care and recognize the importance of their role.

The primary care physician’s role can’t be stressed highly enough, according to Clive Fields, MD, chief medical officer and co-founder of VillageMD, a healthcare management company that supports primary care physicians transitioning to value-based care in Chicago, Ill.

Fields says primary care physicians play such a crucial role in healthcare outcomes, that research shows when you add just one more such physician to a population of ten thousand, it results in a 5.5 percent decrease in inpatient admissions, an 11 percent decrease in emergency department utilization and a 7.2 percent decrease in the number of surgeries performed.

He says that employers and payers are recognizing that the most important way to drive economic and clinical value in healthcare is a long-term relationship with a primary care doctor.

However, he makes clear, “Any physician who thinks he can manage a patient by himself without a team is grossly misled,” he says. “Fragmentation of care is the source of all evil.”

“When patients are touching multiple providers with poor care coordination, you get a less than optimal result,” Fields adds.

THE VALUE OF CARE COORDINATORS
It’s important, Fields stresses, for physicians to bring a coordinated care manager of some kind on board, particularly for more complex patient populations, to make sure there are no gaps in care.

“[Care coordinators] understand the healthcare ecosystem, they understand the limitations of people’s insurance and what a patient’s goals are,” Fields says.

For example, among a senior or chronic care population, he says, his primary care teams includes transitional care nurses, chronic care managers, diabetes educators and social workers.

Leesa L. Bain, RN, CSN, MHA, vice president of care coordination, quality management and transitions to community living for Cardinal Health Care in Charlotte, N.C. agrees that physicians need care coordinators and should consider having one in-house. “Physicians are experts in diagnosis and determining what treatment should be. We need physicians to focus on what they’re experts in,” Bain says.
“Care coordinators are trained to know how to wrap that patient in services needed to keep them out of crisis, whether that’s an inpatient admission or pertaining to better quality of life for them,” Bain says.

The role of care coordinator is even more necessary given that there is still no integrated system for sharing patient records. “We have different healthcare records, different physicians prescribing different medications, specialists versus primary care in different settings. That fragmentation has provided a heightened need for care coordination as well.”

Bain says that healthcare is only growing more complex and thus, “The navigational component that care coordinators provide is of the essence and it’s growing.”

She urges physicians not to undervalue care coordinators. “They can make the physicians’ job easier if they let them,” Bain says.

OVERCOMING BARRIERS IN COORDINATED CARE

Despite the importance of care coordination, there’s a long way to go to close the gaps in care. The NEJM Catalyst’s 2016 Care Redesign Insight Report, which looked at how well care is coordinated between the acute setting, post-acute facilities, and the home environment, found that in only 7 percent of the healthcare facilities interviewed was care fully coordinated, and another 10 percent said care was not coordinated at all.

Michael Casamassa, vice president of solutions and planning for Henry Schein Medical in Austin, Texas, says gaps in coordinated care fall under three key problem areas: Lack of time, lack of financial compensation for coordinated care activities, and technology barriers.

“Primary care doctors are simply too busy and that is likely to get worse unless new disruptive models emerge,” he says.

Casamassa says physicians need to make a choice: “It starts with making a decision on whether or not the office is going to manage care coordination internally or outsource the work to a third party. Someone has to own the care. Without that, it’s incredibly disjointed and expenses start to go up exorbitantly.”

If a physician or practice chooses to outsource, he recommends they use a “turnkey platform” that essentially takes over the care coordination activities as well as manages and analyzes key health metrics that help to intervene upon chronically ill patients.

Other technology that either exists in most practice management systems, or can be integrated into them, he says, are online scheduling programs and referral management programs. Investing in this technology can streamline key aspects of care coordination.

Fields believes that true care coordination can’t be fully outsourced. While there are companies that do product care management, transitional care after you leave the hospital, or collect data, he says, “I’m not sure there is anyone can fully outsource the full suite of services needed, especially for chronic or more complex populations.”

USE DATA TO BE PROACTIVE

Whatever approach a practice takes to coordinating care, Fields says, “Physicians can no longer sit around and wait to be sure that patients are getting the best care. We’ve got to deliver a more data driven, proactive from of primary care.”

With the advent of artificial intelligence-based data analytics, he says, “We can reasonably predict, based on social determinants, the risk of readmission or hospitalization.”

“Any physician who thinks he can manage a patient by himself without a team is grossly misled. Fragmentation of care is the source of all evil.”

—Clive Fields, MD, Chief Medical Officer, Co-founder, VillageMD

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Coding tips for transitional care management

By Lisa A. Eramo Contributing author

Transitional care management (TCM) is a payer target for auditing, which means practices need to focus on following the rules when billing this service. Consider the following common TCM denials and how to avoid them:

**Reason for denial:** The practice doesn’t call the patient within two business days of discharge.

**How to avoid it:** Join a health information exchange to receive daily admission discharge transfer (ADT) feeds and discharge summaries, says Samantha Sizemore, chief operating officer at Holston Medical Group PC in Kingsport, Tenn. Then work with the EHR vendor to incorporate this information into the system so staff can view it easily. Consider hiring a patient navigator who can monitor these discharges and reach out to patients in a timely manner to schedule a post-discharge appointment. In small practices with few TCM billings, nurses, medical assistants, or even administrative staff can also perform this task, she adds.

“The idea is to get the patient engaged in the outpatient setting as quickly as possible,” says Shelton Hager, MD, CPC, a primary care physician at Holston who bills TCM approximately five times a month.

**Reason for denial:** The practice doesn’t document the initial call to the patient.

**How to avoid it:** Develop an EHR template for the follow-up telephone call to the patient, says Sizemore. This template should include the date of discharge, time, and date of the follow-up phone call, and a summary of the conversation. Work with the EHR vendor to automatically pull information from this template into the template for the transition of care (TOC) office note, she adds.

The TOC office note should also include checkboxes to remind physicians of the key components of the TCM code (e.g., review the discharge summary, establish or re-establish referrals to community services, and provide patient education). “These are the components that auditors will be looking for,” says Hager.

**Reason for denial:** The patient is not seen within seven or 14 days of discharge.

**How to avoid it:** Save one or more appointment slots per week for hospital follow-up appointments, says Sizemore. Another option is to double book or have the patient see a different provider in the practice, she adds.

**Reason for denial:** The patient is readmitted or dies within 30 days of discharge.

**How to avoid it:** One option is to hold the TCM claim for 30 days and manually review ADT data before billing to ensure the patient hasn’t died or been readmitted. Another option is to bill TCM at the time of service under the assumption that the patient won’t die or be readmitted. If the patient is readmitted or dies within 30 days of discharge, Medicare will automatically recoup the TCM payment; however, practices can refile the claim using an E/M code based on the documentation. “If you don’t refile it, then you forfeit the payment for the TCM service altogether,” says Sizemore.
He recommends that a nurse or nurse practitioner takes on the role of care coordination, particularly for chronic or elderly populations, and uses data that comes directly from the electronic health records to determine their workflow. “They know in real time who’s been sick, who’s in the hospital, whose lab values are abnormal, for example,” Fields says. “They are reactively reaching out to people rather than waiting for the patients to come to them.”

He gives two examples: One, if an elderly woman becomes a widow, he says she is likely to become more prone to anxiety, loneliness, and depression. Seniors in these situations are also at risk of suicide.

Fields suggests that in cases like these, a single call or check-in won’t be enough to help this patient recover from their loss and integrate back into society. She’ll need consistent follow up.

Another example, he says, is a patient with chronic obstructive pulmonary disease (COPD), who goes to the hospital every September, “Then I’m not a good doctor if I don’t do something about it in August. That’s the tool set physicians will need—the ability to use data to drive proactive interventions instead of waiting for the phone to ring.”

One approach called the “guided care model,” developed out of Johns Hopkins University, validates the value of nurses in coordinating care for patients with chronic diseases such as diabetes and high cholesterol, is the

In this model, a registered nurse (RN) takes responsibility for patients with more than one chronic condition. The RN makes an assessment of the patient’s care needs, create care plans and teach the patients themselves, and their caregivers, how to manage their particular health conditions. The RNs then work directly with the primary care physician to create a care plan and monitor patients over time, arranging transitions between care settings and helping them access community resources.

One study of this model yielded promising results: total health care costs decreased by 11 percent, with patients saving $1364 annually.

**FINANCIAL COMPENSATION**

Fortunately, the Centers for Medicare and Medicaid Services (CMS) has made one aspect of coordinated care a little easier for physicians: they’re now making it possible for physicians to get paid for activities that previously had no reimbursement codes, such as cognitive services, electronic communication with other providers, and transitional care management, Fields says.

“Care coordinators are trained to know how to wrap that patient in services needed to keep them out of crisis, whether that’s an inpatient admission or pertaining to better quality of life for them.”

—LEESA L. BAIN, RN, CSN, MHA, VICE PRESIDENT OF CARE COORDINATION, QUALITY MANAGEMENT AND TRANSITIONS TO COMMUNITY LIVING, CARDINAL HEALTH CARE, CHARLOTTE, N.C.

Several years ago CMS introduced new CPT codes for chronic care management and remote patient monitoring, for example. “Clinicians are allowed to bill for time that is spent in non-face-to-face clinical interactions,” Casamassa says. This includes such activities as updating care plans, facilitating coordination with specialists, and even monitoring the health metrics associated with chronic care.”

While there’s no single right way to close the gaps in care coordination, Casamassa says, it’s important that physicians start to take steps as soon as possible. “Effective care coordination is central to the overall success of our healthcare delivery system in the United States,” he says. □
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Healthy food is a prescription for better health

The burden of chronic disease plagues our nation. Every day, we treat patients with diabetes, heart disease, cancer, stroke, and the list goes on. As a family physician, this is what we anticipate—and even expect—to treat every single day.

But what if we didn’t have to treat patients with as many chronic conditions or comorbidities? Physicians around the country are learning the truth to what our mothers know about feeding us chicken soup when we’re sick: Food is medicine. We need to start viewing food as a way to treat disease. After all, the majority of the top killers of Americans are lifestyle related.

A recent Time Magazine piece highlighted programs like Geisinger’s Fresh Food Farmacy, where patients can pick up fresh produce and recipes along with their prescriptions. Other healthcare organizations and insurers are following suit, including OhioHealth Riverside Family Practice Center in Columbus, Ohio.

This information is not new, nor is the advice we give to our patients to exercise and eat more fruits and vegetables. Typically, my patients respond in one of three ways:

- they want to just take a pill,
- they have no intention to change, or
- they ask, “What do I do next?”

When they ask what to do, my response is to consume a diet full of plants such as green, leafy, and starchy vegetables; beans; legumes; nuts or seeds, such as flaxseeds and chia seeds; and whole, unrefined grains. I advise my patients to strive for at least 30 minutes of a daily physical activity they enjoy that is brisk enough so they cannot maintain a conversation. I also recommend they try to avoid alcohol and smoking as well as practice mindfulness and gratitude daily.

Unfortunately, my recommendations are often met with blank
stares. But, to be honest, I don’t blame my patients. There is a severe lack of education about nutrition and food in general, for our patients as well as for us physicians.

According to a recent survey in the American Journal of Clinical Nutrition, only 27 percent of medical schools actually required a nutrition course. Additionally, the American Journal of Lifestyle Medicine also recently indicated that with “recent data on the rising cost and loss of quality of life secondary to preventable causes, there is an absolute need for a drastic reform of the US medical education system.”

I remember my nutritional education in medical school equated to around 10 credit hours. All of it was biochemistry. I did not learn about the elements of food preparation, how to read a nutrition label, or the environmental awareness of where our food comes from.

However, something I observed early on in medical school was that most of the chronic diseases we were studying were caused by a diet, exercise, and lifestyle imbalance. That made me wonder why there was a heavier emphasis on pharmacology than the eating patterns of diabetic or obese patients. There was no instruction on how plant-based dietary patterns reversed heart disease, as Dean Ornish, MD, proved almost 30 years ago through Ornish Lifestyle Medicine.

I wasn’t satisfied with advising my patients to, “Eat better or move more.” After medical school, I pursued a certification in health coaching at the Institute for Integrative Nutrition and a diploma in health-supportive and plant-based culinary arts from the Natural Gourmet Institute. Now, when I talk to my patients about diet and exercise, I can break down the importance of meal prepping, grocery shopping, and concepts of nutritional density versus caloric density of foods.

“What usually motivates my patients isn’t their health but a connection to personal goals.”

I’m dedicated to sharing these principles with my patients, regardless of why they came in for an appointment, because treating patients’ lifestyle is the best possible medicine.

Some of my less motivated patients roll their eyes at me when I talk about their diet. It’s the same look I get when I tell patients who smoke that smoking is bad for them. They know it, but they aren’t motivated enough to change — yet.

Finding that motivation to change your habits is difficult. I have found that patients who want to change usually get stuck at meal planning. I encourage them by reminding them the prep work is 90 percent of the battle. Or my patients hesitate because they incorrectly assume that eating more plants means sacrificing flavor. Those patients usually salivate when I describe how to create an Indian eggplant curry or a spicy vegan gumbo, proving that healthier foods can also be tasty.

In the end, what usually motivates my patients isn’t their health but a connection to personal goals. It’s helping them to see that making these changes will lengthen their lives and ensure they will see their children get married or grandchildren graduate college. In addition to the personal health benefits of changing to more of a plant-based lifestyle, we need to eat better for our planet’s health.

We are past the point where diet has just a direct correlation with our health. It now affects our planetary health. According to a report by the EAT-Lancet Commission:

“Unhealthy diets pose a greater risk to morbidity and mortality than does unsafe sex and alcohol, drug, and tobacco use combined. Because much of the world’s population is inadequately nourished and many environmental systems and processes are pushed beyond safe boundaries by food production, a global transformation of the food system is urgently needed.”

We are headed for change whether we like it or not thanks to climate change, pollution, less agricultural land in favor of raising livestock, and an estimated population of 10 billion by 2050. We can reverse, or even avoid, this grim future if we change what we eat and how we think about food.

If you became a physician to make a lasting impact on the world, now’s your chance. There’s never been a better time for all of us to come together.

Colin Zhu, DO, is the creator of TheChefDoc and author of Thrive Medicine: How to Cultivate Your Desires and Elevate Your Life.
“All patients have been consumers in other parts of their life, and now it’s coming to medicine.”

KEN HERTZ, FACMPE, CHIEF CONSULTANT, MGMA

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“We drastically undersell behavior as a strategy in diabetes.”

RANDALL STAFFORD, MD, PH.D., STANFORD PREVENTIVE RESEARCH CENTER

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Number of U.S. patients sickened each year by antibiotic resistant infections

PAGE 6

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

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