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When I entered medical practice in 1978, a hospital administrator earned about what I did as a family physician. All that has changed. Hospital administrators are now called CEOs and a “C suite” of other executives has grown to manage health systems. As Marni Jameson Carey pointed out in her April 25, 2019 “First Take” article, CEO compensation has grown to the level of five times more than an orthopedic surgeon.

Here I define a “talker” as someone who does not care for patients, but rather spends their days talking about healthcare. A “doer” is someone who cares for patients, including physicians, nurses, physician assistants, nurse practitioners, pharmacists, and various therapists.

The $3.7 trillion healthcare industry comes from caring for patients. Only the doers generate that revenue, which supports the talkers. Yet the talkers seem to have all the power to set their income levels.

During my 40 years of medical practice, the number of talkers in healthcare has exploded. In addition to any health system loaded with various administrators, there is the complex industry of health insurance plans, consultants, pharma, and medical devices. A whole new industry of talkers has recently developed, the coders making sure the documentation for billing is correct to collect the money. Elizabeth Rosenthal, MD, calls all these high-cost activities “an American sickness” in her book by the same name.

Twenty years ago I was part of a not-for-profit health system that started to lose money. Managed care had flushed out a lot of “waste” in the health industry and cut revenues. The health system responded by laying off a large number of talkers. The doers were considered essential and were kept. Many of the talkers slowly returned as the system became profitable again. There seems to be more talkers today than ever before.

Less than a year ago I gave up administration and went from being a half-time talker to being a full-time doer. My base income went down 30%. As a full-time doer I am working harder and am clearly doing more good for patient care. My professional satisfaction is way up.

When I meet college students looking for a career in healthcare, I encourage them to become doers. That is not to say that healthcare administration is a bad thing, just that the United States is flush with such talkers and job security is not guaranteed. Caring for patients has its deep rewards and will always be necessary, no matter what happens to the economy and society.

In the end, the doers will earn more than the talkers—and I’m not just talking about money.

In healthcare, why do talkers earn more than doers?

“I long for a time of reckoning when we realize we cannot afford a multi-trillion-dollar healthcare industry. My hope is that we will get back to the basics of good patient care.”

READ MORE  Don’t write off independent physicians just yet  PAGE 35
EHR risks
Protect yourself from legal danger  PAGE 6

Also Inside

12 Report from ASCO
News for primary care physicians from ASCO 2019

15 The patient experience
Three ways to increase the loyalty of your patient panel

16 Managing COPD
Strategies to boost adherence for this chronic condition

20 Apologies
When to say sorry to a patient—and what to avoid

21 Bad online reviews
A step by step guide to handling negative online feedback

23 Telemedicine
How to avoid legal issues when using telehealth

28 Cost cutting mistakes
When slashing the practice budget is the wrong move

29 Social determinants
Jacob Reider, MD, on efforts to improve community-wide care

31 Cost of care discussions
Tips for physicians on broaching treatment prices with patients

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Study: Non-physician providers can lower costs of care

In recent years, nurse practitioners and physician assistants have been taking on ever-greater roles as primary care providers, especially for patients with chronic complex conditions. Their expanded use has been driven largely by the shortage of physicians.

A new study suggests that they can also reduce the costs of caring for these patients. The study, published in the June issue of Health Affairs, focuses on approximately 47,000 medically complex patients with diabetes who received care at Veterans Affairs facilities in 2013. It compares the costs and outcomes of those who had physicians as their primary care provider with those who received care from an NP or PA.

About half the patients were older than 65. On average, patients receiving care from physicians had 6.9 chronic conditions, while NP and PA patients had 6.7 and 6.8 conditions, respectively.

The study found that patients getting care from NPs and PAs had fewer emergency department visits and in-patient stays than those who were cared for by physicians. That, in turn, led to lower inpatient, outpatient and pharmacy expenditures. Inpatient spending was 8.7 percent lower for patients of NPs and 6 percent lower for patients of PAs. For outpatient expenditures the differences were 2.9 percent and 5.3 percent, respectively, and for pharmacy the differences were 8.9 percent and 7.7 percent.

Overall, expenditures on patients of NPs were 6 percent lower than on patients of doctors, while for PAs the difference was 7 percent. That translates to a difference of $2,000 and $2,300, respectively, in annual per-patient healthcare costs.

The authors say their findings refute the belief held by some physicians and administrators that using NPs and PAs to treat complex patients drives up care costs, because these providers are less able to handle acute illness exacerbations than doctors, and therefore their patients are more likely to require expensive ED visits or hospital admissions.

For more of the latest healthcare news, visit: MedicalEconomics.com/news

Top 13 reasons for claim denials
Practices that can eliminate these common reasons will find greater financial success.

To view, visit bit.ly/13-reasons-for-claim-denials

Slideshow spotlight

MedicalEconomics.com

Bloggers

“Short of scrapping the entire insurance system of the United States, there must be adaptation to remove roadblocks for digital innovation to flourish in healthcare.”

—Warren Templeton is a finance product expert and startup founder

“I am proud to be a champion of value-based care. It is what patients individually need and what the country must collectively have.”

—Joseph M. Smith, MD, CEO of Reflexion Health and Digital Health Corp
Despite the fact that there is little or no evidence showing cost savings or improved patient outcomes with various value based quality programs and pay-for-performance schemes, CMS and many insurers seem dedicated to expanding these programs and the endless number of acronyms used to describe them.

Many primary care physicians cite such programs and the administrative burden that they impose as a leading cause of burnout and job dissatisfaction. The specifics behind this include tedious data entry, unfair, unrealistic or uncertain performance measures.

Even though it seems obvious that holding someone responsible for things over which they have no control is wrong, these programs are almost entirely predicated on just that. And even though it seems clear that requiring physicians to spend a large percentage of their time doing tedious data entry is counterproductive, wastes patient care time, diminishes access to care and leads to burnout, that is yet another hallmark of such programs.

As such programs become increasingly ungainly and transition from pay-for-performance to punishment-for-compliance-failure it seems the time is right for a primary care bill of rights. I think it should look something like this:

**1.** It is not and will never be the duty of a physician to force, coerce, intimidate, enforce, order or command a patient into compliance with recommended medical practices, preventive care, medications or procedures. Any payment model or compulsion for physicians to assume such a role is unethical.

**2.** In many if not most circumstances, primary care outcomes depend on patient compliance. It is unethical and unreasonable to hold physicians fully accountable for outcomes that are primarily dependent on patient compliance.

**3.** Inasmuch as the two statements above are true and reasonable, no quality metric or credit for such metric shall ever be based on any measure that is primarily dependent on patient compliance.

**4.** Likewise, it is also unreasonable and unethical to hold a physician accountable for outcomes or metrics for which another physician is responsible. In other words, if the patient of an internist sees an endocrinologist for the management of diabetes, the internist cannot be held responsible for any metric, quality measure or outcome related to the patient’s diabetes.

**5.** Data collection and tabulation of quality metrics will be the full responsibility of the collecting agency. No physician will be required to document such metrics solely in the format demanded by the collecting agency. As long as documentation of those metrics has been entered into the patient’s chart in any form of widely acceptable medical record, including written, dictated and transcribed notes, they will be acceptable. It will be the responsibility of the collecting agency to gather and format that data in whichever format they prefer.

**6.** No physician will be held accountable for meeting quality care standards based on fluid, debated or unclear guidelines. More research into chronic disease management and prevention indicate that care and screening should be tailored to individual patient needs. No concrete metrics in these cases is acceptable.

**7.** The idea that quality is more important than volume drives many quality programs. It must be acknowledged that this is a false dichotomy since it is patently and intuitively true that volume also equates to access to care. It must be understood and acknowledged that without access to care, quality of care is meaningless.

Physicians must embrace these simple, common sense concepts and use them to inform employers, patients, payers and the government how cumbersome, unfair and ineffective such programs have become.

George T. Barron, MD
Rock Hill, S.C.
What young physicians want from their first job

Young physicians are in high demand
65 percent of residents surveyed said they received more than 50 recruiting offers, and 45% received more than 100 offers.

Young physicians focus on location, pay and work-life balance
Residents surveyed said the most important criteria when evaluating job opportunities were:
- Geographic location
- Good financial package
- Adequate personal time

Hospitals are their preferred practice setting
Young physicians ranked their preferred practice setting in this order:
- Hospital employee
- Single specialty group employee
- Multi-specialty group employee
- Partner with another physician
- Only 2% said they wanted to go into solo practice

Source: The 2019 Survey of Final-Year Medical Residents, conducted by Merritt Hawkins.

“Physicians coming out of training are being recruited like blue chip athletes. There are simply not enough new doctors to go around.”
—Travis Singleton, Merritt Hawkins

Residents feel less prepared to handle the “business side” of medicine
When it comes to topics such as employment contracts, compensation arrangements and other similar topics, resident they felt:
- Very prepared: 8 percent
- Somewhat prepared: 54 percent
- Unprepared: 38%
53 percent said they received no formal training on these topics in medical school.

What are new physicians most concerned about as they begin their careers?
The top 5 concerns were:
- Earning a good income
- Educational debt
- Availability of free time
- Insufficient practice management knowledge
- Dealing with payers
originally heralded as a tool that would make health-care more efficient and effective, EHRs have revealed themselves to be a mixed blessing.

In addition to frustrations over badly designed interfaces and interoperability issues, physicians are coming to realize that the software they rely on to manage their practices can be putting their patients at risk of medical error and themselves in danger of medical liability.

The problems were highlighted in a recent joint Kaiser Health News and Fortune investigation that showed that EHRs are not living up to their promise, but they have been blamed for everything from incorrect prescriptions to patient deaths and serious injuries.

And while many practices have come

**HIGHLIGHT**

Practices should ban copying and pasting information from one form or page to another. This simple function saves time for users in a rush, but it's one of the worst legal dangers posed by EHRs.
The Doctors Company, a physician-owned medical malpractice insurer, analyzed EHR-related claims it closed from January 2007 through June 2014, followed by a study of claims closed from July 2014 through December 2016. Among the findings:

- From 2007 through 2010, EHRs were a factor in two medical malpractice claims. From July 2014 to December 2016 that increased to 66 claims.

- EHRs typically were a contributing factor in a claim, rather than the primary cause. User factors, such as conversion issues, copying and pasting, data entry errors, workarounds, user fatigue etc., accounted for 58 percent while system factors (technology and design issues, data routing problems, inappropriate drop-down menu responses, failure of alerts etc.) contributed to 50 percent. (Some claims contained both system and user factors.)

“[EHR] components that can come back and bite physicians if they’re not handled correctly.”
— Robert Hanscom, JD, Vice President of Business Analytics, Coverys

### Most common EHR-related user problems

- Hybrid health records or conversion from paper to digital: 15% of claims
- Prepopulating fields or copying and pasting: 14%
- Data entry error: 11%
- User error: 11%

### Most common EHR-related system problems by claim percentage

- Fragmented EHRs (data in separate locations): 12%
- Technology issues, such as out-of-date formulary templates: 12%
- Lack of provider access: 11%
- Documentation problems, such as no free text space: 6%
- Data routing problems: 6%
- Lack of or failure of alerts and decision support: 5%
- Lack of systems integration/EHR incompatibility: 1.5%
to working terms with their EHRs, they might be unaware of the malpractice dangers they can pose. “It’s definitely on our radar,” says Robert Hanscom, JD, vice president, business analytics at Coverys, a medical liability insurer. “We are urging [physicians] to pay more attention.”

Three years ago Coverys created a code to flag EHR-related malpractice claims. The number of cases rose from 21 in 2013 to 63 in 2017 and continues to climb, Hanscom says.

In the Medical Economics 2018 EHR Scorecard, dozens of practicing physicians commented on how their EHR systems made them more prone to errors.

“I make more prescription errors with the EHR than I ever did with paper charts,” said one respondent.

UNINTENDED CONSEQUENCES

Many of the problems stem from the fact that EHRs were forced into widespread adoption after the passage of the HITECH Act in 2009. Rather than mandating a universal standard based on design research, best practices and user experience, the government allowed competing vendors to develop their own EHRs. The result is a hodgepodge of systems that creates unnecessary risk, says Hanscom.

User difficulties and risks are compounded for doctors who work on multiple EHR systems, each with its own user interface, quirks and design flaws. “There are components that can come back and bite physicians if they’re not handled correctly,” Hanscom says.

Another insurance executive says he has seen malpractice cases stemming from EHR-related errors that led to incorrect medication doses and even removal of a wrong kidney.

“Even though the frequency is small, the potential for harm can be catastrophic,” says Darrell Ranum, JD, vice president of patient safety and risk management, The Doctors Company.

EHRs are not going away and the patchwork of competing systems, many of which still don’t work well together, is not going to be replaced anytime soon by a universal, interoperable network. So what can doctors do to prevent errors and subsequent liability?

DOCTORS AND EHRs

In 2018, Stanford Medicine surveyed primary care physicians about their EHRs. Among the findings:

40% believe there are more challenges with EHRs than benefits

49% believe EHRs detract from their clinical effectiveness

59% believe EHRs need a complete overhaul

72% think improving user interfaces could best address EHR challenges in the immediate future

67% think solving interoperability deficiencies should be the top priority

TEST YOUR EHR

No matter how long they’ve used a particular system or how satisfied they are with its performance, practices should test their EHR’s capabilities, says Lorraine Possanza, DPM, JD, MBE, director of the Partnership for Health IT at ECRI Institute, an independent nonprofit authority on the safety of medical practices and products.

Double check to make sure the system is doing everything it should, such as prescribing the correct amount of drugs, delivering prescriptions to pharmacies and sending orders to labs, she says. “The objective is you don’t want to make a mistake you shouldn’t have made. And you don’t want a system that makes it easier to make a mistake,” she says.

Physicians often have no idea how frequently EHRs can make mistakes, says Zach Hettinger, MD, MS, medical director and director of cognitive informatics, MedStar Health National Center for Human Factors in Healthcare. The center tests EHRs and one recent evaluation of a common system revealed a 40 percent error rate in writing prescriptions, Hettinger says.

The center offers free tools that allow practices to test their EHRs. Its “EHR See What We Mean” program explains many common problems with electronic records and how their designers could avoid errors.

In one example, a physician treating an adult male wants to prescribe Tylenol 500mg and, upon entering “Tylenol”, is confronted by more than 80 options, many of which are not relevant to the patient, such as children’s Tylenol. An attempt to narrow the search by adding “500” after Tylenol fails to turn up anything because the EHR search engine, unlike public search engines, does not recognize near matches and requires exact wording. The doctor returns to the original screen of 80 possible matches and scrolls through to find 500mg, which is the 68th option.

A better system would have screened out options irrelevant because of the patient’s age, gender or other factors and presented Tylenol 500mg, the most common adult dosage, as an easily selected choice.

Possanza also recommends creating
**EHR malpractice scenarios**

How easily can EHR-related errors occur? A recent study by The Doctors Company included some chilling examples:

**Claim 1**
A female presented to the ER with complaints of abdominal pain, nausea, and vomiting. An ovarian cyst had been removed two years prior. The emergency physician ordered an abdominal CT scan and called a gynecologist to evaluate the patient. The gynecologist reviewed a CT scan in the EHR that was later found to be the old scan showing the ovarian cyst. The patient was taken to surgery. No cyst was found, and the patient developed a methicillin-resistant Staphylococcus aureus infection. The gynecologist had not been trained on the new system so did not find the new CT scan that was available.

**Claim 2**
A patient was seen by her physician for pain management with trigger point injections of opioids. The physician ordered morphine sulfate (MS) 15 mg every eight hours. In the EHR, the drop-down menu offered MS 15 mg followed by MS 200 mg. The physician inadvertently selected MS 200 mg and did not recheck before completing the order. The patient filled the prescription, took one MS along with Xanax, and developed slurred speech—resulting in an ER visit with overnight observation.

**Claim 3**
A 35-year-old obese male presented to the insured for medical clearance. An ECG showed normal sinus rhythm, normal chest x-ray, heart rate 78, and BP 124/78. Three months later, he returned to the office complaining of chest pain, shortness of breath, and dizziness. His BP was 112/90 and pulse 106. Five days later, he died from pulmonary embolism due to deep venous thrombosis. Defense experts questioned whether the physician had done a complete assessment, because the progress note from the most recent visit appeared identical to the prior visit’s progress note—including the same spelling errors—suggesting that the note had been copied and pasted.
Policy

“You don’t want a system that makes it easier to make a mistake.”
—LORRAINE POSSANZA, JD, MBE, DIRECTOR, PARTNERSHIP FOR HEALTH IT, ECRI INSTITUTE

EHR risks

Continued from page 8
backups and contingencies in case an EHR does fail. Common measures include security measures to prevent hacking, data backup and retrieval tools and more.

REPORT PROBLEMS
While some EHRs allow users to modify them, most improvements must be made by the vendor, either through regular upgrades or specific fixes.

And a vendor can’t fix a problem if it doesn’t know it exists, says Possanza, so she urges users who notice a persistent or dangerous problem with EHRs to document and report it to the manufacturer. Though not always as responsive as users would like, vendors do want to make their products more reliable and user friendly and eliminate errors, she says.

ECRI formed a patient safety organization, where clinicians and healthcare organizations can report, aggregate and analyze data related to patient safety, including EHR faults. Problems also can be reported to the Office of the National Coordinator for Health Information Technology at the Department of Health and Human Services.

“This is a really complex system we’ve implemented and we need to have a multidisciplinary approach to solving the problems,” says Hettinger. “Sharing and collaborating on the information is the only way the system is going to get better.”

However, even if an EHR is fully or partially responsible for a medical error, physicians should not think that blaming the software will get them off the malpractice hook.

“It’s never not the physician’s fault,” says Hanscom, adding that many EHR vendor contracts include “hold harmless” provisions that protect the manufacturer. And while some patients have successfully sued EHR vendors in addition to the healthcare providers, the resulting settlements are usually not disclosed.

BEST PRACTICES
Practices should ban copying and pasting information from one form or page to another, says Ranum. This simple function saves time for users in a rush, but it’s one of the worst dangers posed by EHRs.

Copying and pasting on a chart can propagate incorrect or outdated information, Ranum says, a harmful error that can easily spread like a virus as other users do the same. “We want physicians to be extremely careful with copying and pasting. It’s often better to type it in yourself to make sure it’s the most recent,” he says.

Ironically, an EHR feature designed to prevent mistakes is proving to be one of the biggest problems. Systems come with alerts and alarms that appear when a potential problem is indicated by the information entered, such as a drug allergy or incorrect dosage.

However, some users complain that there are so many alerts—many of which are irrelevant—that they are ignored, which can sometimes cause errors. Hanscom cautions users who do ignore or deactivate alarms to document it and explain why in order to protect themselves in the event of litigation.

Some practices employ medical scribes in order to allow physicians to focus on patients during visits. That can avoid data entry mistakes caused by divided attention and reduce the number of users of the EHR system, which could lead to fewer mistakes.

SHARE INFORMATION
Most practices have been working with their EHR systems long enough to have uncovered many of their weaknesses, quirks and blind spots. However, that level of knowledge can vary among users in a practice, depending on their jobs and experience with the system.

Consequently, it’s important that all users in a practice share best practices about the system and know its dangers, says Possanza. Likewise, any workarounds or steps that can prevent errors should be implemented as practice policy, she says, adding that any fixes must be shared among users, as well.

It’s important that new employees be brought up to speed, particularly if they’re used to a different system.
While you’re protecting your patients

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As genomics and artificial intelligence (AI) change the delivery of medicine, physicians are entering an era where treatment choices will exponentially multiply, creating a new kind of management challenge: communication.

Atul Gawande, MD, MPH, CEO of Haven, the Amazon, Berkshire Hathaway, JPMorgan Chase healthcare venture, and a globally recognized surgeon, writer, and public health leader, says “It seems like our goal (as physicians) was simple: It was to improve health and independence (for our patients). People are coming with much larger questions. They want to know how we can help optimize the quantity and quality of life. They want to know it can be affordable and not bankrupt them along the way.”

Gawande, who made the remarks during a keynote address at the American Society of Clinical Oncology (ASCO) annual meeting in Chicago, says that physicians and other providers need to think differently about any patient fighting a severe illness. We need to ask ourselves about our goals for care and whether or not it is the same for friends and family.

Gawande says that a study published in the Journal of Clinical Oncology, “Effects of Early Integrated Palliative Care in Patients with Lung and GI Cancer: A Randomized Clinical Trial,” offers insight about the impact of early integrated palliative care in patients with newly diagnosed lung and gastrointestinal cancer. The results show that the group who received early palliative care noted an improvement in their quality of life.

“They experienced less suffering; they spent more time at home and less in the hospital. They had fewer chemotherapy costs, and the kicker was they lived 25 percent longer.”

“As I talked to the palliative physicians, they said their job was to bring the best of medicine to improve the quality of a patient’s life. And they were doing it successfully by asking simple questions.

Physicians ask questions like this only 25 percent of the time. “We have learned that when we don’t ask, the care is out of alignment with people’s priorities. The result of that can be suffering.

Gawande asked these questions of one of his patients, and he was surprised by the man’s response.

“Well, if I could eat chocolate ice cream and watch football on television, that would be good enough for me. Keep me going as long as I can do that. It was the best living will ever.”

In a randomized control trial at the Dana-Farber Cancer Institute, including 91 oncologists and 278 patients with advanced cancer, Gawande learned that 90 percent of 48 patients experiencing an intervention would discuss values and goals relating to treatment. Those patients were far more likely to talk about their prognosis or understanding of the illness. Patients experienced less anxiety (severe or moderate), and it cut depression in half.

Gawande says a palliative care nurse he shadowed made a profound impact on how he thinks about serious illness by telling him: “Medicine’s goal is to sacrifice people’s time now for gain more time later. My goal is to use the same medical capabilities to give patients their best day today.

“Is that worth hoping for? Is that worth fighting for? What are we fighting for? Imagine with patients their life worth living and use your medical capability to enable it.”

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**QUESTIONS TO ASK PATIENTS**

Gawande said a better understanding of what patients want from their treatment has created common questions physicians can ask patients, including:

**Q:** What is your understanding of your illness?

**Q:** How much information would you like about what might be ahead for you?

**Q:** What are your goals if your health situation worsens?

**Q:** What are your biggest fears and worries?

**Q:** What is the minimum quality of life you would find acceptable?
Primary care physicians play a crucial role in diagnosis, survivorship of cancer patients

Diagnosis, screening, risk reduction, managing comorbidities, helping to coordinate specialty care, long-term toxicities, palliative care, survivorship, and vaccination are just a few of the roles for primary care physicians related to the diagnosis and care of cancer patients.

The message, delivered today during a panel discussion at the American Society of Clinical Oncology (ASCO) annual meeting in Chicago, sought to address the myriad challenges doctors face when coordinating care after a person is first diagnosed with cancer, during treatment, after care, and in survivorship.

"We are on the front lines for diagnosing cancer, coordinating treatment phases leading to survivorship, and end-of-life care," says Larissa Nekhlyudov, MD, MPH, an internist and survivorship care provider at Dana-Farber/Brigham and Women's Hospital in Boston.

Piyush Srivastava, MD, an oncologist for Kaiser Permanente in Walnut Creek, Calif., says survivorship studies have shown that Stage I and Stage II cancer patients are more likely to die from hypertension or modifiable risks like cigarette smoking than cancer.

"Who would you prefer to manage high blood pressure, diabetes, or other chronic diseases?" "The answer is that the primary care physician needs to be an active member of the cancer care team," he says.

Consider that every 10 additional primary care physicians per 100,000 of population are associated with 51.5 days of additional life expectancy, versus 19.2 days for additional life expectancy with specialists. (JAMA Intern Med. 2019; 179(4) 506-514)

Every 10 additional primary care providers per 100,000 of population are also associated with reduced cardiovascular, cancer and respiratory mortality.

As oncologic therapies advance, it signals a need to adopt a more collaborative approach to patient care, during treatment and when a patient enters remission.

Trevor Jolly, MBBS, a medical oncologist at the University of North Carolina at Chapel Hill, adds that the primary care physician should serve as the medical quarterback. He encourages primary care physicians and oncologists to pick up the phone and communicate about cases and better collaborate on treatment decisions, especially for those patients undergoing chemotherapy or radiation.

"During treatment, patients tend to rely on the specialist," Jolly says. "But in my office, we are referring back to the primary care physician."

Elizabeth Shiff, a cancer survivor and patient advocate at the University of Cincinnati, says that when a patient is diagnosed with cancer, he or she is only thinking about next steps in the treatment plan. "It is important," Shiff says, "to stress to the patient that his or her care will be like a triangle—between the oncologist, primary care physician, and patient.

"Empower your patients with communication about the treatment plan and the role of providers," she adds. "I think we need to have a more collaborative approach where treatment decisions are shared, especially with comorbidities and when hypertension or diabetes is uncontrolled."

As cancer therapies advance, survivorship numbers have been climbing as well. Consider that 1.7 million new cases of cancer are diagnosed each year, but there are 16.9 million survivors. It signals a growing need for improved collaboration between oncologists and primary care physicians.
Cancer survivorship drives the need for new care delivery models

When it comes to cancer care and survivorship, the U.S. healthcare system should take immediate steps to avoid a volume problem in the near future.

While the number of diagnosed cancer cases remain flat each year at 1.7 million, there is a growing population of cancer survivors that is expected to surpass 18 million in 2020. Cancer survivors have their own unique needs to maintain optimal health, explains Catherine M. Alfano, PhD, of the American Cancer Society.

Speaking at the American Society of Clinical Oncologists (ASCO) annual meeting in Chicago, Alfano noted that the United States and the rest of the world face provider shortages and increased patient volumes. The result is a self-perpetuating cycle of stress, overload, and burnout for physicians.

Costs of cancer care are also climbing, and healthcare is shifting from fee-for-service to value-based care. “It is a perfect storm,” Alfano adds.

These trends are fueling the need to reinvent care delivery models to accommodate this growing segment of the population, adds Deborah Mayer, PhD, RN, of the University of North Carolina at Chapel Hill School of Medicine. Successful future models will require more deliberate coordination with primary care and other specialists throughout the healthcare continuum.

These issues, and more, were addressed during a panel discussion at ASCO titled “Implementing Risk-Stratified Cancer Follow-up Care: How, Why, and What Is the Return on Investment.” Alfano moderated the discussion.

Other panelists included: Jane Maher, MBBS, FRCP, of McMillan Cancer Support in London, and Michael Jefford, MBBS, MPH, PhD, of the Peter Maculium Cancer Centre in Melbourne, Australia.

The panelists sought to describe the logistics of developing and implementing risk-stratified follow-up cancer care delivery.

We know that cancer death rates have been declining, Mayer says, and survivorship has been climbing. “But we know far less about the health impacts on longer-term survivors. There are ways to look at lower and higher risk patients,” Mayer says.

Risk stratification is one viable option to improve care delivery and patient outcomes, she adds.

In fact, a summit from the American Cancer Society/ASCO identified strategies to advance personalized follow-up care, including:

- Developing a candidate model (or models) of care delivery to test in various healthcare delivery sites.
- Modeling the effects of personalized follow-up care pathways on patient outcomes, workforce, and healthcare resources. At the same time, future models need to assess utilization and cost outcomes.
- Creating consensus-based guidelines for the delivery of personalized follow-up care pathways.
- Identifying research gaps so as to create and implement personalized follow-up care pathways.

Actions that physicians can pursue include:

- Clearly communicate the role of specialist and primary care physicians at the time of diagnosis. Inform cancer patients that their care will likely transition to primary care providers.
- Examine current patient rosters, clinic utilization patterns, and new patient visit slots. Consider how shifting care of low-risk/low-need survivors to primary care or advanced practice practitioners would affect these factors.
- Reinforce expectations about follow-up care by ongoing communication throughout cancer treatment.
- Shift follow-up appointments after treatment.
- Support patients who are doing well in self-managing their health.
- Build collaborative bridges with primary care providers.

Shifting the model of follow-up survivorship care is part of the solution but needs to be based on risk stratification collaboration between primary care providers and oncologists, team-based care, and supported self-management.
Three ways to improve the patient experience

The healthcare industry is not one known for its emphasis on customer service. An alarming 81 percent of consumers are dissatisfied with their healthcare experience. Despite best intentions, many physicians fail to consider the entire patient experience. Long waits are common. Information is often lost or misplaced. Bills are confusing.

And patients have had enough. Seeking greater value for their money, patients are increasingly turning to providers who regularly connect with them and offer flexibility with how they schedule appointments, share information and make payments.

There is no such thing as a one-size-fits-all approach to patient engagement. Healthcare providers need to think holistically about how each touchpoint with a patient shapes their overall experience. From booking their first appointment to follow-ups and final billing, providers should consider how they can make the experience more thoughtful, starting with these tips:

Offer quick scheduling and check-in

Getting buy-in from staff, who manage the majority of the practice’s non-clinical work, is critical to improving the patient experience. According to a recent study, patients who left negative reviews online often did so not necessarily because of the physician, but because of negative experiences with desk staff, physical environment, wait time, appointment access, or billing. A negative experience when checking in patients can quickly snowball.

To improve the patient experience, make sure appointments can be easily booked online through patients’ phones, tablets or desktop computers. Once a patient arrives, they should not be required to wait for long, asked to fill out information previously provided, or charged incorrectly.

Be warned: If the check-in-and-out process is not quick and painless, patients might start looking for more convenient, customer-friendly options.

Harness smart phones

More than 85 percent of Americans own a cell phone and 90 percent of text messages are read within three minutes, making text messaging the quickest way to reach a majority of patients. Even better, texting is cost-effective for practices to implement and offers more flexibility for patients compared with other communication methods.

Using HIPAA-compliant secure text, for example, healthcare providers can efficiently send patients reminders about upcoming appointments, collect photos of insurance cards, deliver lab results, receive payments and more.

And unlike traditional patient portals, which less than one-third of patients actually use, secure texting shouldn’t require patients to install an app, create an account or remember a password.

Making access to records and provider communications more accessible means patients are more likely to be engaged in their care plans, resulting in better outcomes and an improved patient experience.

Offer video

Telehealth has emerged in the last few years as a way to reach underserved rural patients, as well as for practices to triage patients and reduce unnecessary office visits. Adoption has been limited due to issues with reimbursements, but video doesn’t have to be just about a paid visit. Now, doctors are using live video chat applications in lieu of traditional phone calls because of its personal touch and ability to observe a patient’s remotely.

For example, say a patient is sent home after an office visit but feels their condition is worsening. They can send a text message to office staff, who can flag it to the patient’s doctor, who can jump on a quick video call to determine if more information is needed or if the patient should seek immediate care.

In this way, live video can improve the patient experience by giving them another channel to connect with their provider while also lowering costs from unnecessary office visits.

Michael Morgan is the CEO of Updox. Send your practice management questions to medec@ubm.com
Managing COPD patients

Why treatment requires a multi-pronged approach

by JORDAN ROSENFIELD  Contributing author

Phyisicians often struggle to help patients with chronic obstructive pulmonary disease (COPD) make and maintain the lifestyle changes and medication regimes necessary to manage it. No single approach is sufficient, so experts recommend a multi-pronged strategy to manage this complicated disease.

COPD is shorthand for a group of diseases that cause airflow blockage and breathing problems. While its most common cause is smoking, for a small number of people, the cause is genetic. It affects more than 15 million people, and poses a significant burden to the U.S. healthcare system. The Centers for Disease Control and Prevention (CDC) estimates the annual costs of COPD were $32.1 billion in 2010 with a projected increase to $49 billion by 2020.

CONFIRM THE DIAGNOSIS WITH SPIROMETRY

COPD patients often present with symptoms including chronic cough, shortness of breath during regular daily activities, wheezing, excess mucus, and fatigue.

As a result, COPD and asthma are often used interchangeably, to the detriment of COPD patients, when they are not the same disease process, according to Keith Robinson, MD, an associate pulmonologist with Pulmonary Physicians of South Florida in Ft. Lauderdale. “I spend a good chunk of my time actually erasing diagnoses and giving patients the right term for what they have,” Robinson says.

Before discussing treatment options, it’s important to confirm the diagnosis with spirometry, the primary diagnostic tool for COPD. When patients who truly do have COPD receive a diagnosis it’s also often extra motivation to make the lifestyle changes to keep their disease from progressing, Robinson says.

The test is also important because even smokers who are symptomatic may still have normal lung function that doesn’t qualify as COPD. Those patients will still need education and intervention to prevent COPD from developing, but the treatment process may be different.

Once a diagnosis has been made, the next step is to get patients to stop smoking, says Philip Diaz, MD, a professor of medicine in the pulmonary, critical care, and sleep medicine division at Ohio State University Wexner Medical Center in Columbus.

“Getting off smoking is the best way to prevent the disease from progressing,” Diaz says.

Diaz relies upon a combination of pharmacotherapy—Chantix and Wellbutrin as key medications—and counseling to help patients quit. He finds it more effective to get patients to commit to a single quit date than to titrate slowly off.

Some people’s disease process can still progress even after quitting, but usually more slowly than if they continued.
Robinson also encourages physicians to prioritize the patients who are at the mild and moderate stages of the disease, because they can have the most impact on those patients’ disease process.

**CREATE CARE TEAMS FOR GREATER SUCCESS**

COPD, like many chronic illnesses, isn’t one that physicians can manage alone, says Ken Thorpe, Ph.D., a professor of health policy at Emory University in Atlanta. He says patients are better served when they have a care team that can make sure that none of the elements of their care are not overlooked.

He says that while physicians may do a good job creating treatment plans, things often fall apart in the execution. “A care team is really important. These patients are going to be in a physician’s office infrequently for a short period of time and the key is, what happens when they leave?” Thorpe says.

In addition to the physician, a care team might consist of a pharmacist and a nurse practitioner to manage medications, and possibly a care coordinator to help with transitions in and out of the hospital if the patient is acute. “Care teams are generally very diverse, because people with these chronic diseases often have other chronic diseases,” Thorpe says.

Thorpe also recommends a program created by the CDC known as the National Diabetes Prevention Program. The name is misleading, he says, because it’s really just a useful lifestyle program that offers education, exercise, nutrition, and behavioral advice for anyone with a chronic disease.

“It focuses on reducing the number of diabetics from pre-diabetics by generating weight loss behavior change but it has impact on a whole host of conditions,” he says. “Many physicians don’t know the benefit exists.”

**BEHAVIORAL APPROACHES TO LIFESTYLE CHANGES**

Once a diagnosis is confirmed, quitting smoking is only the first lifestyle change that COPD patients need to make to stay as healthy as possible. Exercise is especially important for COPD patients to manage their symptoms, Robinson says. It may seem counter-intuitive to recommend exercise to patients who are short of breath, but it is effective, he says.

This can be a challenge for many physicians, since patients often are reluctant to begin exercising. “If our patients weren’t really physically active as young adults, they’re not all that inclined to become active after they get a diagnosis of COPD,” Robinson says.

To encourage this behavioral change, his practice treats COPD patients as if they are struggling with an addiction, that addiction being a sedentary life. “We’re learning that COPD is a behavioral disease as much as an obstructive lung process,” Robinson says.

To overcome patients’ resistance, physi-
Money

Managing COPD

3 important COPD ICD-10 codes to know

When reporting COPD, use one of the following ICD-10 diagnosis codes:

- **J44.0** COPD with acute lower respiratory infection—use additional code to identify the infection
- **J44.1** COPD with acute exacerbation
- **J44.9** COPD, unspecified

Note: If the patient has chronic bronchitis, refer to ICD-10-CM codes J41.- or J42.-. For emphysema, report ICD-10-CM code J43.-, J98.2, or J98.3.

Doctors in Robinson's practice rely on motivational interviewing rather than just telling people what they should do differently. “We have patients reflect back on the activity or the lack of activity and ask them about what benefited them or what potentially might be the harm of not trying to change that behavior,” he says.

They also ask patients to reflect on what they have missed out on in life due to fear of shortness of breath or the embarrassment of being seen with an oxygen tank. They’ve also drawn upon scientific research that has found milder forms of exercise such as Tai Chi, yoga, and Pilates meet the same level of activity improvements as getting patients up on a treadmill for twenty minutes.

“More importantly, the mindfulness that they get out of [these exercises] and the awareness of their breathing becomes a foundation for those activities,” Robinson says.

Meditative breathing techniques can also help COPD patients, says Siobhan Bulfin, founder and CEO of Melon Health, a San Francisco-based healthcare consulting company that helps clinicians enable patients to self-manage chronic illnesses.

“At COPD we’ve focused on breathing techniques because we know that shortness of breath causes people with COPD a lot of anxiety,” Bulfin says. They teach physicians and nurses to walk patients through basic breathing techniques that can calm anxiety and restore breathing to a manageable state.

**PRACTICE EMPATHY AND OFFER HOPE**

Along with its physical symptoms, COPD carries a lot of stigma, says Diaz. “I think some patients feel that they’re met with this idea that ‘you smoked, and you’ve done it to yourself,’” he explains.

Patients’ shame over their behavior and stigmas around smoking can prevent patients from getting treatment, which is unfortunate, Diaz says. “I tend to look at it more positively, that there’s always something that can be done. You can keep them out of the hospital, try to improve their quality of life, look into more advanced therapies.”

He does recommend setting realistic goals with patients, however. A person with COPD probably won’t run a marathon, but they might be able to play their favorite sport or get to the gym regularly.

Bulfin says they help patients create intrinsic rewards and make incremental changes. “An intrinsic reward is, ‘Oh I just did something I couldn’t do before’, or ‘I just walked three times in a week,” she says.

She says that for COPD patients with acute symptoms, improvement may be slow. With treatment, a patient may be able to walk to the end of their driveway every morning to pick up a newspaper, or maintain some basic mobility. But however small, every bit of progress is important.

Additionally, Robinson says, it can be productive when physicians show their human side with their patients by discussing their own failures. “In pulmonary rehab, we have a chance to [talk about our failures] often, by saying, ‘I failed you by choosing the wrong inhaler, let’s try a different delivery,’” Robinson says. “Or ‘maybe this class of medication isn’t making you feel well, let’s try a different class.”

**PEER SUPPORT**

Another crucial, and often overlooked, area of patient support is for physicians to help patients meet with other COPD patients.
Belfin says her company has helped physicians be successful in getting COPD patients to engage in better medication adherence and lifestyle changes by connecting them to their peers. Melon Health does it through a HIPAA-compliant, online community where people with COPD can communicate with each other. It is overseen by a community manager nurse who can also advise and offer resources.

“Changing behavior and managing chronic illness is really hard, but it’s easier to do if you know that you’ve got other people to do it with,” Belfin says.

Whatever strategies a physician employs, Diaz emphasizes offering patients hope. “I think navigating these patients through their illness can really help them. Even though COPD is not something that can be cured, you can help them manage it.”

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**Patient education tips**

*When providing COPD education to patients, consider these tips:*

1. **Form a COPD team in the office.**
   Enlist the help of physician assistants, nurse practitioners or medical assistants who can answer questions and review critical information after the physician sees the patient, says Regina Lohr, MPP, senior consultant at Advisory Board.

2. **Involve family members.**
   This helps reinforce information discussed during the appointment, says Steven Weinberger, MD, a pulmonologist. Family members can also help keep patients accountable, he adds.

3. **Provide COPD group sessions.**
   These sessions are an opportunity for patients to talk about their COPD-related challenges, ask questions and receive information from physicians about best practices, says Weinberger. (Note: physicians can bill for these sessions using CPT code 98960, 98961 or 98962, depending on the number of patients counseled. Each code requires at least 30 minutes of counseling; however, as with many time-based codes, physicians can report these codes when they perform more than half the time specified in the code description. For group session codes, physicians must document at least 16 minutes. When performing an hour of group counseling, report two units of the appropriate code.)
When should physicians say ‘I’m sorry’?

| 1 | Knowledge of what happened along with an apology. |
| 2 | Understanding of why it happened. |
| 3 | Explanation of what preventative measures are being implemented to prevent the harm from occurring again with other patients and |
| 4 | Financial remuneration. |

Historically, the belief was that if doctors apologized, then the risk of a lawsuit and/or the amount of the settlement would be reduced. Researchers from Cornell University and the University of Houston analyzed healthcare facilities in states that have adopted apology laws. Their findings, published in the *Journal of Risk Uncertainty*, found that “statements of regret facilitated faster settlement times and a decrease in malpractice claims.”

However, saying “I’m sorry” or “I apologize” can have significant consequences depending on a state’s law. Most apology laws apply to statements and gestures of benevolence, usually stated in the vortex of an unanticipated outcome, to either a patient and/or a patient’s family member.

Additional research has found that apologies can benefit the patient or patient’s family members as well as the provider. According to an article in *Stanford Law Review*, “[based on case studies indicating that apologies from physicians to patients can promote healing, understanding, and dispute resolution, 39 states (and the District of Columbia) have sought to reduce litigation and medical malpractice liability by enacting apology laws.” Each state has its own nuances, so a simple “I’m sorry” may cause additional legal evidentiary issues, depending on the jurisdiction. Some questions providers should first ask their attorneys include:

- Does the state’s law expressly mention to whom the apology may be relayed (e.g., family member or friend)?
- Does the state’s law allow for the admission of expressions of sympathy?
- Is there a time limit during which an apology is inadmissible?

Perhaps most importantly, providers must be able to convey a distinction between a statement of sympathy versus an admission of fault. Maine and Louisiana, for example, say that nothing in the statute prohibits the admissibility of a statement of fault. In contrast, Vermont’s law says that “liability protections … shall not be construed to limit access to information that is otherwise discoverable.”

Apologies are expected by patients and may be a mitigating factor in litigation or a settlement figure. However, providers should understand the laws of the states in which they practice, as well as what is admissible, so they know what they can and cannot say.

Rachel V. Rose, JD, MBA, advises clients on compliance and transactions in healthcare, cybersecurity, corporate and securities law, while representing plaintiffs in False Claims Act and Dodd-Frank whistleblower cases. She also teaches bioethics at Baylor College of Medicine in Houston. Send your legal questions to medec@ubm.com
Defamatory reviews
How to protect your reputation

by JUSTIN T. KELTON, JD Contributing author

Maintaining a positive online presence is vital to the success of any medical practice. A recent survey from Doctor.com revealed that as many as 63 percent of respondents would choose one provider over another because of a strong online presence. Similarly, 60 percent of respondents have chosen one provider over another based on a positive online reputation.

As patients increasingly rely on the internet to determine which provider is best for them, online reviews play a critical role in the success—or failure—of modern medical practices. Unfortunately, it is often impossible for a potential patient to differentiate truthful and accurate reviews from fraudulent ones. Worse, a single disgruntled patient may leave many reviews across a number of platforms, inflicting untold harm with a few keystrokes.

The risks posed by online reviews are especially dangerous for healthcare practices since health complications can arise or worsen even if providers have done everything properly, and reviewers may be completely misinformed regarding the standard of practice applicable to their situation.

Physicians have a right to defend their reputations and livelihoods against reviewers who spread false and damaging claims. Fortunately, there are a variety of legal options available to combat defamatory online reviews.

KNOW YOUR RIGHTS
Defamation laws vary from state to state but, generally, a person may be liable for defamation when he or she posts a review that contains demonstrably false assertions of fact (as opposed to opinion), that are damaging to the subject of the review.

Patients are entitled to post reviews that are statements of opinion, such as “I didn’t care for the doctor’s bedside manner” or “The office was poorly decorated.” While a provider may disagree with a patient’s opinion, those disagreements are not proper bases for legal action because opinion is generally protected by the First Amendment.

Patients can also provide reviews that contain statements of fact, so long as those assertions are accurate. Like statements of opinion, truthful statements of fact are protected free speech under the First Amendment.

However, if a review contains a false assertion of fact, the reviewer may be liable for defamation. This may include statements such as “I was billed for procedures that were not performed” or “The doctor botched the procedure.”

SEEK LEGAL ADVICE
Unlike many other industries, healthcare providers operate in a highly-regulated environment. Providers should be extremely careful when confronting defamatory reviews, as they must not violate any of the ethical, legal, or regulatory guidelines, e.g., HIPAA, that govern doctor-patient relationships.

In addition to regulatory concerns, healthcare providers may consider the severity of the harm inflicted when determining whether to pursue legal action. They may also want to make a sustained effort to increase the number of positive reviews. Asking satisfied patients to post truthful online reviews can increase a physician’s overall rating.
Operations

“Consider the severity of the harm inflicted when determining whether to pursue legal action.”

Care practices should keep the following steps in mind when considering whether or how to address negative online reviews:

Seek a lawyer. Consult a lawyer with experience handling defamation matters for healthcare providers. These matters are fraught with potential peril if not handled properly, so you need to work with a qualified and effective advocate. After all, your business and reputation are on the line not only because of the defamatory review but in how you respond to it.

Determine if the review qualifies as purported fact. Work with your lawyer to determine whether the statements in the negative online review qualify as statements of purported fact. To do this, you may need to parse the language carefully to determine exactly what the reviewer was communicating. Often times, statements may initially appear to be factual but after a deeper look may constitute opinion, or vice versa.

Address the review. If the review contains only statements of opinion, consider alternative methods for addressing it, such as pursuing any takedown procedures or other features the review platform provides to help business owners.

Increase positive reviews. Make a sustained effort to increase the number of positive reviews. Asking satisfied patients to post truthful online reviews can increase a provider’s overall rating and may dilute the effect of one older negative comment compared to more recent positive reviews.

Determine if a legal claim is viable. If you believe that the review is indeed defamatory, ask your lawyer about whether you have a viable legal claim. When determining whether to pursue legal action, keep in mind that:

- If a review is posted anonymously, you may be able to obtain a court order compelling the internet service provider to disclose the identity of the wrongdoer so that he or she may be taken to court.
- To prevail in court, you will need to prove that the statements in question are false. There are many different ways of establishing the falsity of the reviewer’s claims, including through the testimony of witnesses (such as office personnel), records, or other evidence.

Ask yourself if legal action is worthwhile. Consider the severity of the harm inflicted when determining whether to pursue legal action. A widespread defamatory review can lead to the loss of patients as well as reputational harm. Pursuit of a legitimate defamation claim can result in both removal of the offending review and an award of damages to the provider to compensate for the harm suffered. On the other hand, in cases of very minor misstatements, legal action may not be worth it.

Take action
Some healthcare practices have begun fighting back against defamatory online reviews. Although many cases settle outside of court, providers have been increasingly seeking court intervention where the damages are significant.

For example, in a recent case in Arizona, two doctors successfully sued a patient who used her own website and other online review sites to post negative claims about her surgeries and other procedures. The jury awarded the doctors $12 million before the parties reached an agreement.

In another recent case, Great Wall Medical P.C., et al. v. Levine, a Manhattan gynecologist filed a lawsuit for defamation, libel, and inflicting emotional distress based on allegedly false and defamatory reviews posted on ZocDoc and Yelp. The doctors allege that the defendant, acting under a pseudonym, posted an online review containing several fabrications, including statements that the doctors had “zero knowledge,” engaged in “medical fraud” and tried to “scam” the reviewer. The case is ongoing.

Although physicians operate in a highly-regulated environment, they have the right to defend their reputations and businesses when they are defamed. If this happens, physicians should consult experienced lawyers to ensure they take appropriate legal measures that comply with HIPAA and other regulations while effectively addressing damaging and defamatory reviews.

Justin T. Kelton, JD, is a partner at Abrams, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP, where he focuses resolving significant disputes in federal and state courts.
Telemedicine

How to avoid legal risks

by MARY K. PRATT Contributing author

Judd Hollander, MD, holds a medical license in Pennsylvania, where he practices, but to ensure that he could legally treat his patients virtually, even when they’re traveling out of state, he sought out medical licenses in an additional 18 states.

Hollander obtained those credentials after surveying 3,500 of his patients and asking about their travel showed that obtaining licenses in those 18 states, along with Pennsylvania, would allow him to see his patients nearly any time they needed him.

Hollander, who in addition to practicing is a senior vice president of Healthcare Delivery Innovation at Jefferson Health, a regional healthcare system based in Philadelphia, says this step allows him treat his patients without worrying about whether he is legally out of bounds.

Hollander says that it takes time and effort to manage the requirements associated with all those licenses. “It’s a half-time job keeping up with them,” he jokes, but he says physicians need to take such steps if they want to offer telemedicine services and be compliant with administrative rules and legal regulations.

Patients are increasingly seeking out virtual medical care, while more physicians are working toward providing increased telemedicine services.

However, as physicians add such services to their practices, experts say they need to consider legal and compliance issues around providing such care, from telemedicine-specific regulations to state licensure requirements and even malpractice-related questions.

“You do have to be careful. You can be successful if you’re meticulous, use good resources, have risk managers looking at policies and procedures, and have good technology selection, appropriate documentation and training around telemedicine,” says Neal Sikka, MD, chief of the innovative practice and telemedicine section at the George Washington University Medical Faculty Associates.

MULTIPLE STATE LICENSES MIGHT BE REQUIRED

Technology now enables physicians to deliver a range of medical services virtually. Experts group these services into two categories: telemedicine, which is when the physician delivers care via telecommunications to a patient located at another site, and telehealth, which includes technology-enabled health services such as remote patient monitoring.

A leading consideration when implementing telemedicine is state licensure, experts say. Telemedicine adds a complication to licensure needs, because the technology

HIGHLIGHT

Some telemedicine applications allow physicians to incorporate into their telemedicine workflows the appropriate consent forms and checks on patient locations, thereby helping them follow the rules applicable to their practice.
Technology

"You do have to be careful. You can be successful if you’re meticulous, use good resources, have risk managers looking at policies and procedures, and have good technology selection, appropriate documentation and training.”

—Neal Sikka, MD, Chief of the Innovative Practice and Telemedicine Section, George Washington University Medical Faculty Associates

enables physicians to see patients who are located in a state where the doctor is not licensed to practice.

As such, physicians and other clinicians will likely need a license to practice in multiple states if they want to treat their patients virtually.

Experts advise physicians to examine their patient panel to determine if they have patients living out of state—for example, in a neighboring state if their practice is near a state line. Physicians may want to determine if they have a significant number of patients who re-locate for part of the year—such as retirees who head to warmer climates during the winter—or if a large percentage of their patients travel extensively.

Thus, a physician seeing a patient via video link needs to know where that patient is located at the time of the visit—known as the “originating site”—and understand that state's licensure requirements.

Some states are making it easier for physicians to practice in other states. The Interstate Medical Licensure Compact, which encompasses 28 states and the territory of Guam and their 38 medical and osteopathic boards, offers an “expedited pathway to licensure for qualified physicians” seeking to practice in multiple states.

It also offers reciprocity, with the members recognizing each other's licensing requirements so physicians don't have to review and meet each state's requirements to obtain a license, says Steven E. Waldren, MD, MS, vice president and chief medical informatics officer for the American Academy of Family Physicians.

Waldren notes that although physicians still need to apply and pay license fees for each member state where they want to practice, the IMLC offers a more efficient way for physicians to obtain additional state licenses.

However, physicians seeking licenses in states that aren't part of the compact will have to meet the requirements of each of those, Sikka says.

RULES VARY BY STATE

Physicians also need to understand the differences in state regulations governing telemedicine, experts say.

Some require physicians to see patients in person before offering any type of telemedicine service, while some have additional regulations that could apply to physicians billing patients located in those states. Some states have restrictions on asynchronous visits—interactions where the clinician and patient do not interact in real time—while others allow both synchronous and asynchronous visits as well as a broader range of telemedicine services.

States vary in their regulations in other ways, says Rachel Dixon, a consultant and telemedicine expert with the Medical Group Management Association (MGMA). For example, some states allow physicians to prescribe certain controlled substances via telemedicine visits under certain circumstances. Such rules, she says, require physicians to understand such regulatory differences if any of their patients are out of state.

Furthermore, she says, states generally require physicians to obtain consent from patients before treating them, but some states have specific requirements around consent that others do not.

California, for instance, requires the originating site provider to obtain and document patient consent, according to the Center for Connected Health Policy, while Kentucky says the treating physician who delivers or facilitates the telemedicine ser-
Technology

“You should have contractual assurances that third parties will follow all the rules around HIPAA.”

— RONALD WEINSTEIN, MD, FOUNDING DIRECTOR, ARIZONA T ELEMEDICINE PROGRAM

Telemedicine

Jitendra Barmecha, MD, MPH, FACP, who chairs the American College of Physicians’ newly formed Digital Health Advisory Group, says physicians should seek to ensure compliance with the varying state rules and regulations by building them into their telemedicine workflows.

For example, he says, just as most practices have front-office workers automatically obtain consent as part of the check-in process, the telemedicine application can include the appropriate consent documents based on the state rules where the patient is located at the time of the visit.

Medicare rules add another layer of complexity for physicians expanding into telemedicine, says Mollie Gelburd, JD, associate director of government affairs at MGMA.

For example, Gelburd explains, both the originating site and the physician providing the service are expected to submit documentation of the visit. Failure to meet that extra requirement would mean noncompliance with the federal rules.

SECURITY, PRIVACY RISKS

Telemedicine must also meet all HIPAA requirements. “The rules are no different for telemedicine than for [in-person visits],” says Ronald Weinstein, MD, founding director of the Arizona Telemedicine Program.

This means physicians need to ensure they’re in a location where no one can overhear the virtual visits, which would violate HIPAA’s privacy and confidentiality requirements. Additionally, physicians must use technology that’s compliant with HIPAA rules. The technology should have fully encrypted data transmission and provide secure connections. Experts stress that consumer videoconferencing platforms, such as Apple’s FaceTime application, do not offer those features.

Physicians that opt to work with another business or a technology provider to offer telemedicine services to patients must ensure that those partners are compliant with HIPAA regulations, too, Weinstein says.

“You should have contractual assurances that third parties will follow all the rules around HIPAA,” he adds.

MALPRACTICE CONCERNS?

Experts say physicians offering virtual services don’t face new malpractice rules or risks.

“Telemedicine isn’t really high risk, but you do want to make sure you’re practicing under the board of medicine for the state where the patient is located, and practicing under the terms of your licensure and the standards of care for the conditions and for your practice focus,” Sikka says.

Physicians who comply with licensing rules, who document appropriately and who follow the same standards of care they would for in-person treatments don’t create additional malpractice risks just because they’re offering their services virtually.

Still, there are risks if physicians don’t diligently adhere to the rules. For example, Waldren says, physicians could face a loss of malpractice insurance coverage if they treat a patient located in a state where they aren’t licensed to practice—even if that error was inadvertent.

As a result of the potential for such situations, Waldren advises physicians to consult with their attorney as well as with their malpractice insurance company before starting to offer telemedicine services.
Technology

Internist use of telemedicine is on the rise

More than half of internal medicine physicians (and subspecialists) are working in practices that have implemented telehealth, according to new survey results from the American College of Physicians (ACP).

The survey of ACP members, released in April, shows that 51 percent have adopted at least one of these telehealth services:

- **e-consults** (33 percent implemented, 10 percent considering)
- **remote care management/coaching** (24 percent implemented, 11 percent considering)
- **visits** (18 percent implemented, 17 percent considering)
- **remote patient monitoring** (14 percent implemented, 11 percent considering)
- **integration of data from patient wearables** (9 percent implemented, 9 percent considering)

**Other notable findings**

- About 63 percent of respondents with e-consult technology use it every week
- Having the technology does not equate to adoption and usage of telehealth services, the survey reports. Among those with the technology, only 19 percent use video visits every week, while 50 percent use remote care management every week.
- **Physician respondents were typically not making decisions to implement the technology**
- Many physicians are interested in learning more about available technology solutions (55 percent of those with no technologies implemented, and 51 percent of those with some implementations)

**Barriers to adoption**

- **42 percent:** Challenging to integrate virtual care into practice workflow
- **36 percent:** Patients don’t have access to the technology to support virtual care
- **29 percent:** Concern about potential medical errors
- **23 percent:** Security and privacy of patient information
- **18 percent:** No barriers identified

Reimbursement, licensing, and regulatory issues were also recognized as barriers to telehealth applications.

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**TELEMEDICINE TRAINING A MUST**

Technology can help physicians adhere to the various regulations and laws that govern telemedicine services.

Some telemedicine applications, for example, allow physicians to incorporate into their telemedicine workflows the appropriate consent forms and checks on patient locations thereby helping them follow the rules applicable to their practice.

Additionally, experts advise physicians to seek out training in delivering telemedicine services to ensure that they’re not only following the applicable rules, but also so they’re delivering the best possible care in this new setting. Institutions that offer training in telemedicine services for physicians include the American Telemedicine Association, the American Medical Association, the Arizona Telemedicine Program and Thomas Jefferson University.

Experts say physicians shouldn’t let complicated regulations over licensure, rules and regulations stymie their adoption of telemedicine, because patients will increasingly seek out virtual visits and other technology-enabled care.

At the very least, Hollander says, physicians should offer telemedicine service to their existing in-state patients if they want to remain relevant in healthcare. “You have to figure out how to do it.”

**Advantages of telemedicine**

Here are some reasons why integrating telemedicine into a medical practice benefits both physicians and their patients, according to Faraz Zubairi, CEO of ExamMed:

**Increases patient satisfaction.** It has been proven that patients are far more likely to be satisfied with a virtual appointment when it is administered with a doctor they know and trust.

**Improves patient outcomes.** Telemedicine makes it easy and convenient for patients to stay engaged with their treatment plan and receive a stronger clinical outcome.

**Increase practice revenue.** By offering telemedicine, physicians can be reimbursed for a number of interactions that do not actually need to have a patient present in-person.
Blood pressure is a benchmark of health — and yet, many doctors and patients remain in the dark on effective blood pressure measurement.

In this podcast, Thomas Schwieterman, MD, MBA discusses techniques for obtaining accurate and consistent readings — as well as the use of automated devices that reduce variability and user error.

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When cutting costs is the wrong move

In our consulting business, we find that when physician practice owners and healthcare executives have concerns about profitability, their first question almost always is something like “are we spending too much?” or “is our overhead too high?” or “are we overstaffed?”

Of course, true overspending might indeed mean generating less profit than the business could—or should. But it’s odd that looking to cut expenses has become so reflexive, considering that increasing revenue is a much more powerful way to strengthen the business. What’s more, efforts to save money may even weaken the business—and, sometimes, those weakening effects can be very hard to spot.

This is the essence of a false economy: an action that feels like a savings, but is actually costly. And the quest to keep expenses in the medical practice as low as possible often leads to these kinds of unfortunate mistakes.

Classic examples of false economies are things like cheap tires and cheap shoes. They cost less out of pocket, but you replace them more often, so the cost over a lifetime of use is actually higher than for better tires that cost more to buy.

Of course, teaching examples like these make spotting false economies sound easy. In the day-to-day reality of running a business, though, it can be more challenging to know what does and doesn’t constitute a genuine savings.

Consider a common decision about staffing. For example, perhaps an employee takes an unexpected or extended leave, and you’re unable to replace her for, say, a month or two. During that time, you find that you’re able to “get by” without that job being filled. Does that mean you’ve been overstaffed? And if the employee ends up departing, should you opt not to replace her?

It may seem like a no-brainer: If you’re getting by without that person, making the change permanent will mean the value of that salary and benefits expense goes right to the bottom line. Instant profit, right?

But that conclusion implies the assumption that changing one variable will have no effect on anything else. In this case, the assumption is that all other variables affecting your profitability will remain unchanged when you reduce staffing. Staffing cuts that have little noticeable effect in the short term—probably because everyone is stretching a bit to fill the gap—may actually have a negative effect on profitability over time. Here are a few reasons why:

- If physicians are picking up the slack, their productivity will decrease. Even if the decrease is slight, the effect on revenue will add up over time. It doesn’t take much productivity loss to decrease revenue by more than your practice saves by cutting a staff job;
- Having one fewer employee may lead to more overtime—which means paying more for hours that are typically less productive (as other staff stay later and try to fill in the gap);
- Any other stress on the workflow—such as an unexpected absence of a colleague, or a big surge in demand (e.g., a busy flu season)—will be much more taxing for everyone, because there will be one fewer person to help carry the extra load. If the stress becomes too much, staff turnover will increase—which can quickly add costs and cut further into productivity.

Before making any kind of cost-cutting decision, considering these ideas can help avoid a mistake that can be very costly over the long haul. And the same thing applies to everyday business investments, such as upgrading equipment or adding technology. When the out-of-pocket cost is significant, it’s always tempting to “save” by delaying needed spending. But the initial cost mustn’t be the only consideration, because making these improvements can have a significant positive impact on productivity and profitability.

Laurie Morgan is partner and senior consultant with Capko & Morgan, a healthcare consulting firm based out of San Francisco. Send your financial questions to medec@ubm.com.
The increasing emphasis on social determinants of health is based on recognizing that health starts in our homes, schools, workplaces, neighborhoods and communities. It’s well-documented that health plan members are often treated “downstream” of where their health problems actually begin. This is especially true of economically disadvantaged people who face housing, transportation, food, and related social challenges that exacerbate their health problems and that medical care alone can’t resolve.

Because of this, communities across the country are investing “upstream” in social services that address social factors, sometimes called social determinants of health, to help improve the long-term health of their most vulnerable citizens, many of whom receive their healthcare from public programs such as Medicaid.

However, community-based social service delivery organizations tasked with these goals vary in size, shape, funding sources, and level of community interaction. Some organizations are very collaborative and interact with other social services providers and medical providers, while others are more isolated, and often do not collaborate or interact with others.

Moreover, most social service delivery organizations have little experience with the principles of value-based payment or using data-driven performance measurement or performance-based payment models.

**CREATING SYNERGIES**

To address those challenges, some managed care organizations (MCOs) are working with social service delivery organizations in a more formalized way to identify and address social issues for better patient care and outcomes.

For example, in New York’s Capital Region, we have recognized the extraordinary potential of social service providers to contribute to the improved health of our communities. We have funded activities that are focused on curating and managing a high-performing, regionally shared network of accountable social service delivery organizations.

The technology-driven network, built on top of the Unite Us referral platform, helps these organizations migrate toward value-based care through risk-sharing arrangements and facilitation of referrals, plus services such as process optimization assistance, group purchasing, and back office.

The benefits of this synergistic approach include improved population health, fewer preventable emergency department visits and hospital admissions, and generally improved regional economic conditions.

As a product of this collaboration, here are four ways that MCOs and social service delivery organizations can work together via a connected network to address members'
Social determinants of health

“While many states set goals for social determinants in contracts, comparatively few offer payment incentives.”

Jacob Reider, MD, FAFP, is CEO of Alliance for Better Health in Albany, New York, a nonprofit organization that is building a unique model for using technology and services to provide a coordinated network of community-based social service delivery organizations that managed care organizations can tap into to address social determinants of health in their beneficiary populations. He previously served in the Obama administration as the Chief Medical Officer and Deputy National Coordinator for Health IT at ONC.

individualized social and medical needs toward better health:

1/ Electronically connect patients in real time to clinical and social service providers, such as homeless shelters, benefit navigators, workforce development agencies, behavioral health providers, and food pantries.

2/ Track patient progress and receive automated feedback from partners to ensure care and services are received.

3/ Collaborate with community-wide teams to ensure that both social service and medical care providers are on the same page regarding their shared patients’ progress.

4/ Capture data, including structured patient outcomes to measure the network’s impact, such as time to service and effectiveness of care.

Ideally, these networks allow everyone to electronically refer between each other and close the loop on every intervention. Enabling all organizations in the network to work together as one community service team helps ensure that all the needs have been addressed.

SCALING THE CONCEPT

Once more states have developed these kinds of cultural and technical collaborations, the next step is to scale the concept across the country and transform the entire care delivery continuum into one that recognizes the role of social factors in population health and incentivizes health and prevention. It sounds like a big goal—and it is.

In fact, it’s such a big goal that states can’t be expected to achieve it on their own. A December 2018 report by the Association for Community Affiliated Plans, a national trade association, found that making social determinants-focused collaborations more common requires enhanced agency collaboration at the federal level. The Association represents not-for-profit safety net health plans and the Center for Health Care Strategies (CHCS), a nonprofit policy center dedicated to improving the health of low-income Americans.

The report found common themes in how states leverage systems and partnerships—and structure authority and funding—to most effectively address social determinants. Although it’s common for state contracts with MCOs to include provisions around social determinants, the report—which examined Medicaid managed care contracts in 40 states, as well as 25 approved demonstration projects—found that many states do not clarify within the contract how MCOs can take advantage of flexibilities within federal law to address social determinants. And while many states set goals for social determinants in contracts, comparatively few offer payment incentives for meeting those goals.

The report concludes with several policy recommendations that would expand innovative programs connecting medical and social service providers. One recommendation, for example, calls for CMS to improve vulnerable populations’ access to health services and care coordination, as well as to clarify how MCOs can improve (and pay for) social interventions.

One possibility for helping to make collaboration more common, the report notes, would be for CMS to approve more demonstrations that test social care strategies, and provide support for outcomes-based payment for social interventions. That way, dollars are being used on proven and successful initiatives and models.

THE ROLE OF SOCIAL FACTORS

Expanding these MCO/social service provider networks creates and maximizes civic value. That’s because they respond to, rather than dictate, community needs by providing services that extend well beyond necessary and avoidable care and focus instead on improving health for underserved community members. Additionally, provider groups benefit from the reduced friction and greater reliability of referrals into social service delivery organizations.

MCOs that participate in an accountable, reliable, predictable social care services coordination network can make a sustainable impact in achieving the Triple Aim by improving population health, and by supporting the performance objectives of existing regional efforts, which in turn reduces total costs of care and improves patient, employee and provider satisfaction.
Discussing costs of care with patients

by DEBORAH ABRAMS KAPLAN Contributing author

If patients are complaining that they’re paying more for their healthcare than in the past, it’s because they probably are. Between 2006 and 2016, employees paid 8.2 percent more than their salary increase for employer-sponsored insurance, and their out-of-pocket costs rose by 53.5 percent, according to the Economic Policy Institute.

Whether or not patients share cost concerns with physicians, financial issues are a growing part of healthcare decision-making. Many patients would like to talk with physicians about those costs.

Until recently, physicians have been wary about these discussions. But the landscape has shifted in the last decade as health plans have steadily raised deductibles and cost-sharing requirements. In 2013, The New England Journal of Medicine published a physician-authored essay that called costs a “side effect” and urged physicians to “disclose the financial consequences of treatment alternatives just as they inform patients about treatments’ side effects.”

Linda Oberstein, MD, an internist in Burlingame, Calif., has been practicing medicine for more than 20 years, and has noticed patients’ growing reluctance in the last five to seven years to undergo a test before finding out what their insurance would cover.

“I’m getting more and more questions about how much tests will cost,” she says. “Patients come back to me and say they had to pay $300 for a blood test, and they have insurance and don’t know why it wasn’t covered,” she says.

As a result, Oberstein now weaves cost into her discussions more frequently, even though that can be uncomfortable at times.

The problem is that not all physicians are engaging their patients on cost the way Oberstein does. While 76 percent of patients surveyed by Avalere Health felt it was important to discuss the costs of their care with their physician, 21 percent said they received some, little, or no such information during a doctor visit.

The place to start when talking about cost of care with patients is to consider the discussion fair game with every patient. Physicians should not make assumptions about which patients may want to have financial discussions, says Emmy Ganos, Ph.D., a program officer at the Robert Wood Johnson Foundation.

“It’s not just about finding patients who can’t afford to pay their co-pay or for prescribed medications,” says Ganos, a participant in the recently-published Cost Conversation projects. “It’s also for people who want to plan for what’s coming down the road.”

BARRIERS TO DISCUSSING COST

Experts cite a variety of reasons why doctors are reluctant to discuss care costs with their patients. Among them:

Cost uncertainty

Most healthcare services don’t come with a set menu of prices. Moreover, the patient’s
Operations

Cost of care discussions

“I’m getting more and more questions about how much tests will cost. Patients come back to me and say they had to pay $300 for a blood test, and they have insurance and don’t know why it wasn’t covered.”

—LINDA OBERSTEIN, MD, INTERNIST, BURLINGAME, CALIF.

portion can depend on their insurance plan, deductible, and billing code. So rather than seeking the exact cost of each treatment option, says Ganos, find out the relative cost of the most-frequently prescribed medications or services, and places with potentially lower pricing.

While Oberstein doesn’t always know which lab charges preferred rates for which insurance plan, patients sometimes know which labs or imaging centers their insurance company prefers. Or she’ll tell them that there may be a cost for the service, and suggest that the patient find out what lab the insurance company recommends.

She may ask the patient to find out if their insurer will cover a blood test as preventive lab, and if not, she sometimes can order it using a different code, like noting a strong family history of the disease.

Time
Doctors think cost discussions with patients are more time-consuming than they are, since data show that the amount of time they actually take is quite short. A study in the Journal of Oncology Practice showed that cost conversations took a median 33 seconds in a 12-minute appointment. Moreover, cost conversations can potentially save time in the long run, as the doctor may be able to avoid subsequent calls from the pharmacy for an alternative prescription, or not have to identify potential adherence issues at future visits, says Ganos.

Lack of ready solutions
“I think that physicians often experience stress asking [patients] about cost because they’re not always aware of resources to help patients,” says Syed Yousuf Zafar, MD, a cost-of-care researcher and medical oncologist at Duke University, in Durham, N.C. “Primary care physicians have more alternatives than oncologists, in that there are often generic medications, which might be less expensive,” he says.

Primary care doctors can also refer patients to pharmaceutical companies’ financial assistance programs or use apps such as GoodRx, which can sometimes provide discounts on prescription drugs.

While some medical treatments and diagnostic tests are unavoidable, others can be spread out to help with budgeting. This may give the patients the option to choose between different treatment pathways, or delay a test or procedure the patient ultimately decides is not worth the cost.

Oberstein sometimes delays ordering tests for patients who are clinically stable so they won’t have to pay for tests they might not need. She says that while she talks with patients about the costs of outside treatment, she is uncomfortable bringing up the cost of her own visits, especially follow-ups.

“I want them to come back, to see how they’re doing. I sometimes will say to follow up with me in six weeks, or if that’s difficult, to email me and let me know how you’re doing” through the secure portal. She offers that option for issues such as blood pressure monitoring, if she is confident their equipment is accurate.

Quality of care
Even if doctors bring up cost issues, patients may be reluctant to discuss them,
How to talk to patients about billing  

By AVERY HURT contributing author

You know how much you have invested in your career and how much money it takes to run a medical practice, but your patients may not. If you let patients know from the beginning that you are running a business and expect to be paid, you’ll have far fewer collections problems in the long run. Fortunately, having this conversation is not as difficult as you may think.

DON’T BE SHY

“We’re often embarrassed about collecting money, but we shouldn’t be,” says Kenneth Hertz, FACMPE, principal consultant for the Medical Group Management Association Health Care Consulting Group. “You can explain in a friendly tone that you are a business and want to be around for a long time to provide care to your patients. That means you have to collect payments.”

Once patients understand this, they are more likely to pay their bills on time. But doctors have to be consistent with this message.

“Most patients understand their obligations and are willing to pay,” says Elizabeth Woodcock president of Woodcock and Associates, a practice consulting firm. “A few are going to resist.” For those few, you have to make it clear from the outset that you expect to be paid in a timely manner.

This means having a billing and collections policy and sticking to it — no exceptions. “Often, the doctor tells the billing staff to collect what patients owe, but then tells patients not to worry about payment. I’m always hearing from staff [who are] frustrated by doctors making exceptions to the policies,” Woodcock says, adding that if patients learn they don’t have to pay, they never will.

Of course, you can — and should — still make arrangements with people who can’t afford to pay. But you must have a detailed policy for handling financial hardship, and every employee in your practice needs to understand and abide by that policy.

Setting expectations requires more than posting a set of billing policies. If you expect patients to comply with your policies, you must stick to those policies, too.

EDUCATE CLINICAL STAFF

It would be nice to leave billing to the billing department and patient care to the clinical staff. But that’s not always possible.

Billing staff don’t know what’s going to happen before or during the visit. For example, a clinician may perform a procedure that requires an additional copay. “[Before] these things happen, someone from billing needs to come back and explain the

out of concern that they won’t be offered all care options in the future, or that they’ll receive lower quality care, says Ganos. So after determining that finances are an issue, Ganos recommends that doctors reassure patients that they’ll make all medical decisions together, and that the patient will be presented with all options, regardless of cost.

Oberstein, though, has seen patients share less with her during the annual physical or wellness visit, since the session may

not be fully covered by the payer if additional health issues are discussed. The receptionist gives patients coming for their Medicare annual wellness visit or private payer check-up information alerting them that there may be some charges for an office visit instead.

For the insurance-covered wellness visit, “I can’t talk about anything but what’s covered in the annual visit, by strict guidelines,” she says. “If we talk about your blood pressure and it’s high and I change your prescription, I have to charge for it.” Oberstein says

extra charge to the patient,” says Karen Lake, healthcare consultant at the accounting firm Pearce, Bevill, Leesburg, Moore.

Clinical staff need to be prepared to address these situations as well. The rise of patient consumerism means that patients are more aware of their care costs and are more likely to ask what they’ll be expected to pay for procedures, lab tests, and the like. Often, those questions come up in the exam room.

“Physician assistants and nurses deal with this all the time, so it’s a good idea if the billing department does in-service training so that the clinical staff have a better idea of billing and insurance issues,” Lake says. “They don’t need to know all the details, but they do need to know when to call in the billing department for clarification.”

GIVE PEOPLE A CHANCE

The majority of patients take their financial obligations seriously. They value your services and expertise. They just need to understand what they are responsible for paying. It’s your job to explain that to them.

“The conversation doesn’t have to be all ‘Thou shall,’ ‘Thou shall not,’ and ‘We reserve the right,’” Hertz says. “Be up front, human, and matter-of-fact. It’s just a matter of person-to-person communication.”

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this puts her at odds with her patients, who come expecting a free annual visit. Some tell her they have other medical issues but won’t share them because it means they’ll have to pay for the visit.

**HOW TO TALK ABOUT COST**

It’s important for the physician to bring up cost of care, because patients don’t always know they can ask about it.

“It’s clearly something that patients worry about, and we’ve seen in our research the stress that the financial impact of medical care puts on people at a vulnerable time,” Ganos says.

Some patients feel ashamed and don’t want to raise the issue. To create a welcoming environment, physicians can use language like “a lot of my patients have trouble affording medications. Has that been an issue for you?” Ganos says. People don’t want assumptions made about their financial situation, so physicians can say that it’s something they ask all patients. “The universal approach makes people feel more comfortable,” Ganos says.

Zafar frames cost as a side effect patients should expect. “We’re careful to inform our patients about the side effects they might experience from treatment, and cost is one of the side effects,” he says. Even if he can’t give an exact amount, he tells patients if they will face expenses not covered by insurance as a result of the treatment he’s prescribing.

Zafar prefers to talk about affordability rather than cost. “If I tell the patient I want to make sure they can afford the treatment, that helps align my interest with theirs,” he says. He’ll say, “I want to make sure you get the best treatment possible and that you can afford that treatment. Let me know if you have problems paying for your care.”

The physician is often the best person to initiate the cost discussion, says Zafar, because they are responsible for the treatment plan. But other team members can sometimes help as well. If the office uses a nurse or medical assistant for medication reconciliation, that person can include a question about the affordability of medications during the intake.

A practice’s financial navigator can take this on as well. Smaller practices that don’t have a financial navigator can train someone for this role. Zafar suggests meeting with practice staff to find out what patient questions they’re getting about cost, and who gets which questions. They can share resources, such as which facilities offer less expensive imaging, procedures or medical supplies.

**COST OF CARE TOOLS**

One outcome of RWJF and Avalere’s Cost Conversation projects is a series of practice briefs available to physicians on America’s Essential Hospitals website. It includes examples of conversation starters, such as “Have you ever had trouble going to your appointments due to things like travel or childcare?” or “Do any of these medications/treatment plans represent a significant financial burden for you? If so, which ones?” or “How about if we take another look at your medications/care plan and see if there are any less expensive alternatives?”

The practice briefs also include resources on medication discount programs, how to integrate cost conversations into the workflow, and examples of flyers practices can post to make patients more comfortable asking about cost issues.

Care costs can also include transportation, child care and lost wages. “Oftentimes physicians and care providers have strategies they can share, or resources that make a difference, but you don’t know if someone will need that help unless you ask,” Ganos says.

While a solution may not exist for every cost issue a patient faces, physicians are better able to help their patients if they know the patient’s challenges. “Not talking about it isn’t working,” Ganos says.
he news comes as no surprise: “For the first time in the United States, employed physicians outnumber self-employed physicians,” says a new study released this month by the American Medical Association.

Let’s set aside for a moment that this finding, which the AMA deemed a “milestone,” was based on a pretty small batch of doctors: only 36 percent of the 3,500 doctors surveyed responded. That those 1,260 doctors represent the nearly 1 million doctors in the United States may be a statistical stretch. That said, other reports say only one in three doctors today is independent.

Regardless, the rate of doctors forgoing their independence for steady paychecks is, by all accounts, continuing. And the trend is not healthy for doctors. It’s not healthy for patients. And it’s not healthy for America.

WHY WE SHOULD WORRY
When hospitals or private equity groups buy up doctors, costs skyrocket, quality goes down, and, if the hospital doing the acquiring is nonprofit, communities suffer financial harm because all the taxes that independent practice once paid come off the tax rolls.

What’s more, when doctors become employees, they suffer burnout much more often than their independent counterparts. Today, the suicide rate among doctors is the highest of any profession. The corporatization of medicine is part of the problem.

Yet hospitals continue to roll up practices for one reason: Money. The more doctors that hospitals or private equity companies own, the more market share they capture, the more bargaining power they have with insurers, the more facility fees they can charge (added costs hospitals charge for outpatient services that independent doctors don’t), and the more referrals they drive into their systems.

This adds up. According to a 2019 report from Merritt Hawkins, hospitals make on average $2.4 million a year net for every doctor they employ. No wonder they want to lure doctors into indentured employment. Doctors sign away their autonomy to escape a burdensome regulatory environment—and often regret it later.

Though many employed doctors will privately tell you they want out, non-compete clauses in their employment contracts keep them in shackles.

A PENDULUM SWING
However, this story has another side, a brighter one. While the trend toward doctors becoming employees continues, it has slowed. Meanwhile, another trend is afoot: Doctors are also leaving employment at record rates.

Let’s get back to the numbers for a moment. The AMA study found that 47.4 percent of all patient-care physicians in 2018 were employed while 45.9 percent were their own bosses; this tipped the employed doctors over the halfway mark, by AMA math. The study also noted a 6 percent increase in employed doctors and a 7 percent drop in self-employed doctors between 2012 and 2018.

However, the AMA also reported that more than half of the shift toward employment occurred in the first two of those six years, between 2012 and 2014. Since then, the trend has slowed.

At the Association of Independent Doctors, we believe this is partly because word about the negative impact of hospital/medical group mergers is getting out. Since our association started being the voice for independent doctors six years ago, we have enlightened consumers, lawmakers, businesses and media about why the survival of independent doctors is so essential, and why consolidation is harmful.

We are witnessing employment slowing, and the tide turning.

Last fall, 88 doctors in Charlotte, NC, ended their 25-year employment relationship with Atrium Health and re-invented themselves as Tryon Med-

“Independence is not a thing of the past. Rather, it is the future.”

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medical Partners, an unapologetically independent practice. “As an independent practice, we can better control how we practice medicine and our destiny,” said Dale Owen, MD, the group’s CEO.

Buoyed in part by that success, another large group in the Charlotte area announced in January that they were leaving their hospital employer, Novant Health. The head of the 42-physician group said the doctors wanted to “use their new-found independence to improve the quality of their own lives and the care they provide patients,” according to the Charlotte Observer, further citing the need to make healthcare affordable.

More recently, in northeast Wisconsin, 15 cardiologists severed ties with ThedaCare, a major health system in the region and the group’s employer since 2011, and started an independent practice in April. Again, they gave as their reason, “a desire to have more control over all aspects of their work.”

I hear almost daily from doctors who are converting their practices into direct pay models. By opting out of the strangling triangulation that comes from dealing with third-party payors, they are bringing costs way down, greatly eliminating the burdens of data collection, and, unlike their employed colleagues, are happier in their profession.

All of these recently liberated doctors have something in common: the certainty that they are at the forefront of the new trend in medicine. Numbers only tell part of the story. The rest of is that independence is not a thing of the past. Rather, it is the future.

Marni Jameson Carey is executive director of the Association of Independent Doctors.

Employed physicians outnumber independent physicians for the first time  By Chris Mazzolini

For the first time in the United States, more physicians are now employed rather than own their own practice, according to a new employment study released this week by the American Medical Association (AMA).

In 2018, the latest available data, 47.4 percent of physicians worked as employees, compared to 45.9 percent that were owners, while the remaining 6.7 percent of physicians work as independent contractors. That’s a 7 percent shift since 2012, according to the AMA.

The change in employment status for U.S. physicians is not surprising—it’s a culmination of a decades-long trend that has ebbed and flowed along with the market and policy landscape and has included hospitals buying up independent practices and large organizations merging to achieve economies of scale and better negotiating leverage with payers.

“Transformational change continues in the delivery of healthcare and physicians are responding by re-evaluating their practice arrangements,” said Barbara L. McAneny, MD, the AMA’s president, in a news release.

The AMA report cautions that while the trend toward physician employment has continued for decades, it is not guaranteed to last forever. In fact, the rate of physicians switching from practice owners to employees has slowed in recent years. The majority of physicians who care for patients (54 percent) still worked in physician-owned practices in 2018 either as an owner, employee, or contractor. In fact, many physicians prefer independent arrangements if they can make them viable.

For primary care specialties, the ownership vs. employment trend broke down in this way:

- **General internists**: A slim plurality remain owners of their own practices—46.9 percent were owners, 46.8 percent were employees and 6.3 percent were independent contractors.

- **Family physicians**: The majority of family physicians are now employees—57.4 percent are employees, 37.5 percent remain owners and 5.1 percent are independent contractors

And despite the ownership shifts, in 2018 most physicians (56.5 percent) still worked in small practices with 10 or fewer physicians. This share has fallen slowly but steadily since 2012, when the number was 61.4 percent.

“This change has been predominantly driven by the shift away from very small practices, especially solo practices, in favor of very large practices of 50 or more physicians,” the AMA report reads.
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“Treat your life as a business (Me, Inc.) and you’re the CEO.”

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

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

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Internal Medicine / Hospice and Palliative Care  
Austin, Texas

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“The hospital is not your friend.”

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

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“Spoken words evaporate. Written words are eternal.”

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Staten Island, N.Y.

“Slow down.”
“There are [EHR] components that can come back and bite physicians if they’re not handled correctly.”

ROBERT HANSCOM, JD, COVERYS

PAGE 6

“I’m getting more and more questions about how much tests will cost.”

LINDA OBERSTEIN, MD, INTERNIST, BURLINGAME, CALIF.

PAGE 31

45% of final-year residents got more than 100 job recruitment offers in 2018, according to a survey

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Primary care physicians are at the center of the controversy known as the anti-vaccination movement. What can physicians do to both communicate with patients effectively regarding the importance of vaccination? How can they navigate these difficult conversations? What can physicians do as a profession to push back on this trend and improve patient care?

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