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You Deserve to Get Paid

☐ Master E/M levels
☐ Use modifiers correctly
☐ Avoid Incident-to denials
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How independent physicians can combat hospital consolidation

Independent physicians across the country continue to experience changes to the way we practice. While the public might think the most significant changes are driven by new medicines or technologies, the increasing rate of hospital consolidation is perhaps the most pressing threat we face today.

As the healthcare landscape evolves, challenges to our daily practices include frequent government-mandated changes, insurer intrusions and ever-changing marketplace dynamics. We are being confronted with the ongoing monopolization of healthcare by hospital systems aggressively acquiring independently-run physician practices. For those of us who are committed to treating patients in our communities, these mergers are occurring at an alarming rate.

I’ve seen and felt the impact of hospital consolidation firsthand as a practicing independent urologist for the last 30 years. Many of my colleagues could no longer compete. They felt they had no choice but to agree to be purchased by a hospital system. Hospitals across the country are purchasing private practices in all specialties to extend their service areas.

The Large Urology Group Practice Association (LUGPA) commissioned data that demonstrated a majority of Americans (65 percent) trust independent physicians in general and associate us with more personalized and patient-focused care compared to physicians employed by hospitals.

Hospital systems’ continued purchase of independent practices is making my patients nervous. Nearly one-third of older Americans worry they won’t get the care they need at a location they choose for a price they can afford. Their concern is not surprising given that hospitals are usually more expensive than independent practices.

It’s simple economics that pricing increases when a player monopolizes the market. As a result of unchecked hospital monopolization, patients are left with fewer options and higher costs — contrary to the benefits hospitals claim mergers offer. Data from LUGPA also revealed more than two-thirds of Americans want a solution to the growing trend of hospital purchases of independent practices. They also want payers to compensate all medical practices equally, a concept known as site-neutral payments.

The numbers don’t lie, and the evidence is clear: Patients want to be in control of their health and have the ability to choose the best option for their care. Patients do not want to be forced to rely on large, impenetrable and much more expensive hospital systems that are gobbling up the local family practices they’ve been visiting for decades.

The care we offer as independent physicians is incredibly valuable to patients. Likewise, it is both a reward and a privilege to care for them.

Richard G. Harris, MD, is president of LUGPA, the only nonprofit urology trade association in the United States that provides resources to preserve and advance the independent practice of urology.

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Get paid what you deserve

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Are EHR-generated emails increasing physician burnout?

Reducing the number of e-mails doctors get due to EHR-generated algorithms could help improve physician job satisfaction and combat burnout, according to a new study.

The study looks at the sources of in-basket messages among 934 doctors at a multispecialty healthcare organization, the Palo Alto Medical Foundation. It found that doctors received an average of 243 messages per week. The largest number—47 percent—were generated by the EHR system in the form of prior authorizations, patient reminders, and orders sent automatically according to algorithm-driven health maintenance reminders, among others.

It also found that internists and family doctors receive significantly more system-generated messages than other specialists—about 250 percent more than surgeons, 400 percent more than nonprocedural E/M-oriented specialists and 500 percent more than nonsurgical specialists.

The remaining 53 percent of messages came from other care team members, the physician using the EHR (for items such as results of lab tests the physician had ordered) or from patients.

Separately, respondents were asked questions designed to measure burnout, such as whether they felt physicians are highly valued, and how much control they had over their work schedule.

Results of a regression analysis found that receiving more than the average number of system-generated messages led to a 40 percent greater probability of burnout and 38 percent higher probability of intending to reduce their clinical work time in the following year.

The authors note that the connection between the quantity of in-basket messages and burnout could lead healthcare organizations to rethink their e-mail response policies.
Are primary care physicians underpaid?

New study suggests the answer is yes

A new study from Merritt Hawkins compares the average salaries of various medical specialties compared to the average annual inpatient/outpatient revenue they generate for their affiliated hospitals—and found pay for primary care physicians is lacking.

The results from the 2019 Merritt Hawkins Inpatient/Outpatient Revenue Survey found that primary care physicians—defined by the survey as internal medicine, family practice and pediatricians—ranked near the bottom in terms of salary as share of the average revenue they generate.

“Physicians typically generate considerably more in ‘downstream revenue’ than they receive in the form of salaries or income guarantees,” the survey results read. “This is particularly true of primary care physicians.”

Here’s how various specialties ranked in terms of salary compared to annual revenue generated:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Average Revenue Generated</th>
<th>Average Physician Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology (non-invasive)</td>
<td>$2,310,000</td>
<td>$427,000</td>
</tr>
<tr>
<td>Cardiology (non-invasive)</td>
<td>18.48%</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>$2,161,458</td>
<td>$386,000</td>
</tr>
<tr>
<td>Urology</td>
<td>17.86%</td>
<td></td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>$2,024,193</td>
<td>$324,000</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>16.01%</td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td>$1,789,062</td>
<td>$272,000</td>
</tr>
<tr>
<td>Nephrology</td>
<td>15.2%</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>$2,675,387</td>
<td>$261,000</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>9.76%</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$1,612,500</td>
<td>$230,000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>14.26%</td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td>$2,111,931</td>
<td>$241,000</td>
</tr>
<tr>
<td>Family Practice</td>
<td>11.41%</td>
<td></td>
</tr>
</tbody>
</table>
Coded demystified
Boost revenue by getting it right

by Lisa A. Eramo, MA
Contributing author

It’s every physician’s worst nightmare: Receive payment for services rendered, but then a payer identifies an aberrant pattern in claims data, audits the records, decides it has overpaid the practice, and recoups those funds. That money you already allocated for overhead, staff salaries, bonuses, or new medical equipment? Gone. With one post-payment audit, you now owe thousands of dollars or more. The good news is, physicians can take steps to focus on accurate billing and avoid costly recoupments. This article explores five billing vulnerabilities and provides tips to maintain compliance.
E/M coding  Four tips to select the correct level

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>Average Medicare payment, new patient</th>
<th>Average Medicare payment, established patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201/99211</td>
<td>Level 1 office visit</td>
<td>$45</td>
<td>$22</td>
</tr>
<tr>
<td>99202/99212</td>
<td>Level 2 office visit</td>
<td>$76</td>
<td>$45</td>
</tr>
<tr>
<td>99203/99213</td>
<td>Level 3 office visit</td>
<td>$110</td>
<td>$74</td>
</tr>
<tr>
<td>99204/99214</td>
<td>Level 4 office visit, new patient</td>
<td>$167</td>
<td>$109</td>
</tr>
<tr>
<td>99205/99215</td>
<td>Level 5 office visit, new patient</td>
<td>$211</td>
<td>$148</td>
</tr>
</tbody>
</table>

Source: 2019 Medicare Physician Fee Schedule

Payment don’t usually deny evaluation and management (E/M) codes on the front end, says Toni Elhoms, CCS, CPC, a provider coding and education consultant in Denver. It isn’t until they look at the totality of the data retrospectively—long after physicians are paid—that financial penalties ensue, she adds.

“Payers are like the IRS,” says Elhoms. “You don’t want them on your back because recoupments are insidious. They come out of nowhere.”

Consider the difference in reimbursement for established patient office visits levels 2 versus 3 (i.e., CPT codes 99212 and 99213)—approximately $29. Let’s say 10 to 20 times per week over a year, a physician bills 99213 when their documentation only supports 99212. They’ll be paid initially, but likely have a $15,000-$30,000 recoupment on their hands if a payer uncovers the error during a post-payment audit.

Here are four tips to help physicians avoid denials due to incorrect E/M levels:

1. **Ensure the E/M code supports the specific patient encounter.**
   Not every patient with asthma, for example, will justify reporting CPT code 99213, says Elhoms. Some cases may be exacerbated and/or require medication management and referrals to specialists while others may be relatively straightforward and controlled.

2. **Refer to the E/M guidelines**
   Assigning an E/M code is not a subjective process. Instead, physicians should refer to the 1995 or ’97 E/M guidelines that include specific requirements for time-based billing as well as billing based on the three key components: history, exam, and medical decision-making, says Elhoms. She says the most common mistake physicians make when applying these guidelines is under-documenting E/M level 4 and 5 visits for new patients. More specifically, they omit one or more systems in the requisite general multi-system exam or they omit a complete past family and social history.

3. **Use copy and paste functionality with caution.**
   Copy and paste can save time, but it can also cause serious compliance problems, says Elhoms. That’s because when physicians automatically bring historical information from a previous encounter forward into their current note, they may inadvertently inflate the E/M level. Best practice is to validate any information copied forward to ensure it’s accurate and relevant to the current encounter—or turn off the functionality altogether, she adds.

4. **Watch out for pre-populated EHR templates.**
   Pre-populated templates not only lead to upcoding (e.g., if certain body systems are always indicated as having been reviewed even when they’re not relevant to the current encounter), they can also lead to contradictions that raise red flags with payers, says Elhoms. For example, a physician diagnoses a patient with strep throat. If the template defaults to a normal exam for ear, nose, and throat, this could open the door for a post-payment audit. Physicians should ensure their documentation is aligned with the patient’s diagnosis even if it means manually unchecking certain boxes in the template.
Time-based billing for E/M services

Three tips to avoid recoupments

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Typical time spent</th>
<th>Counseling and/or coordination time that's required before time-based billing is permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 minutes</td>
<td>More than five minutes</td>
</tr>
<tr>
<td>99202</td>
<td>20 minutes</td>
<td>More than 10 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30 minutes</td>
<td>More than 15 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45 minutes</td>
<td>More than 22.5 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60 minutes</td>
<td>More than 30 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Five minutes</td>
<td>More than two-and-a-half minutes</td>
</tr>
<tr>
<td>99212</td>
<td>10 minutes</td>
<td>More than five minutes</td>
</tr>
<tr>
<td>99213</td>
<td>15 minutes</td>
<td>More than seven-and-a-half minutes</td>
</tr>
<tr>
<td>99214</td>
<td>25 minutes</td>
<td>More than 12.5 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40 minutes</td>
<td>More than 20 minutes</td>
</tr>
</tbody>
</table>

Time-based billing for E/M services is appropriate only when the physician meets face-to-face with the patient and/or family and spends more than 50 percent of the encounter counseling and/or coordinating care, says Elhoms. It’s not appropriate when the counseling and/or coordination of care is rendered over the phone or via email, she adds. To avoid denials, consider these tips:

1. Know how much time is typically associated with each E/M level as well as the amount of time a physician must spend counseling and/or coordinating care to bill solely based on time rather than the three key components (i.e., history, exam, and medical decision-making).

Consider doing the following:

2. Document the total time spent face-to-face with the patient as well as the total time spent counseling and/or coordinating care.

3. Explain what the counseling and/or coordination of care entailed (e.g., answered questions regarding the treatment plan or extensively discussed treatment options.) Note that counseling and coordination of care does not include administrative tasks such as documenting in the EHR, dictating, refilling prescriptions, completing workers’ compensation applications, communicating with other professionals, or reviewing records and tests before or after the face-to-face visit.

Prolonged services

Focus on documentation to ensure compliance

When physicians report prolonged services (i.e., CPT codes 99354 [first hour of the prolonged service] and 99355 [each additional 30 minutes]), they signal to payers that they spent face-to-face time above and beyond what’s typically associated with an evaluation and management service. CPT code 99354 yields approximately $132, and CPT code 99355 yields approximately $101.

Physicians frequently provide prolonged services for new patients who are medically complex as well as established patients.
presenting with new and complex problems, says Sonal Patel, CPMA, CPC, a healthcare coder and compliance consultant with Nexsen Pruet LLC, a business law firm in Charleston, S.C.

“Internists are the first line of defense for some of these patients, and they can easily talk for two hours, for example, with a patient who has diabetes before they refer them out to a specialist,” she adds. The same is true for patients requiring a cardiology workup.

It’s important to document why this additional time was necessary, says Patel. More specifically, documentation should include the following:

- Total duration of the face-to-face visit
- Start and end times of the face-to-face prolonged service
- Specifically what was discussed with the patient during the additional time

Patel provides these three additional tips for reporting prolonged services correctly:

1. Always report a prolonged service code with an E/M code. Prolonged services cannot be billed alone because they are ‘add-on’ codes.

2. Know how much time is required before billing a prolonged service is permitted. Consider the following:

3. Use the EHR to help calculate time spent on the prolonged service. Some EHRs enable physicians to use a timer when documenting, making it easier to track how much time was spent on the prolonged service and whether that service is separately billable.

<table>
<thead>
<tr>
<th>Total duration of prolonged service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes</td>
<td>99354 (x1)</td>
</tr>
<tr>
<td>75-104 minutes</td>
<td>99354 (x1) and 99355 (x1)</td>
</tr>
<tr>
<td>105 minutes or more</td>
<td>99354 (x1) and 99355 (x2 or more for each additional 30 minutes)</td>
</tr>
</tbody>
</table>

Modifiers -25, -26, and -59

Expert advice to mitigate risk

When appended to a CPT code, modifiers provide additional information about how payers should reimburse certain services. Consider the following:

Physicians need to ensure they send the right message to payers so that message doesn’t come back to haunt them in the form of a recoupment, says Joette Derricks, healthcare compliance and revenue integrity consultant in Baltimore. “Many commercial payers have also tightened their reimbursement edits to deny modifier -25 claims upfront,” she says. It’s important to check with each payer to determine whether it has published any guidance before establishing a policy within the practice for reporting modifiers, she adds.

Dorothy Steed, CCS, CDIP, a revenue cycle consultant in Atlanta agrees. “A lack of knowledge doesn’t typically work well as a defense,” says Steed, adding that physicians should study these modifiers and, if financially feasible, hire a certified coder to validate claims before submission. “If physicians don’t protect their financial resources, they’ll be in trouble and possibly out of business,” she adds.
Consider the following tips to help maintain compliance:

**Modifier -25**
Apply this modifier to the E/M code—not the code for the procedure.

Document why the additional E/M service was necessary and why it went above and beyond what’s typically required for the procedure. For example, a patient falls and suffers a laceration that requires stitches. If deemed necessary, the physician may perform a workup to determine whether the patient suffered a concussion during the fall. The physician could report a separate E/M service with modifier -25 for the workup if they document why they felt the patient was at risk for a concussion and what the workup entailed. The same is true for an annual wellness visit and separate problem (e.g., heart arrhythmia) that requires additional cardiology workup.

Use this modifier with caution when performing pre-scheduled and/or repetitive procedures (e.g. skin tag removals or pain injections). The E/M service associated with these procedures (e.g. checking the patient’s heart, lungs, and blood pressure) is not usually significant and separately identifiable. Other services may be separately billable, depending on the circumstances.

**Modifier -26**
Apply this modifier to a global procedure code (i.e., one that includes the interpretation and test itself) when a more specific code is unavailable. For example, apply modifier -26 to CPT code 71045 (single-view chest x-ray) when the physician performs the interpretation only. If the physician owns the equipment and performs the test, modifier -26 isn’t necessary, and reporting it can actually result in an underpayment.

Know when a more specific code is available. Consider this scenario: A physician performs the interpretation and report of a routine electrocardiogram (EKG), but doesn’t perform the tracing. In this case, report CPT code 93010 (interpretation and report only)—not CPT 93000 (EKG with tracing, interpretation, and report) with modifier -26.

Ensure compliance when using an outsource coding vendor. Derricks says she provided consulting services to an internal medicine practice that owed several thousand dollars back to the payer because its coding vendor failed to apply modifier -26. The vendor wrongly assumed the physician performed various radiology procedures in addition to the interpretation, resulting in a significant overpayment.

**Modifier -59**
Only apply this modifier when appropriate to non-E/M codes with a Correct Coding Modifier Indicator of ‘1’ (modifier allowed). To view modifier indicators for each code, visit https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html. Most practice management systems also include this information.

Think of this modifier as a ‘last resort.’ If another modifier is more appropriate, use that modifier instead. Consider these other options first: -RT (right), -LT (left), or -50 (bilateral procedure). Payers may also accept modifiers -XE (separate encounter), -XS (separate organ or structure), -XU (unusual non-overlapping service), or -XP (separate practitioner).

Know the criteria. Medicare recently published Medlearn Matters article SE1418 that includes clinical scenarios and guidelines for proper use of modifier -59.
healthy vitals

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Incident-to billing

Know the requirements to ensure compliance

Incident-to billing enables non-physician providers to bill services under a supervising physician’s National Provider Identifier (NPI) rather than their own NPI so the practice can collect 100 percent of the Medicare physician fee schedule amount, rather than 85 percent. However, incident-to billing has several requirements that, if unmet, can cause costly recoupments during post-payment audits, says Jamie Claypool, CPC, CPMA, practice management consultant at J. Claypool Associates Inc. in Spicewood, Texas.

Following are several common reasons for denials and how to avoid them:

Reason for denial: Incident-to services are billed for a new patient visit.

How to avoid it: Schedule all new patients with a physician who can establish a plan of care. Then schedule all follow-up appointments for the same problem with the non-physician provider, and bill those appointments incident-to the physician, says Joette Derricks, healthcare compliance and revenue integrity consultant in Baltimore.

Reason for denial: Incident-to services are billed for an established patient with a new problem.

How to avoid it: Ask the supervising physician to talk briefly with the patient and establish a plan of care for the new problem. The physician must then document their assessment of the problem, including any relevant history, exam, and medication decision-making as well as the plan of care itself. If a physician isn’t available to do this, bill the visit under the non-physician provider’s NPI, assuming they are credentialled with the payer, says Derricks.

Reason for denial: Incident-to services for new problems do not meet supervision requirements.

How to avoid it: Ensure a supervising physician is always in the office suite and immediately available. Note that the supervising physician doesn’t need to be the same person who established the initial care plan, says Claypool. It simply needs to be a physician employed by the practice, she adds.

Payers will go so far as to request access to daily schedules to determine whether the physician under whom the incident-to service was billed was in the office and immediately available (e.g., whether they too saw patients in the office during the same timeframes), says Claypool.

Nursing home visits can be tricky. If the non-physician provider sees patients in a nursing home, they can’t bill incident-to a physician unless that physician has an office in the nursing home, sees patients in that office, and is immediately available, says Derricks. A non-physician provider could also bill incident-to if the physician is in the room during the visit, but this doesn’t happen often because it’s counterproductive to tie up both providers with the same patient, she adds.

Reason for denial: Commercial payer requires -SA modifier to denote incident-to services.

How to avoid it: Know whether the payer requires it and for what types of providers, says Derricks. For example, some Medicaid programs such as California Medi-Cal and Texas BCBS require physicians to apply modifier -SA to all nurse practitioner services submitted under the physician’s NPI. Texas also requires it for physician assistants, and Tufts health plan in Massachusetts requires it only for nurse practitioners.

Continued from page 10
Practices need policies for physician marijuana use

Although still illegal under federal law, more states continue to decriminalize cannabis use across the country. As a result, employers are struggling with how to handle cannabis use by employees.

Currently, many physician practices completely prohibit the use of all drugs for physicians. However, because the use of cannabis is now legally permitted on physicians’ own time in many states, physician practices are struggling with whether they should modify existing policies that prohibit the use of any drugs and how to handle cannabis used on physicians’ own time.

When my clients ask me how to handle physicians use of cannabis, here is what I advise them to consider:

Check the legality
Every state has its own laws regarding the use of cannabis. Physician practices should find out what laws apply in their state and be aware of any changes that may be occurring in the near future.

Employer protections
In states that do allow the use of cannabis, the laws often specifically address protections for employers. The Illinois Cannabis Act is a good example of this. The Illinois law makes it clear that employers are not required to permit employees to be under the influence of or to use cannabis in the workplace under the Cannabis Act. This would also apply to physicians who are not in the workplace but are on call.

Many other states permit employers to take disciplinary action or terminate employees who violate employment or workplace drug policies. This means that employers do not need to change their view on drug use in the workplace simply because cannabis might be legal.

Moreover, most states still allow employers to maintain policies on drug testing, consumption of drugs and even storage or use of marijuana in the workplace, as long as the policies are applied in a nondiscriminatory manner.

Document impairment
Employers are also allowed under most state cannabis laws to discipline or terminate employees who reasonably appear to be impaired or under the influence of cannabis. The employer must typically have a good faith belief that the employee is impaired before taking action, so understanding and documenting the signs of impairment at work can be important. Training staff to recognize the signs of impairment is also key. Employers need to understand that terminating an employee for cannabis use without a reasonable belief (or any other actual evidence), can open the employer to liability.

Review policies
Employers should make sure they are familiar with any requirements to provide reasonable accommodations to employees under state laws. For example, if practices have employees who have a legal right use to medical marijuana, how does this impact their policies?

Although many state laws do not require employers to make an accommodation for the use of medical marijuana, some states do allow patients diagnosed with specific medical conditions to possess and use medical marijuana. Every practice must assess whether an accommodation can be made for medical use of cannabis if such use could impact job safety or performance.

It is essential for every employer to review changes in state law regarding the use of cannabis and whether such changes require the creation or modification of practice policies. Hopefully, more formal guidelines will become available. Until then, seek advice of legal counsel and put together policies that will best protect the practice.

Ericka L. Adler, JD, has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@ubm.com.
Motivational interviewing

Benefits and advice for busy physicians

by DEBRA A. SHUTE Contributing author

HIGHLIGHTS

Motivational interviewing not only helps physicians improve patient adherence, but experts say physicians who use the technique are more satisfied with their careers.

It’s not a dead end if a patient isn’t ready to change. Rather, physicians should ask the patient if it would be okay to revisit the topic at a future visit.

To improve health outcomes, today’s physicians must be able to communicate effectively with their patients. One approach many experts encourage physicians to use is motivational interviewing (MI), a series of techniques to get at the root of patient concerns and help encourage them to make healthy behavior changes.

These techniques are based on the work of William R. Miller, PhD, who originally came up with the concept to address problem drinking. Miller later teamed up with Stephen Rollnick to write a book on the subject, which is now in its third edition.

The promise of MI, according to interviews with experts, is for physicians to cease wrestling with their patients to adhere to their advice, and begin to feel they are dancing as partners.

“There’s a lot to motivational interviewing, but when it’s done well without taking too much time, it can help a busy healthcare provider ‘come alongside’ the patient,” says William H. Polonsky, Ph.D., CDE, president of the Behavioral Diabetes Institute and associate clinical professor at the University of California-San Diego. “When the physician and patient feel they are on the same side, everything gets a little easier. Patients will be more willing to probably tell their doctors the truth, and maybe more willing to follow recommendations on things like taking medication.”

BENEFITS TO PHYSICIANS

This transformation does not occur overnight, but it can have a profound effect not only on patients’ health, but on physician satisfaction, says Damara Gutnick, MD, an internist and the medical director of the Montefiore Hudson Valley Collaborative.

Introduced to MI while taking part in a chronic disease depression collaborative at Bellevue Hospital, Gutnick began applying MI-based techniques for goal setting and action planning with her patients.

“At this point in my career, I was quite burnt out,” she says, explaining that her population was quite sick, yet patients continued to keep drinking, smoking, or failing to take their medications. “When I learned motivational interviewing, I changed the way I was with my patients, and as a result my patients changed.”

This change was also reflected in Gutnick’s physician report card for diabetes control and other measures. “Mine were all in the green. It was the same patient panel that used to frustrate me and not take their medication, but it all changed when I did,”
she says. It also vastly alleviated her feelings of burnout. "Motivational interviewing gave me the opportunity to connect with patients again, which is what I loved most about medicine," she says.

‘THE LISTENING IS THE DOING’
The concept of OARS offers a snapshot of the skills involved in MI:

- **O** - Open-ended questions
- **A** - Affirmations of the patient's inner strength
- **R** - Reflective statements
- **S** - Summary statements

Open-ended questions can be anything that requires more than a yes or no response, but there are some that are especially useful in getting to the heart of the matter. Polonsky, a diabetes psychologist for more than 30 years, always asks patients to identify at least one thing that really bothers them about their disease. "I may not be able to solve it, but it changes the tone of the interaction in an important way. You're going to see your patient differently, and they're going to see you differently because you're interested in them as something more than a number, such as their A1c or blood pressure."

Affirmation and reflection are equally useful, says Gutnick. "If you reflect back and say, 'You've been through a lot. You're a survivor,' you're picking up on the strength of the individual, and that's an act of doing something," she says. Even if a clinician can't directly solve a problem the patient identifies, such as an emotional or psychosocial issue, it's a valuable interaction. "It's an act of doing what matters, because you're meeting the person where they're at, and you're acknowledging that they're struggling. The listening is the doing."

Summary statements are helpful to use at transition points in the conversation as well as at the end of the visit. Experts recommend phrasing such as, "Here's what I've heard. Tell me if I've missed anything."

John Cullen, MD, a family physician in Valdez, Alaska, has been employing motivational interviewing techniques throughout his 23-year career. "Don't get too caught up in the terminology," he suggests. "It's also important to close the computer in order to be present and empathetic. I would recommend being truthful, yet positive and supportive."

CAPTURING THE SPIRIT OF MOTIVATIONAL INTERVIEWING
Another useful mnemonic is CAPE, which Gutnick says captures the spirit of the motivational interviewing philosophy.

"If you put a cape on somebody, such as when they're graduating, it's a sign of respect," she says. "If it's raining, it keeps them warm and dry. Or they become a superhero. You can use CAPE to empower your patients to make changes for themselves," she says.

- **Compassion.** The entire interaction is driven by the best interest of the patient.
- **Acceptance and respecting autonomy.** Individuals have the right to change or not change, says Gutnick. "If somebody is not ready, you respect that and you don't push. You might use some skills to try to guide them toward change, but if you're
“There’s a lot to motivational interviewing, but when it’s done well without taking too much time, it can help a busy healthcare provider ‘come alongside’ the patient. When the physician and patient feel they are on the same side, everything gets a little easier.” —WILLIAM H. POLONSKY, PH.D., PRESIDENT, THE BEHAVIORAL DIABETES INSTITUTE

WAYS TO LEARN TECHNIQUE

There are many ways physicians can familiarize themselves with motivational interviewing skills, including articles, online modules, and workshops. However, Damara and Gutnick, who are both members of the Motivational Interviewing Network of Trainers, advise that these modalities are best used as an introduction, and that ongoing training is a must.

Polonsky says in-person training is necessary to really grasp the concept. “Studies have found that training that’s online and brief doesn’t really stick. As healthcare providers, what we all do is go back to our old habits. Live and ongoing support is most effective.”

And even when one-off trainings truly inspire clinicians, they’re unlikely to implement the skills without a framework that allows them to practice them with feedback, Gutnick says. “Any behavior change is really hard. People might have the desire, but if you don’t have the milieu that allows you to try it, then it’s going to be very hard to implement.”

CAVEATS AND CHALLENGES

The biggest obstacle physicians face in learning and practicing motivational interviewing skills is time. Even though this form of communication can be more efficient and productive in the long run, it takes a great deal of practice to do it well.

A frequent mistake that clinicians make, for example, is rushing into creating an action plan with a patient before he or she is truly ready to change, says Polonsky. “You want to capture a patient’s commitment and enthusiasm about..."
We are seeking stories from physicians about the moments that made you a better doctor. We want to hear your stories about: a memorable patient experience, the mistakes that taught you a valuable lesson, great advice from a mentor, an idea that transformed how you practiced, and anything else that made you better!

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“There is great satisfaction in finding that interventional moment that will allow a patient to change their behavior.” —JOHN CULLEN, MD, FAMILY PHYSICIAN, VALDEZ, ALASKA

saying, ‘I see this as a priority for myself, I feel less ambivalent than before, and I’m raring to go.’

When patient’s aren’t quite ready to change, it’s the rough equivalent of a man or woman standing at the alter and saying they might take the other person to be their wedded husband or wife rather than they will, says Gutnick. The way to identify an adequate threshold of readiness is to listen for “change talk,” she says.

Change talk indicates that a person has already taken steps toward change, such as buying walking shoes or setting a quit date. However, especially when pressed for time, doctors have a tendency to rush into the nitty-gritty of action planning when patients may still have ambivalent feelings, Polonsky says.

When the physician doesn’t spend enough time getting a true “I will” from patients and rushes into asking patients what actions they’re going to take the next day—How? What time?—patients might begin to give lip service to plans with which they won’t follow through, he explains. “Sometimes we move forward into antagonizing people about taking action before they’re ready to do so,” Polonsky says.

Cullen reiterates that patience is essential. “There is great satisfaction in finding that interventional moment that will allow a patient to change their behavior,” he says. “For some of my patients, it has taken decades.” Other attributes of motivational interviewing include willingness to be silent, to let patients talk, and to be present for them, Cullen says.

**Motivational interviewing Do’s and Don’ts**

**Do:**
- Express empathy
- Ask open questions
- Explore instead of explain
- Collaborate
- Respect patient autonomy
- Ask permission

**Don’t:**
- Argue or disagree
- Challenge or confront
- Criticize or warn
- Judge
- Try to persuade with logic
- Give commands

**WATCH ONLINE**

To see a video interview of Damara Gutnick, MD, explaining the basics of motivational interviewing, visit: https://www.medicaleconomics.com/news/watch-damara-gutnick-md-explains-motivational-interviewing-basics
Technology is beginning to make accurate patient cost estimates possible and thereby help medical practices engage in best practices for collections. Patient cost identification should focus on more than running patient eligibility and returning back copays, deductibles and coinsurance levels. An accurate estimate in specific procedure codes that apply to a patient encounter as well as processing logic of the specific payer to get to an actual allowable rate — in addition to the standard check for eligibility and benefits.

The number of patients using high-deductible health plans (HDHPs) has exploded over the last decade, to the tune of nearly 400 percent growth. The nearly 22 million Americans using these HDHPs creates expanding patient responsibility balances and will be vital to control so as to minimize write-offs and bad debt.

When communicating patient estimates, practices need a mechanism to assist in disseminating this often-complex information to patients. Research suggests that 74 percent of patients are confused by their explanation of benefits (EOBs). Therefore, structure your patient access teams and materials to be consultative so that patients actually understand the rationale behind their financial liability.

By educating patients in this way, your practice will see improved patient collections as well as better patient satisfaction scores since there will be fewer large surprise balances.

Given that 73 percent of practices take longer than 30 days to collect balances, accelerating this timeline can have a direct impact on your practice’s financial performance.

Here are five steps your practice can take to assist in patient responsibility collections:

1/ Review the layout of your patient estimate or patient statement. If it doesn’t make sense to you, it definitely won’t make sense to patients.

2/ Focus on verifying insurance benefits in advance of the visit so you can be aware of HDHPs or even patients with inactive coverage. Leverage electronic verification wherever possible.

3/ At a minimum, be prepared with the insurance allowables for your most common procedure codes. Although having an automatic system in place to help with this is much more efficient, knowing what your insurance allows is a step in the right direction.

4/ Work with your patient access department, physicians and healthcare providers to ensure that all parties are in alignment prior to discussing estimated costs with a patient.

5/ Change scripting at point-of-service or during pre-registration to make patients aware of possible liability and even suggest collecting payment in full, down payments or establishing payment plans, prior to the patient’s visit with their physician or other healthcare provider.

The financial experience is having an ever-greater impact on overall patient engagement. Medical groups that continue to strive towards transparency will yield better patient financial performance, improved patient experience and healthier patient relationships.

Since regulations may be passed to force medical groups to improve cost and care transparency, strive to be ahead of the curve. If you do, you will see improvements across the patient spectrum.

Andrew Harding is the vice president of customer success at Rivet. Send your financial questions to medec@ubm.com.
Drinking from the data firehose

How physicians can get useable data from wearables

by KAYT SUKEL Contributing author

HIGHLIGHT

Based on an individual patient’s specific medical needs and interest in wearable devices, providers can help curate what information is coming in from patients.

Your last patient of the day, a 58-year-old woman with a history of type 2 diabetes and hypertension, opens her smartphone immediately upon entering the examining room. You are still clicking through the electronic health record (EHR), looking for her vital signs and information from your last visit, when she tells you she’d like to show you the apps that track her blood glucose levels, diet, and daily step count.

And, by the way, her son recently told her about some other apps that could track her blood pressure as well as monitor when she takes her medication. Should she download them? Is there a way to get you the data?

Patients today are collecting and curating a phenomenal amount of health-related data—some useful, but most not. Many patients have some kind of smartphone or device in their pocket for most of the day that can provide real-time information about aspects of his or her health status. In addition, the technology market is quickly growing in this area, with new state-of-the-art medical devices, apps, and other programs, offering individuals the ability to monitor everything from glucose levels to UVA exposure to medication adherence.

Bharat Rao, Ph.D., a data and analytics leader for KPMG’s Healthcare and Life Science Practice, a global professional services firm, says the combination of market forces, healthcare regulation and consumerism—plus the proliferation of data and the rise of cheap computing—has led us to this point.

“There are all of these devices that have the potential to provide useful patient data, particularly for patients who have chronic medical conditions,” he says. “But there’s a lot of data out there. Probably too much data, in some senses. So while there is likely to be a few nuggets of value in all that information, the potential distraction in trying to deal with it all is so large that many wonder if it’s worth it.”

If doctors can get the right kind of data at the right time, the information collected from these wearable devices may offer a strong potential for more accurate diagnoses, more personalized treatments, and better outcomes. The question remains, however, how can physicians get and manage the flow of all this new data to actually improve patient care?

MORE DATA, MORE VALUE?

Ida Sim, MD, Ph.D., a primary care physician and director of digital health for general internal medicine at the University of California, San Francisco, says while many in the healthcare and technology sectors herald real-time collection and monitoring of patient data as a way of transforming patient care, this new data, in and of itself,
Data from wearables | Technology

“We can’t develop and or expect new devices and systems to be used and adopted if the doctor and/or their patients don’t see the added value.”

—JIM WEINSTEIN, DO, MS, HEAD OF INNOVATION AND HEALTH EQUITY, MICROSOFT HEALTHCARE

Jim Weinstein, DO, MS, the head of innovation and health equity at Microsoft Healthcare, the arm of the technology giant dedicated to innovative healthcare solutions, agrees. But he says several studies show that today’s new wearable data can be quite valuable. While President and Chief Executive Officer (CEO) of Dartmouth-Hitchcock Health, an academic health system in New Hampshire, Weinstein spearheaded a pilot project called IMAGINECARE that used 24/7 patient monitoring through smart phone sensors and Microsoft tools to improve the health of employees who had three or more chronic health conditions.

“Most patients see their doctor intermittently, at best. We now have the ability to monitor many of these diagnostic tests remotely,” he says. When IMAGINECARE did so, they were able to help 50 percent of those participating in the pilot get their blood pressure under control within a few months. Furthermore, 96 percent of the participants said they liked the program—and the health system projected their cost savings to approximately $250 per employee per month.

Weinstein says he and his team were very pleased with the results. And while many physicians were wary of the IMAGINECARE program initially—as well as other programs in the health system that utilized patient monitoring data—Weinstein says providers eventually became “believers,” seeing benefits in having access to such data.

“We can’t develop and or expect new devices and systems to be used and adopted if the doctor and or their patients don’t see the added value. Whatever we bring forward must improve care and lower the friction of delivering that care,” he explains. “We have optimism that these kinds of opportunities will grow in the future.”

But Rao says while there is vast opportunity, with many use cases suggesting an important role for such data in the improvement of healthcare, there is also uncertainty. Healthcare information technology partners will have to think long and hard about how to present this data to both patients and physicians so that it is both meaningful and actionable. With so many physicians already frustrated with their interactions with EHR systems, adding more data to the pile without proper support is simply unsustainable. Dealing with such a data deluge cannot be done without technological assistance.

“There need to be algorithms, machine learning programs, that will take all this data, make sense of it, and then present the valuable nuggets of information to the physician in a way that fits in with their workflow,” Rao says.

Eric Rock, CEO of Vivify Health, a company that offers a remote patient monitoring platform, agreed. While it would be easy to say that one could simply port data from wearable devices into the EHR, it’s just not that simple. Physicians need a tool set that can take data and bring meaning to it so it can add value for both doctors and patients.

“You just can’t dump enormous amounts of biometric data from smart devices into the EHR,” he says. “It will just be a complete failure and doctors won’t use it.”

Sim says that with so many devices and apps already available to consumers, healthcare has “opened the firehose and doesn’t know what to do about all the water that’s spewing out.”

“This isn’t something that can be dealt with by an individual practitioner,” she says. “We are struggling at the front end because this data comes in so many different formats—a .pdf file here, a [step tracker] read-out here, a blood glucose app output there. It’s all in different formats from different vendors, which leads to a lot of cognitive overload for providers.”

**MAKING THE DATA WORK FOR YOU**

Certainly, many technology companies are attempting to provide the kind of tools and platforms to relieve such cognitive overload. But Sim says that there is still a lot of work to do to understand how monitoring patient data can improve patient care. That said, she believes that until more of the uncertainty is
resolved, physicians can use patient monitoring data to improve patient engagement and, in doing so, improve patient self-management and compliance.

“We can use this information to find ways to provide our patients the feedback and interactions that they want—and I believe, as a physician, they deserve,” she says. She suggests that practitioners discuss with patients what kind of data they are collecting, why they are collecting it, and what they hope to do with it.

Based on an individual patient’s specific medical needs and interest in wearable devices, providers can help curate what information is coming in from patients, separating the proverbial wheat from the chaff.

“You can discuss the different devices and apps that may be available with your patients and make decisions together about what makes sense,” she says. “When you discuss with them what kind of data they could be tracking, either to share with you or to use for their own self-management, you have an opportunity to explain what these data points mean and where they can be helpful.”

One can also, she adds, tell patients what data is not helpful.

“Sometimes, patients will say, ‘Oh, I want to collect this information,’ and, frankly, it just isn’t that useful,” she says. “I just say they can go ahead and do it for their own needs if you want and tell me how it goes. Candid discussions about what kind of data is helpful is just not something we do right now—and we are going to have to start doing it.”

Weinstein added that wearable data not only can help patients with chronic diseases manage their day-to-day care—but this data may also provide an opportunity for doctors to prevent patients from developing chronic medical issues.

“Prevention has been underutilized and is an important part of our future success in healthcare,” he explains. “Diet, exercise, and socioeconomic indicators have been woefully underappreciated when, in fact, they are some of the best predictors of outcome and health in various population segments.”

Medical device trends to pay attention to

By Kayla Matthews Contributing author

Medical devices play instrumental roles in helping physicians diagnose or monitor patients. They can also improve the quality of life for patients who use medical equipment that helps physicians track changes in chronic conditions outside of office visits.

Here are five medical device trends likely to impact the healthcare sector this year and for the foreseeable future.

1. The medical device market is booming

Market analysts keep a close eye on the medical device market to assess expected changes. Reports suggest 2019 revenues for medical devices will surpass 2018’s numbers. The U.S. Food and Drug Administration (FDA) recently announced a faster pathway for medical device approvals, and that’s a primary driver of growth in the medical device market.

Moreover, product manufacturers continually look for ways to use medical devices to remove care management barriers. An increasingly older population means physicians will likely see an increase in chronic conditions. Medical devices could help manage them, especially if they allow at-home monitoring.

2. Contact-powered devices

Battery replacements for medical devices can be inconvenient. But, researchers at Rice University developed a method using laser-induced graphene that charges devices with help from the triboelectric effect. It produces static electricity when the material becomes separated from substances with which it initially had contact. The scientists attached the laser-induced graphene to a flip-flop sandal, and the resultant charge generated as someone walked powered a small capacitor.

If this trend withstands real-world usage, people might never have to worry about plugging their medical devices in or changing the batteries. The gadgets may stay powered up through everyday activities.

3. New devices to treat depression

Medical devices may soon be a
Devices or apps that can collect this kind of data—and more—are likely on the horizon. And Weinstein says the same algorithms that will help make sense of wearable data can incorporate these kinds of social determinants of health data, too. In doing so, he believes such technologies will ultimately help to bring greater health equity to different populations within the United States.

Rao says that wearable data is here to stay—and the amount is only going to grow. But Weinstein says that if the data can be seamlessly pulled from multiple technology sources and platforms, presented in a digestible format that makes sense to physicians, and delivered at the point of care, the benefits will quickly add up.

“Physicians are generally resistant to things that could potentially harm their patients or interfere with their ability to care for them,” he says. “Therefore, any strategy involving this kind of data needs to involve the health system, doctors, nurses, other providers, staff and the patients themselves as we move forward. These technologies should be augmentative, to enhance the incredible efforts of physicians and nurses who dedicate their lives to those most in need. That is a marriage worth pursuing.”

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4. **New bacteria detection devices**
Antibiotic resistance is a severe problem that makes previously effective antibiotics no longer work to fight off bacteria. There is no single cause for the problem, but one of the contributors is the over-prescribing of antibiotics. Physicians often take that route if they want patients to get started on treatment while they wait for lab results to come back.

But, researchers at Penn State University developed a medical device that detects the presence of bacteria in minutes and classifies it into types. This achievement could make it so doctors no longer need to unnecessarily prescribe antibiotics for their patients, thereby helping cut down on antibiotic resistance.

5. **Growth in devices for children**
Many of the medical devices on the market are only for people 18 or older, which leaves children out of luck and looking for other options. However, that’s gradually changing as more gadgets become available for children to use.

The FDA recently gave the go-ahead for a nerve-stimulation device that sits behind the ear and relieves pain for kids with irritable bowel syndrome who are as young as 11. There’s also the Insulet’s Omnipod Horizon System, a tubeless insulin pump for pediatric patients with Type 1 diabetes who are as young as 2.

In 2018, the FDA hosted a workshop to discuss the scarcity of pediatric medical devices in the market. That raised awareness could mean the marketplace becomes more populated with devices children can use.
The shingles vaccine shortage: How to handle the high demand

With demand for the newer shingles vaccine, known as Shingrix, far outstripping the pace at which the manufacturer can supply it, shortages will likely continue throughout 2019, predicts the CDC.

There are a few steps physicians can take to make sure their practices can handle demand for the vaccine.

How to handle the shortage
Establish a standing order with the manufacturer for monthly deliveries: Doing so can guarantee your practice will have a regular Shingrix supply, even if it’s not enough for every patient who wants it, says Julio Viola, PharmD, the director of centralized pharmacy services at Northwell Health Systems.

Set aside a second dose for each patient who receives a first dose of the vaccine: “That way, you complete the process for each person and no one is hanging out there [without the full course of treatment],” says Viola. Dennis Gingrich, MD, a family physician in Hershey, Penn., says his office does reserve a second dose for each patient who receives a first one.

Triage who gets Shingrix first: “Prioritize older patients who are immunocompromised over healthy individuals,” says Viola, explaining that they are at greatest risk for the disease. Gingrich concurs. “We identify and address the needs of the most at-risk patients as well as trying to respond to patient requests,” Gingrich says.

The old vaccine is still an option: A physician can offer the old live vaccine to patients, and assure them that the newer vaccine becomes available they can be re-immunized with it, says Viola. That approach has been approved by the CDC, he notes.

Gingrich’s practice has opted not to offer its patients the older vaccine, but instead to wait and administer the newer vaccine as it becomes available.

Establish a call list: Invite patients to put their names down for notification from you when you have Shingrix available, suggests Viola. When they get the first dose, book their appointment for the second, and remind them to come in for that final injection, he says.

Advertise patients to check certain websites and to be persistent: GSK offers patients a Shingrix locator, although the information at the site is often out of date as supplies go quickly. Patients can also call your office and local pharmacies for up-to-the-minute notifications of vaccine availability.

Putting this vaccine in context
Gingrich encourages all healthcare providers to educate patients about the enormous value offered by vaccines.

“Vaccines are among the most safe, cost effective ways to keep people healthy. We, as healthcare practitioners, need to remind the public of that fact on every occasion that we can.”

He also notes that physicians must often try to persuade patients to do what’s best for them. This is not true with Shingrix, he says: “They are asking for it before I can get the suggestion out of my mouth.”

Milly Dawson is a contributing author. Send your practice management questions to medec@ubm.com.
Sexually transmitted infections are on the rise

What should primary care physicians do about it?

by JORDAN ROSENFELD Contributing author

Despite advances in medication that have reduced occurrences of sexually transmitted infections (STIs) like HIV, other STIs are increasing. The CDC recently reported that chlamydia, gonorrhea, and syphilis reached an all-time high of 2.3 million in 2017 and emergency departments saw a 39 percent rise in STIs.

While the causes of this increase are multi-factorial, some experts say that one of the most influential factors is that primary care physicians are not routinizing sexual health discussions as part of general health screenings.

Veronica Whitehead, M.Ed, director of programs at the North Texas Alliance to Reduce Unintended Pregnancy in Teens (NTARUPT), based in Dallas says, “We have found that physicians don’t talk about sexually transmitted infections until there is an infection.”

There may be a variety of reasons why physicians are not comfortable discussing sexual health, ranging from personal discomfort to the frequency with which they see their patients.

“If the physician isn’t comfortable with talking about sex, they probably say that one of the most important factors is that primary care physicians are not routinizing the discussions as part of general health screenings.”

Victoria Mobley, MD, MPH, North Carolina Department of Health and Human Services, HIV/STD medical director and adjunct assistant professor in epidemiology at UNC Gillings School of Global Public Health suggests another cause of the rise in STIs may be that physicians stick too closely to traditional screenings—urine, vagina, cervix, and urethra.

“We know that sexual experiences are much broader than that,” Mobley says, “People have oral sex, people have anal sex, including a good portion of heterosexuals.”

She points out that a urine-only screening will miss more than 50 percent of infections in individuals who have exposures in other sites.

“We have to be culturally competent in how we’re asking the questions about exposure and where we’re screening based on those answers,” Mobley explains.

There may come a time when more people can take advantage of newly available home STI testing kits, which can be taken in a private setting and then shared with a doctor via mail or a follow-up appointment.

But for now, the best method is to go to a physician. These kits are still relatively new and do not screen for all STIs.

HIGHLIGHT

Every primary care physician should conduct a thorough sexual history with patients on every visit, experts say.
Mobley says the opioid epidemic, which is linked to risky sexual practices, including the exchange of sex for drugs or other goods or services, may also be contributing to the rise in STIs. “In some places in the country, they’ve seen quite a significant increase in STIs associated with drug use, particularly meth use.”

**OPENING THE CONVERSATION**
The key to better screening, Mobley says, is making it routine to stave off some of the discomfort of this personal dialogue.

“Every primary care provider should have a sexual health history as a part of every visit,” Mobley says. “If you do it for every patient, whether it’s a 22-year-old sexually active young man or a 54-year-old sexually active married woman, you ask the same questions, so they come to expect it.”

For physicians who aren’t comfortable discussing sexual health right away, Ada Stewart, MD, a family practice physician with the Eau Claire Cooperative Health Center in Columbia, S.C., recommends making it part of written questions for the patient to fill out before the visit.

Once a year, Stewart asks her patients to answer written questions about sensitive issues such as smoking, alcohol, drug use, and sexual issues. “Make it simple and as easy as possible so that you’re not overwhelmed and your patients don’t feel you’re rushing them through a visit.”

**The importance of HIV counseling**

With significant advances in HIV treatment over the last ten years, including Pre-exposure prophylaxis (PrEP) treatment and improved medication regimes for those who have the virus, public alarm about acquiring HIV has ebbed.

However, Mellissa Withers, PhD, associate professor at the USC Institute on Inequalities in Global Health at the University of Southern California Keck School of Medicine in Los Angeles, suggests that physicians still need to counsel patients to use protection and get screenings for the virus because it infects an estimated 38,000 people in the United States alone every year.

“Because [living with HIV] is not a death sentence anymore, people aren’t using condoms and they’re still engaging in risky behaviors,” Withers says.

Worse, she says, as much as 14 percent of the 1.1 million people who live with HIV in the U.S. don’t have any symptoms.

Because there are a lot of different ways to acquire HIV, Withers urges physicians to suggest HIV screening to all patients and not make assumptions about who might need such a screening.

“Make the recommendation standard in your practice and offer testing to everybody,” she says.

Withers says physicians should counsel patients not to have unprotected sex until both/all partners have had cleared health screenings.

“Even if you’re in a monogamous relationship, there’s a small window where an HIV test might not detect something in the first few months,” she says.

Even for people who use PrEP they should also use prophylactic protection, Withers encourages, since PrEP doesn’t protect against other STIs.

Since bringing up the topic of HIV is often sensitive, she suggests physicians discuss the issue of screening with a simple script, such as:

“A lot of people who have HIV don’t know they have it, and there are a lot of different ways to acquire HIV. Even if you don’t have symptoms, you may still have it, so it’s really important to get on medication as early as possible if you have it. Have you ever been screened for HIV?”

Screening is important because early diagnosis is key, Withers says. Treatment is much more effective the earlier a patient can get on the medication.

Treatment is also a form of prevention.

“The treatments have now come
Most important, she says, is developing a relationship of trust so the patients feel that they can talk about these issues. “It’s all about making patients feel comfortable with you and the care you’re going to provide them.”

Horberg says that a sexual health screening need not be convoluted or invasive. He suggests beginning with two very simple questions, which are recommended by the CDC-supported Health Care Action Group, “Have you been sexually active in the past year?” And “Have you been sexually active with men, women, or both?”

Asking the second question in particular can help determine which testing is needed. The CDC report found that the rise of syphilis was especially high in populations where men have sex primarily with men. While no single population should be named as the culprit, Horberg emphasizes, it is important to note that as sexual relations with types and numbers of partners increase, so potentially do STIs.

“We also know there are a lot of people who have sex with multiple sexual partners, both same sex and heterosexual sex, so if one population has an increase, it’s eventually going to spread to the other population,” Horberg says.

Horberg acknowledges that medical schools don’t do a good job of teaching physicians to be comfortable discussing sexual health.

“We forget sometimes that physicians come in with all of their anxieties,” Horberg says. “We try to leave them all at the patient’s door but sometimes it is hard to do. And it takes practice. Good sexual history like any other part of exam, it’s an art, something you have to practice,” Horberg says.

He says that physicians should initially work from a script to reduce anxiety and standardize the process, which may make these conversations more natural over time. He also hopes that EHRs will eventually integrate sexual health screenings in a way so far that HIV can be effectively managed and the viral load reduced so it’s really undetectable. This pretty much eliminates the chance that it could be passed onto someone else, at least during sex,” she explains.

While treatment for HIV has made it possible for people with the virus to live almost as long as normal life expectancy, Withers points out there are other considerations, such as childbearing that have to be handled carefully when a person is infected. “A large percentage of people who have HIV get diagnosed young, and they may want children,” Withers says.

It is now possible for partners with HIV to successfully have children without passing on the virus, but it requires assisted reproductive technologies and cesarean birth, and not everyone may be able to afford to do those things.

Additionally, people who have the virus must regularly have their viral load assessed with frequent blood draws, and must be disciplined about taking their medications.

If physicians screen a patient who turns up positive for HIV, Withers says they should refer that patient to an infectious disease specialist, though the providers may work together to coordinate care.

Physicians might also want to refer an HIV-positive patient to a mental health provider, since, Withers says, “It can be a big shock and people can get depressed.”

Of equal importance in stopping the spread of the virus, she says, “Physicians should have a discussion with the patient about disclosure to their partner or partners. Embarrassment and shame sometimes mean that a patient doesn’t disclose and that, obviously, is a problem.”

In fact, physicians are mandated by law to report cases of HIV to their county public health department.

Regular screenings and simple conversations can stop the spread of this once-devastating virus.■
“Every primary care provider should have a sexual health history as a part of every visit.”
—VICTORIA MOBLEY, MD, MPH, HIV/STD MEDICAL DIRECTOR AND ADJUNCT ASSISTANT PROFESSOR IN EPIDEMIOLOGY, UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

that makes it easier for both physician and patient.

Some resources for scripts include the AAFP’s article on “The Proactive Sexual Health History,” the National Coalition for Sexual Health’s guide, “Sexual Health and Your Patients: A Provider’s Guide,” and a guide by the American Sexual Health Association, “Sexual Health: Resources for Healthcare Providers.”

EDUCATE PATIENTS

Robert Segal, MD, a Manhattan-based cardiologist and founder of LabFinder, which offers home testing kits for a variety of medical issues, including some STIs, says it’s just as much a part of the physician’s role to educate patients as to screen them, as well as ask them more than routine questions, such as number of partners, and use of protection.

“No matter our patient demographic, if they’re sexually active, we should be educating them not only on the importance of using protection, but on the fact that some STIs don’t always exhibit symptoms and the only way to know if you’re carrying a disease or infection is to get tested,” Segal says.

This will be most effective, Segal says, when this is done with the intent to reduce a patient’s anxiety. “[Physicians] need to have an open and non-judgmental demeanor when inquiring about a person’s sexual history,” Segal says.

Horberg also points out that patients need to know about the long-term effects of untreated STIs, which can lead to a variety of very significant health problems.

“Even though many STIs are asymptomatic, the long-term effects of untreated STIs are legion,” Horberg says.

While most physicians have a ways to go at becoming more comprehensive in helping patients prevent and treat STIs, the patient also has to play a role. Horberg says, “It’s important to mention that STI prevention is still also based on safer sex practices and rekindle those conversations.”

THE TEEN TREND

Another likely cause of rising STIs is a vulnerable population: adolescents.

“Young people feel indestructible. STIs are just not on their minds,” Mobley says.

Physicians who see teens, whether pediatricians or family practice doctors, may not all be screening their patients for sexual activity or STIs for reasons that could range from personal discomfort to parents interfering.

According to a 2015 article in JAMA Pediatrics, teens report low discussion rates around sexual issues during regular health visits and a reluctance to bring these issues up on their own. One-third of all teen participants reported having regular health visits in which their physicians did not mention sexual issues at all.

Mobley says this lack of discussion is especially concerning for teens, particularly girls. “A lot of these infections can be asymptomatic and if you don’t catch it in these young women, the consequences long term can be so severe.”

Whitehead says that both physicians and parents need to work together to make sure these conversations, and when necessary, screenings, are taking place.

She recommends that physicians start the conversation from a health perspective and make clear, “We’re not assuming anything about your child. We’re just sharing information.”

Adolescents are hungry for this information, she says, because much of what they are getting non-medical sources, such as their peers or the internet, is incorrect. When her organization brings in a nurse practitioner to schools to discuss sexual health issues, she says: “The students just absorb it. The nurse practitioner will talk about anything from how STIs are transmitted to pap smears and breast exams. The students really appreciate that dialogue.”

When it comes to discussing sexual health, she says: “Everybody is nervous. We have to put ourselves out there as the adults whether as a sex educator or as a physician.”
The challenges of being a female doctor

Women are half of all medical school entrants in the United States. They are a third of the profession and growing. Despite this, and evidence that they provide higher quality care than male physicians in some instances, their experiences as doctors are much different on average than their male counterparts, and not in a good way. They earn significantly less doing the same kind of work, often tens of thousands of dollars less.

Compared to male physicians, women physicians are more likely to get divorced. Working longer hours for them means higher chances for divorce, whereas for male doctors, working longer actually decreases divorce risk.

Women physicians may experience negative psychological states like depression and burnout more than their male counterparts. More of them compared to male doctors may engage in thoughts of suicide. They experience work-family conflict to a larger degree than men do, in part because they take on more of the home and parental duties. They have greater chances of being harassed at work and are often less likely to be promoted or move into leadership positions. They marry other doctors at a higher rate than their male colleagues, and in such dual career cases, are more likely to sacrifice aspects of their medical careers, work less, and earn less money.

These issues are more challenging to solve given that the profession is medicine. Why is that?

First, all physicians are at the top of the occupational food chain. They are paid very well in the relative sense, experience higher levels of autonomy in their work, and have working conditions far better than that of most occupations. The perception of doctors as a privileged profession may lessen the urgency by which those in and outside of it acknowledge the gender divide.

Second, this insensitivity to poorer treatment of its own members continues to be a normal part of the medical profession’s adverse alpha culture. Evidence of this culture is seen in how medical students and residents are often still treated. Women doctors pay their own price for being immersed in that culture.

Third, medicine is a profession built on power and control. Young physicians are reluctant to push back against an unfair system.

Finally, and more subtle is that female physicians often report high levels of job and career satisfaction despite the presence of these negative realities, as I discovered in a review myself and a colleague did several years ago. This implies a degree of compartmentalization that may allow some female doctors to navigate through hostile workplaces and yet still find rewards in the joy of clinical practice and other aspects of their work.

I have witnessed this dynamic first-hand in women doctors that I have interviewed over the years, for example, as they talked about dealing with harassment from patients and other colleagues, and unfair treatment by employers. I remember one female physician who expressed a high degree of job satisfaction telling me that if she got mad about the gender bias she experienced on a consistent basis, she would end up being mad every minute of her workday.

Healthcare employers are a significant part of the problem where physician gender bias is concerned. Take the compensation disparities observed between male and female physicians. In 2004, several colleagues and I published a study of a new group of doctors called hospitalists. In that study, we found women hospitalists earning thousands of dollars less annually than male
hospitalists, even after controlling for things like workload, type of job, and job tenure that might reasonably account for a pay difference.

What was surprising about this finding was that it was occurring in a new medical specialty, one in great demand at the time. Other recent studies have supported this general finding among doctors across different specialties, including one that showed significant starting salary disparities between male and female physicians, illustrating showing that the problem begins at the start of a female physician’s work career.

At the time, we speculated that part of the gender pay disparity could be the result of employers playing a different negotiating game with female doctors. For example, they may offer lower compensation to women physicians by taking advantage of the greater concerns some of them have for gaining other benefits in their jobs. These other benefits may align better with their tendency to take on more of the spousal and parental roles in their households, benefits such as time off, flexible work schedules, and day care support for their children. Many women physicians believe, and survey data in some instances show, that they are at a disadvantage when negotiating contracts, that health care employers pay them less, that their performance gets evaluated using different criteria compared to men, and that there is gender discrimination in hiring and promotion evaluations.

The medical profession shares blame. In many instances, the negative realities women doctors end up experiencing start as early as medical school and residency training. In my research, I have spoken to many young female doctors who realize during their training and early career that despite having earned their way into the most competitive profession on Earth, they still will likely encounter a fair number of colleagues, employers, and custom- ers that treat them like second-class citizens.

For some, this realization starts at the very outset of their careers to drive negative perceptions of their chosen profession as well as producing higher rates of negative psychological states like depression. It also may immediately narrow the types of job and employment choices some women doctors believe are available to them, especially if they wish to marry or have children.

None of this gets fixed on its own, nor are there magic bullet solutions. At a minimum, women doctors would benefit from greater workplace protections and using whatever means possible to collectively bargain with their employers at a local level. There is strength in numbers. They also need many more champions and role models, especially later career mentors, who will whistle blow and take risks to push for change when injustices are apparent. Medicine is a strict hierarchy rooted in experience, and older female physicians can help if they are willing to lead the way for their younger colleagues. In addition, women physicians should seek solidarity where appropriate with male physicians, since there are many workplace issues that now affect both groups in similar ways that lessen career and job satisfaction.

There is a crisis in healthcare with respect to how its fastest growing and most prized talent pool is treated. Recognizing the scope of the crisis is an important first step. Solving it is what matters now.

Timothy Hoff, Ph.D., is professor of Management, Healthcare Systems, and Health Policy at Northeastern University in Boston, a Visiting Associate Fellow and Associate Scholar at Oxford University, and author of the 2017 book, “Next in Line: Lowered Care Expectations in the Age of Retail- and Value-Based Health”, published by Oxford University Press.
“Motivational interviewing gave me the opportunity to connect with patients again.”

—TAMARA GUTDICK, MD, MEDICAL DIRECTOR, MONTEFIORE HUDSON VALLEY COLLABORATIVE

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“There’s a lot of data out there. Probably too much data.”

—BHARAT RAO, PH.D., DAT AND ANALYTICS LEADER, KPMG

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IN PRACTICE:
TREAT HIV ASAP

As more evidence has emerged, guidelines have changed to recommend starting antiretroviral therapy (ART) as soon as possible. Patients require education on the importance of early treatment and adherence; treatment may be deferred on a case-by-case basis, as appropriate. This shift has allowed patients to start treatment as early as time of diagnosis, shortening the time for patients to achieve an undetectable viral load.1-5

Advantages of starting treatment earlier:
• Shortens the time between diagnosis and viral suppression, which may also
  ° reduce systemic inflammation and immune activation1
  ° restore and preserve normal immune function1,6
  ° decrease future risk of AIDS events and non-AIDS health complications1
• Lowers the risk of secondary transmission of HIV sooner1

Considerations:
The Treatment1
• Treatments best suited for early initiation are those that are not commonly associated with transmitted resistance mutations and hypersensitivity
• Treatment can be initiated before drug resistance test results are available and then modified if warranted once results are available
• DHHS Guidelines recommend starting treatment-naïve patients on a triple therapy

The Patient1
• Consider a patient’s resistance profile and determine which lab tests are needed
• Assess potential side effects and drug-drug interactions

For more information, including the latest clinical guidelines and supporting studies, visit TreatASAP.com.


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