PHYSICIAN BURNOUT
The scope of the crisis—and how to fix it
INCLUDING

- The causes of burnout, explained
- Doctors share their solutions
we live in a hyperconnected world. why work in a disconnected one?

In this day and age, medical providers shouldn’t have to suffer through cumbersome, poorly connected software systems. That’s why athenahealth created the most connected interoperable network in healthcare. It saves you valuable time and is better for your bottom line and, of course, patient outcomes.
ver notice a tendency to focus more on what’s wrong than what’s right? To notice what people do wrong more than what they do well? Or to offer criticism or advice more than positive appreciation?

Well, you are not alone: Our brains are hardwired for a negativity bias. That means that negative experiences and information grab more of our attention, are more memorable and their effects last longer than positive experiences. At the end of the day, it’s the negative experiences that we remember more than the positive ones.

The negativity bias affects not only how we feel, it also impacts work culture and patient care. Let’s first look at its implications in the workplace.

If people are more strongly impacted by the negative than the positive AND they tend to notice the negative more, then people are probably getting more criticism or “helpful” advice (which, when unsolicited, is perceived as criticism) than they are appreciation or positive acknowledgments.

This is what I consider low-hanging fruit for improving interactions at work. We know that it takes about eight or nine positives to counteract the negativity bias. By giving employees specific and genuine recognition for a job well done, we can shift the workplace culture to one of greater collaboration and appreciation.

And best of all, it’s easy and free. Tell people what specific behaviors they are doing or have done that made a positive impact. Recognition or appreciation is rewarding to the brain. What’s more, anything that is rewarding tends to be repeated. Not only does positive feedback make people feel good, it reinforces behaviors that we want to be reinforced, a win-win.

An additional benefit of mitigating the negativity bias is that when people feel appreciated by others, they are more likely to want to collaborate and contribute. Their morale and engagement at work improves as well, making them more productive and effective.

Now let’s shift our focus to how the negativity bias impacts patient care. The negativity bias is alive and well in medicine. It starts in medical school where students are frequently exposed to teaching methods that create feelings of shame, ineptitude and incompetence. Early on in their careers, physicians learn both the importance of preventing and avoiding errors as well as the need for perfection.

And yet, we know that mistakes are inevitable. We also know that if we talk about them, we are more likely to prevent their recurrence. The problem is that healthcare workers often avoid acknowledging that an error has occurred. This is typically due to a culture where mistakes are accompanied by some form of punishment, and people often feel humiliated and blamed.

Hospital settings can also perpetuate a culture where the negativity bias is enhanced with physician peer review committees and incident reporting systems.

We need a solution. We need to transform a culture of blame into a culture of learning, where the reporting of medical errors is welcomed because it serves as a teaching opportunity. Even the word “error” can sound intimidating. I encourage healthcare professionals to instead think of errors as learning opportunities to make it easier to talk about.

Catherine Hambley, PhD, is CEO of Brain-Based Strategies Consulting, where she specializes in executive coaching, leadership and team development and organizational transformation.
Physician burnout

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JAMA study: Health equity declines as income inequality grows

As income inequality worsens in America, the health of its less-fortunate patients continues to decline, according to a new study conducted by researchers with the CDC.

The study, published this month in JAMA Network Open, collected survey data from the CDC from 1993 to 2017, which included 5.5 million Americans ages 18-64. Researchers asked individuals questions about their overall health during a one-month period and used it to assess trends in health equity based on race, gender, and income level.

Despite the national goal to increase health justice and equity—the idea that every patient should have a fair opportunity to be healthy regardless of their income, race or gender—the authors conclude that the situation has only worsened.

“Improving health equity often figures as an important goal for communities, thought leaders, and policy makers in public health,” the researchers write. “Yet, this analysis suggests that across the past 25 years, the promise of improving health equity has not been met. Greater or different efforts than those tried in the past will have to be mustered if health equity is to improve.”

The researchers found that only 10 percent to 20 percent of healthcare outcomes were determined by the provision of healthcare services, and that living conditions, education, income and other social determinants played a much larger role.

Frederick Zimmerman, the study’s lead author and a professor at the UCLA Fielding School of Public Health, told NPR that health outcomes for wealthy people remain stable—or stagnant—but the health of the lowest income groups is “declining substantially over time.”

For example, research shows that low education accounts for the same number of deaths as heart attacks. In addition, it could also be beneficial for the health of the population to address concerns in a person’s environment. “The results of this study show a worrisome lack of progress on health equity,” the researchers write.

To optimize efficiency, automating as many steps as possible within the practice’s integrated clinical and administrative workflow will both save staff hours and help avoid unwanted surprises in the form of denials, ineligibility, or larger than expected patient responsibility.”

—Naveen Sarabu, vice president of product management, AdvancedMD

“Real transparency is the single, first, and most important step toward bringing down healthcare costs and creating a competitive marketplace.”

—Marni Jameson Carey, executive director, Association of Independent Doctors
Physicians, stop ignoring online reviews

A majority of physicians and healthcare providers are concerned with maintaining a quality patient connection, yet nearly one third of practices do not spend the time or resources to achieve this, according to a newly released survey by online vendor PatientPop. Here are some quick takeaways from the survey:

1. PHYSICIANS DO READ ONLINE REVIEWS
Most physicians think a positive online reputation is the key to optimal patient-practice communication, yet too few prioritize digital patient feedback from online reviews.

2. PHYSICIANS DON’T RESPOND ENOUGH TO REVIEWS—ESPECIALLY NEGATIVE ONES
A majority of survey respondents who posted negative online reviews were never contacted about the concerns expressed in their review.

3. PATIENTS READ REVIEWS BEFORE THEY SEE A PHYSICIAN
The number of physicians who say a patient decided to visit their practice after reading an online review.

4. PHYSICIANS NEED A SYSTEMATIC PROCESS FOR MAINTAINING THEIR ONLINE REPUTATION
Practices should create an online reputation management workflow, including:
- Asking patients to post feedback about their visit on online platforms, including social media and reviews sites such as Google and Yelp
- Tracking online reviews.
- Responding to patient feedback when it appears, positive or negative.

“Based on their responses, a greater percentage of providers understand online reputation management. But a sizeable amount of inactivity or lack of planning is still present. These passive healthcare practices will find themselves at a disadvantage as others actively take control of the online reputation.” —PatientPop
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.

STOP THE VIRUS.
Working together to help stop the virus.

Getting paid for the new virtual check-in code

In 2019, there is a new Medicare code for virtual check-ins, G2012. It appears to be for when the patient calls to see if he needs an office visit. I want to use it for those weekend calls while on-call, but our management says we shouldn’t. Can you please give me your interpretation of this code?

A: You have the basics correct. The Centers for Medicare & Medicaid Services (CMS) describes code G2012 as “a brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed.” Under certain circumstances, there is no reason you couldn’t use this code when patients contact you while you are on-call.

But there are several qualifying descriptors for this code as well as some circumstances to consider. This new G2012 code, similar to the codes in the CPT manual for telephone and other electronic contacts, requires that these communications:

- are limited to established patients,
- can’t be related to an office visit in the previous seven days,
- can’t result in being seen for a next available office appointment or within 24 hours, and
- must have 5 to 10 minutes of medical discussion.

After discussion, you might end up sending the patient to a specialist, a more acute setting, or even advising them to make (or keep) a future appointment with you to address the problem. If all the above conditions are met, you can code for a virtual check-in.

Payers like virtual check-ins because the provider is prescreening a problem—triaging it if you will—to determine whether the patient needs an office visit soon or not. If the patient does, the call is bundled into that visit.

From the payer perspective, this virtual check-in does two things:

- It may save an office visit.
- It may direct the patient as needed to the appropriate caregiver in a medically necessary situation, perhaps leading to cost savings down the road.

This is also in line with CMS’s movement towards technology-based solutions.

One reason not to use this code might be as simple as the copay. Even though the Medicare copay on this would be around $2.50, you can imagine how patients might perceive this when they receive a bill: “You mean I can’t even call my doctor without you charging me $2.50 for the phone call!”

Patients are sensitive to billing. This code could actually be a huge patient dissatisfier even though you provided a valuable and timely service.

Perception is everything, so be prepared if you decide to use the G2012. Train your staff on when to use it—and what they should say to upset patients.

Bill Dacey, MHA/MBA, CPC is principal in The Dacey Group, Inc., a consulting firm dedicated to coding, billing, documentation, and compliance concerns for physicians. Send your coding questions to medec@mmhgroup.com.
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Physician burnout is a crisis. Our healthcare system has many problems, but the truth is that none of them can be fixed without reducing the physical, mental and emotional toll that practicing medicine takes on physicians.

For the first time ever, Medical Economics has conducted an exclusive survey to gauge the impact of burnout on physicians’ careers and what physicians practicing today believe should be done about it. More than 1,200 physicians weighed in.

Accompanying our survey results are three physician-authored essays discussing their explanations for the reasons for physician burnout, and what can be done to change the practice of medicine for the better.
Exclusive Results: 2019 Physician Burnout Survey

Have you felt burned out from practicing medicine at any point during your career?

- Yes: 92%
- No: 8%

Do you feel burned out right now?

- Yes: 68%
- No: 32%

What has contributed the most to your feelings of burnout?

- 37% Too much paperwork and government/payer regulations
- 19% Poor work-life balance/work too many hours
- 17% EHRs
- 9% Lack of autonomy/career control
- 7% Insufficient pay/declining reimbursements
- 5% Overwhelmed by patient needs
- 1% Non-adherent patients
- 5% I don’t feel burned out
### How do you cope with burnout?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Coping Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>Spending time with family and friends</td>
</tr>
<tr>
<td>26%</td>
<td>Exercise</td>
</tr>
<tr>
<td>13%</td>
<td>Nothing, I don’t cope</td>
</tr>
<tr>
<td>10%</td>
<td>Hobbies</td>
</tr>
<tr>
<td>6%</td>
<td>Eating junk food</td>
</tr>
<tr>
<td>5%</td>
<td>Practicing yoga/mindfulness/meditation</td>
</tr>
<tr>
<td>4%</td>
<td>Alcohol</td>
</tr>
<tr>
<td>7%</td>
<td>I don’t feel burned out</td>
</tr>
</tbody>
</table>

*“My dogs come to the office with me every day. I am in solo practice, and control my hours, who works with me, the color of my office carpet, etc. I work two full-time jobs essentially, but control is the answer. Plus, my dogs keep it all in perspective, what’s important.”*

*“Trying to create pockets of time away from medicine responsibilities.”*

*“Treat my work more like a job and less like a profession. Since I am treated like a cog in a wheel, I am starting to put less personal importance in work.”*

*“Volunteer activities and spending time with family and friends and hobbies.”*

### Do you plan to seek or have you sought professional help/counseling dealing with burnout?  

- **80%**  
  - NO

### Have you ever talked to fellow physicians/colleagues about feeling burned out?  

- **64%**  
  - YES

### Have you avoided expressing feelings of burnout because you’re afraid of being judged negatively by peers?  

- **63%**  
  - NO

*7% preferred not to answer*
Q: What do you believe is the solution to physician burnout?

“Collective bargaining by and for physicians, utilizing agents as chief negotiators. We have our ethics and individuality used against us. An individual doctor rarely wields any power versus a hospital or insurer. However, the ability of a group or union could/would be a game changer. Use the NFL players union as an example.”

“More physician empowerment.”

“Physicians leading the future of medicine.”

“Work-life balance, being in a field that you enjoy, having great relationships with patients.”

“The autonomy to practice without micromanagement by pharmacy benefit managers, dramatic simplification/elimination of the ridiculous documentation requirements for billing.”

“Give doctors more autonomy over their practice environment.”

“Empower physicians to have more control of how, when, and where they practice. Physicians feel powerless when they have no choices.”

“Less hours and less paperwork.”

“More emphasis on patient care and outcomes that matter over check boxes and money.”
About the survey

More than 1,200 physicians took our 2019 Physician Burnout Survey, which was deployed to our email newsletter subscribers in June via Survey Monkey. Here is a snapshot of who took the survey, including their medical specialty, practice setting and more.

What is your medical specialty?

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family practice</td>
<td>36%</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>33%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>9%</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5%</td>
</tr>
<tr>
<td>Surgery</td>
<td>3%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>2%</td>
</tr>
<tr>
<td>Urology</td>
<td>2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1%</td>
</tr>
</tbody>
</table>

Which of these best describes your practice setting?

- 48% Office-based independent practice
- 23% Office-based hospital-owned practice
- 12% Outpatient clinic
- 10% Hospital
- 6% Academic (research, military, government)
- 1% Direct/concierge practice

How many years have you been practicing?

- >5 years: 1%
- 6–10 years: 5%
- 11–20 years: 23%
- 21–30 years: 37%
- 30< years: 34%

Do you own your practice?

- 57% Yes
- 43% No
Burnout Trends

How many hours do you work per week?

- >40: 18%
- 41–50: 31%
- 51–60: 26%
- 61–70: 14%
- 71+: 11%

What is your age?

- >35: 1%
- 35–44: 8%
- 45–54: 28%
- 55–64: 41%
- 64+: 22%

What is your gender?

- 406 Women
- 796 Men
- Average 1 woman to every 2 men

*25 preferred not to answer
Doctors are dissatisfied and demoralized with how they are required to practice today, and as a result physician burnout is taking a huge toll on medicine.

Innumerable surveys show that more than 50% admit to at least one symptom of burnout and that many are relocating in hopes of finding a better practice climate, or exiting clinical practice through early retirement, moving to administration, or simply leaving medicine altogether. But we contend burnout is an inaccurate diagnosis for the condition and instead, that physicians are experiencing moral injury.

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

The underlying problem is we doctors are being pulled in too many directions. We took oaths to put the needs of our patients above all else, but over time that priority has eroded in the face of economic drivers in healthcare and competitive realities. Too often now, physicians must choose between the needs of their patients and the demands imposed by their employers, productivity metrics, insurance companies, mandates to reduce “leakage,” and satisfaction surveys.

The patients’ needs cannot always win—and often don’t.

Physicians are not taught when, why or how to set boundaries, nor are we often encouraged or empowered to do so. In fact, much of a physician’s training contravenes establishing boundaries of reasonableness or responsibility. Lacking comfort and experience in refusing requests or setting limits, physicians fail to demand or negotiate acceptable expectations regarding tasks, responsibilities, allegiance and priority.

When asked to assume responsibility for some aspect of patient care, no matter how thin the thread tying them to that burden, physicians are usually loathe to refuse it. As a result, physicians have gradually taken on the job of data entry clerks, insurance go-betweens, educators in healthcare literacy, coders/billers, and chiefs of customer service.

COMPETING ALLEGIANCES
As the list of responsibilities grows, doctors have not negotiated sufficient off-loads.

While other providers such as nurse practitioners, physician assistants and registered nurses have assumed some patient care tasks, the ultimate responsibility for that care typically still resides with the physician. We are a hyper-responsible, control-freakish
lot because legislation requires it and everything in our preparation and training has conditioned us to be so.

Not surprisingly, physicians incur moral injury in the face of these competing allegiances and, among other consequences, it is driving the physician suicide rate to more than twice that of the general population. Yet despite a decade of recognition and a rapidly proliferating industry to promote wellness, studies indicate the problem has only grown worse.

Any physician whose treatment for a patient failed so profoundly would reconsider whether the diagnosis was accurate and the treatment strategies well-aligned. In this case, the problem is that moral injury, rather than being an individual challenge with individual solutions, is actually a symptom of underlying dysfunction in the healthcare system, a dysfunction that results in doctors being torn between competing allegiances.

THE SOLUTIONS

The systemic nature of the problems means they are not amenable to easy solutions.

Nevertheless, it is essential to begin making inroads into the crisis of moral distress. The first step is to recognize the untenable conflict for physicians imposed by multiple competing allegiances in order to begin establishing boundaries around those obligations. Being caught in the double- and triple-binds of serving opposing masters is a major contributor to moral distress.

And while resilience is important for any high-intensity career, the solution in this case is not simply to train physicians to be more resilient a system that disempowers them but to create a system in which the physician is enabled, empowered, and encouraged to do the job of taking care of the patient above all else.

In addition, we need health systems led by practicing clinicians who are committed to improving clinical care. Those leaders understand, on a visceral level, the day-to-day challenges of trying to care for patients. They understand, for example, that accomplishing a single task in an EHR might require clicking through a dozen windows and re-populating fields. They know where the EHR needs to change to improve the user experience and to facilitate care, rather than interfering with it.

Those hospital leaders also have a mandate to communicate to their physicians not just what salary they are worth, but the unique value physicians as a whole, and individuals in particular, bring to the organization. By pushing back against unreasonable insurer requests, unproven requirements of the Joint Commission, regulatory demands, pressure to adopt a retail model of care that undermines the doctor-patient relationship, and redundant institutional requirements, clinician leaders demonstrate to their physicians that their time and efforts matter, and that they are an asset worth protecting.

Medicine also needs a robust process for identifying young physicians with leadership potential and investing in developing those skills. The military has done this for decades, largely successfully. While we are not advocating a “military” style of training, there are lessons we can learn about how to spot those with leadership talent, when and how much to invest in developing them, and what are the skills one needs to hone in order to lead effectively.

Finally, we must refuse to accept competing allegiances, nonsensical responsibilities and any solutions that erode relationships with our patients. Only by saying “no” to some of what is now asked of physicians can we begin to break the binds that tie us to moral distress and injury.

“Only by saying ‘no’ to some of what is now asked of physicians can we begin to break the binds that tie us to moral distress and injury.”

Wendy Dean, MD, is a psychiatrist and senior vice president of program operations at the Henry M. Jackson Foundation for the Advancement of Military Medicine.

Simon G. Talbot, MD, is a reconstructive plastic surgeon at Brigham and Women’s Hospital and associate professor of surgery at Harvard Medical School.
In June 2019, the World Health Organization formally labeled burnout a medical condition. I believe this to be a misdiagnosis, as burnout is not an illness.

Rather, physician burnout is a symptom of a healthcare system broken by innumerable cracks, a system refusing to call attention to its disfiguration and failings. The public and lay press have latched on to the idea that physicians are burned out—with fatal implications of personal failing, exhaustion and shortcoming. This is a distraction, a redirection away from the fundamental pathologies in our healthcare system. This dangerous paradigm of burnout runs the risk of eroding public trust in medical professionals, and avoids confrontation with the ultimate systemic failings that stoke the fire.

If the system is unwilling to identify its faults, I will vocalize those that have led me to huddle at my desk and cry to myself at night in an empty office. The first and most pervasive is the shift from the care of those in need to the business of medicine as a volume proposition for revenue generation. Bloated administrative salaries and unnecessary overhead parallel lavish marketing expenditures. Many systems have entered the sordid business of luring customers and seeking five-star reviews, as opposed to putting care of patients and communities first. There appears to be little to no accountability for the “non-profit” status so many systems carry. What results are so-called “customers” that arrive to visits with increasing expectations of their time and experience. This is coupled with rising complexity of illnesses, rapid pace of change of evidence at the point of practice, and little or no additional time or resources for each patient seen.

As physicians, we are far too willing to ignore own health and humanity, and far too willing to transfer our own stress on to our colleagues.”

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“STOLEN AUTONOMY”
Ultimately, while many physicians don their white coat to care for those in need, they are confronted by a system that has stolen their autonomy and relegated them to the silent position of “provider.” My symptoms of burnout in practice have come as a result of being overwhelmed with the extent of illness, of too many conversations about death, depression, addiction, and suicide on a daily basis. It is a feeling that I do not have the time to make the number of right and safe choices for my patients, or respond to the amount of care that they need in a given day.

It is often an impossibility for me to finish the day and feel ethically and morally satisfied. No duty hour rules can shield against such emotional onslaught.

The list of cracks in the system goes on. Much has been written about extensive documentation requirements that are unnecessarily cumbersome in outmoded EHRs. The ordering of unnecessary tests for the sake of liability not only compounds our untenable cost crisis, but undermines physician decision making and intuition.

Insurance companies play shell games with medication and medical bills, and prior authorizations add a superfluous and
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“My symptoms of burnout in practice have come as a result of being overwhelmed with the extent of illness ... It is a feeling that I do not have the time to make the number of right and safe choices for my patients.”

Too often the consequences of these failed machinations land on the shoulders of the physician at the point of care. This disrupts hallowed patient-physician relationships and wastes precious time that could otherwise be spent in caregiving and counseling.

Thankfully, in recent years we have witnessed some proactiveness in preparing trainees to recognize burnout. Likewise, our systems now provide new resources and counseling to respond to it.

These approaches are essentially bookends to the underlying condition but fail to fully confront the causes. In doing so, they unintentionally, yet implicitly, suggest that burnout is an unfortunate inevitability. Such an approach is akin to telling a young man that diabetes is a disease, and then sitting back until the first signs of elevated hemoglobin A1c. It ignores so many of the elements in the interim that can be influenced to prevent the outcome in the first place.

We treat burnout in much the same way, almost as if it is an expected side effect, a rite of passage or even a badge of courage.

Our healthcare systems fundamentally ignore the call for decreasing stress, offloading documentation burden, and restoring autonomy and joy to practice. Adding a suicide help line and an annual doctor’s day golf outing is far from a systemic cure.

One local health system formed a burnout committee in response to overwhelmed physicians, and the first initiative was a monthly wine night held on Thursdays.

None of the primary care physicians I spoke to were able to attend, as they were all busy in the office working on documentation until after 10 p.m.

Many systems have added similar interventions such as lunchtime yoga sessions or coffee coupon cards for physicians. We respond to the symptoms of the disease, instead of working on preventive measures to address the problem at its core. These “treatments,” in other words, ignore the heart of the problem.

Unfortunately, the symptoms of burnout tend to beget more burnout. Much more than a spreading plague of negativity, compounded stress from a broken system has pressed physicians to bear the burden or pass it on to equally stressed colleagues. Neither responses are particularly healthy.

As physicians, we are far too willing to ignore our own health and humanity, and far too willing to transfer our own stress on to our colleagues.

**HARMING EACH OTHER**

There is one area that I can speak to that is within our grasp as physicians to resolve: How we treat ourselves.

While I have witnessed acts of intense selflessness, compassionate camaraderie, and bonds among teams, I have also observed infractions of character, defamation, and belittling. Lost somewhere in our intense focus on doing no harm to our patients, we often neglect the application of *non nocere* to ourselves.

Yet, within the world of medicine, there is so much unspoken harm we do to one another. The overworked emergency room physician is berated by the overworked hospitalist for the tenth admission of the night. The attending surgeon belittles the intern for poor closure technique as the intern scrambles to fulfill the administrative tasks that are a hospital priority. The time-pressed primary care physician hastily sends a patient to the emergency room unnecessarily for something they could have addressed in-office with more time available. The specialist dumps a plethora of patient problems back to primary care. It becomes a vicious cycle in which, lacking time to deliver care in the right way, physicians pass patients like hot potatoes.

We burn each other with these repeated moral injuries, and instead of blaming the
root cause of these actions, we instead
scapegoat each other.
I am burned out on discussion of burn-
out. Incremental changes will only allow dis-
parate inadequacies to flourish and become
more prominent. As physicians we have our
collective voices to call out the injustice
inherent in these failures. But we also have
the capacity to avoid self-harm, both to
ourselves and to our colleagues. While we
embrace the shift away from the discussion
on burnout, and the coming necessary sys-
temic changes, physicians need consider a
broader application of their charge for non
nocere and seek to do no harm to patients,
colleagues, and yes, even ourselves.

Medical training has drained
my brain.
Not in the good way—
that satisfying cognitive
fatigue after hours of deep,
engaged work. Just the
opposite. My attention span
is scattered. My focus is
fuzzy. My brain is fried from
the fire of incessant disruptions. My mon-
key mind meanders amok. Purportedly, the
average attention span for humans is now
reportedly less than that of a goldfish. Gold-
fish-level attention feels aspirational for me
nowadays.

Many of the reasons that residents
suffer distress and burnout are evident
and well-characterized. Causes include
physical and emotional fatigue, the imbal-
ance between effort and reward, and a lack
of control. Now, in my last week of residency,
I recognize another, more insidious cul-
prit—years of distraction eroding my ability
to focus. The struggle to concentrate and
focus on a single task underlies much of my
dissatisfaction, stress and burnout.

MULTITASKING BEGETS BURNOUT
Data is now validating my lived truth—the
multitasking demanded in our work is likely
an under-appreciated, but substantive fac-
tor in physician burnout.
Cognitive Load theory, articulated by
John Sweller, relates to the amount of infor-
mation that working memory can hold at
one time. Short-term working memory
Burnout describes our capacity to store and manipulate information in service of complex tasks. A limited resource, short-term working memory shrivels under physiologic or emotional stressors. The greater the cognitive load, the more difficulty we experience when trying to pay attention, rehearse, and remember. Learning new information requires minimizing distraction—so-called extraneous cognitive load—to maximize the transfer of important information into long-term memory.

Multitasking is a myth, or better yet, a misnomer. When we multitask, we actually shift our attention rapidly between multiple tasks. Our brains are built to single task. When we task-switch, we interrupt ourselves and lose time in the process. Often touted for hyper-efficiency, multitasking actually reduces productivity, increases mistakes, and contributes to information overload, according to a study in The Journal of Experimental Psychology titled “Human Perception and Performance.” With each switch, a so-called “residue” of attention remains stuck thinking about the original task.

Studies find that frequent multitaskers have reductions in gray matter in areas that control empathy and emotions and exhibit weakness in both working memory and long-term memory. We become increasingly distractible and may even be more prone to depression and anxiety. The chronic stress inflicted by multitasking restricts our available resources for attention and working memory.

Burnout emerges when the stresses of a job outstrip one’s ability to cope effectively. A systematic review of job burnout and cognitive functioning shows a clear correlation between burnout and a decline in three major cognitive functions—executive functions, attention, and memory.

THE ‘HIDDEN CURRICULUM’

In medicine, the increasing cognitive load is a function of the mounting workload and the complexity and pace of the work flow.

The high-stakes environment adds another layer of anxiety. Beneath this fester a corrosive culture and the “hidden curriculum” of medical training, still rife with mobbing, bullying, and harassment. This overwhelming cognitive load heightens stress and likely accelerates burnout by clouding attention and working memory.

FINDING FLOW

In contrast, our brain works most efficiently when it can focus on a single task—even if boring or frustrating—for a longer period of time. Focus is foundational for job satisfaction.

As originally described by psychologist Mihaly Csikszentmihalyi, “flow” is “a state in which people are so involved in an activity that nothing else seems to matter; the experience is so enjoyable that people will continue to do it even at great cost, for the sheer sake of doing it.”

Elements of flow include:

- present moment concentration on a singular task
- a clear objective with immediate feedback, an intrinsically rewarding experience
- a sense of effortlessness
- an appropriate balance between perceived challenge and skill
- a sense of control
- an absence of time and self-consciousness

We might refer to this colloquially as being “in the zone.” This heightened sense of awareness of the here and now is inaccessible if distractions interfere.

Excessive cognitive load is understandably perilous for patient safety. Do you remember entering the wrong medication for a patient while toggling between multiple patient charts on the electronic health record? Or perhaps you accidentally forgot to note that critical task for a patient amid the deluge of questions, pages, and alarms?

Many of us have been there, tiptoeing along the precipice of medical error. Mental overload can bring us to the edge of catastrophe.

“Solutions to physician burnout must enable us to spend time, energy, and focus immersed in the essence of our craft.”
REDDING COGNITIVE LOAD

Underappreciated is how maddeningly difficult it is to get “in the zone” while practicing medicine nowadays.

Harry and colleagues conducted the first large-scale study to interrogate the intuitive link between cognitive load and burnout in health professionals. The investigation used the Task Load Index from NASA to evaluate the cognitive load of work environments as determined by four main subscales: mental demand, physical demand, temporal demand, and effort.

As hypothesized, the sum Task Load Index scores were strongly and independently correlated with emotional exhaustion, depersonalization, and the overall risk of burnout across specialties.

Solutions to reduce cognitive load must target both the individual and the work itself. Techniques like meditation, breathing exercises, and other stress reduction techniques help to enhance working memory in high-demand environments. Learning how to manage stress and anxiety is a core competency for any professional in today’s frenzied work environment.

On a system level, we must devise mechanisms and tools to reduce extraneous cognitive load. Checklists, for example, help automate and streamline workflow and enhance patient safety. Storing patient data in one reliable location on the EHR would reduce the redundancy, and hence cognitive load. We should reduce the extraneous cognitive load on trainees by limiting the number of patient charts that can open simultaneously, restricting interruptions during dedicated education sessions, triaging alerts and nursing requests based on clinical severity, and using one dedicated platform to communicate about patient care with consulting services.

These solutions, albeit critical, chip away at the margins rather than getting at the core question—how do we rediscover a sense of flow in the work of doctoring? Harry recounted a recent episode that may provide a clue. While sharing the concept of cognitive load with a group of surgeons, many of them noted the “sacred” space of the OR, in which they do their craft with minimized interruptions, limited pages, and no email.

To be clear, many surgeons are suffering from intense burnout. But perhaps when they are able to access flow in the operating room—one of the few remaining workspaces that prioritizes and facilitates intense focus—this may confer some protective effect.

This begs the question of how we create environments that support “deep work” for all physicians. For internists and others who primarily do cognitive work, consider designing workflows that batch the endless communications about patient care in order to free up protected blocks of time to actually think and devise the best possible care plans.

For emergency medicine doctors, consider skill-based shifts, where one trainee is exclusively doing procedures, one is taking histories, and one is triaging patients based on acuity.

Medicine is a heterogeneous profession with diverse personality types and a complex division of labor. But the desire to experience flow in work is universal. Solutions to physician burnout must enable us to spend time, energy, and focus immersed in the essence of our craft.

“Burnout emerges when the stresses of a job outstrip one’s ability to cope effectively.”

Rich Joseph, MD, MBA, is a senior resident in primary care-internal medicine at Brigham & Women’s Hospital in Boston, Mass. His clinical practice going forward will focus on Weight Management and Obesity Medicine.

Elizabeth Harry, MD, is the assistant medical director for the Brigham & Women’s Physician Organization and director of faculty development and wellbeing. She practices as a hospitalist.
5 metrics to improve practice finances

With a busy staff and full schedule of patients each day, it may appear as if your practice is thriving. But take a closer look at some of its vital signs — net collections, accounts receivable (A/R), write-offs and other revenue trends — and you may realize your practice suffers from conditions that could threaten its longevity.

It’s challenging to transition your practice from a fee-for-service model to value-based care while also striving to stay financially healthy. This is especially true when you’re contending with a strict and ever-changing regulatory environment in which high-deductible health plans and complex payer fee schedules are increasingly the norm.

To ensure your practice is financially strong, it’s important to gain a deeper understanding about how to get paid for specific services, which key performance indicators (KPIs) are most important to track over time and how to make necessary improvements or adjustments.

Here are five key metrics that can shed light on your practice’s financial health:

### Days in A/R
This represents the average number of days it takes for your practice to be reimbursed. Rejections and/or denials, incorrect coding, credentialing issues and incorrect posting and appeals processes can stretch out the time it takes to be paid. Practices should break out days in A/R by insurance plan and patient so they can get a better sense of where problems exist, such as consistent coding errors, that they can address to speed up payment time. Any A/R that has surpassed 365 days from date of service should be considered for potential write-off.

### Unexpected denials
These are wholly preventable and can be remedied with a change in process, policy or behavior. Problems that lead to these unexpected denials include inconsistent benefits and eligibility verification, lack of review of medical policy changes, incorrect coding processes and inconsistent maintenance of system tables. It’s possible to recoup some of this money, but resubmitting denied claims comes at a cost — and that takes away from the bottom line. The Medical Group Management Association (MGMA) estimates that it costs a practice an average of $25 for each denial that must be reworked and resubmitted. Overall, industry standards indicate unexpected denials should comprise less than 5 percent of total denials.

### Posting lag
This is the number of days between date of service and claim submission. The posting lag can vary because of provider coding processes or whether the patient is there for an office visit or a procedure. Practices should strive to reduce the lag to less than five days for office-based services and 12 days for combined hospital and office-based services.

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Marvin Luz is a senior director of revenue services for Greenway Health, a leading health information technology and services provider. Send your financial questions to medec@mmhgroup.com.
David Boles, DO, owns a family medicine clinic with four physicians in Clarksville, Tenn. In recent years, he has seen an upsurge in competition from retail clinics, urgent care centers and a freestanding emergency clinic.

Those alternative care sites have hit his bottom line hard by taking away the lion’s share of the minor acute-care visits that used to be his practice’s bread and butter. That has left him and his colleagues to deal with the harder cases that they get paid less for in relation to the amount of time they take.

“If I see 25 patients in a day, it will be 25 complicated patients,” he says. In the past, he recalls, his practice saw a lot of patients with the flu during flu season and did most of the patients’ immunizations. But now the alternative care settings—including four new urgent care clinics and the freestanding ER—are taking all the easy cases. As a result, he often finds it difficult to keep his midlevel practitioners busy.

Boles’ situation is not unique. Russell Kohl, MD, a board member of the American Academy of Family Physicians (AAFP), says he’s heard similar complaints from some AAFP members. Jillian Schneider, manager of the department of medical practice for the American College of Physicians (ACP), acknowledges that alternative care settings are also a challenge for internists. And Scott Cullen, MD, a consultant with ECG Management Consultants, says that fast-growing alternative care settings pose significant competition for some primary care physicians.

Along with physical care sites, telehealth services are part of the provider mix that is meeting some of the demand for minor acute care. FAIR Health, a research organization, says that telemedicine utilization leaped by 1200% from 2012 to 2017. The bulk of that growth appears to represent consumers’ use of telehealth services.

Although a growing number of practices—especially larger groups—are doing telehealth visits with their own patients, a recent ACP survey found that just 18% of internal medicine practices had the technology needed to do secure video visits, and a third had online consult capabilities.

Meanwhile, the number of alternative care settings is soaring. At latest count, there were about 2,200 retail clinics, of which more than half were operated by CVS or Walgreens. The number of urgent care clinics jumped from 6,946 in 2016 to 8,774 in November 2018, according to the Urgent Care Association.

**CONVENIENCE AND ACCESS**

People use alternative care settings for low-acuity conditions because they offer convenience and access. Sick patients don’t want to wait to see a primary care doctor in a conventional office. Often, they can’t leave work to visit a physician practice during office hours. They may not be sure whether they need to see a doctor, or they may just need a prescription.

Price can be a differentiator. Urgent care centers are more cost effective than

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**HIGHLIGHTS**

First, investigate the possibility of collaborating with alternative care sites. Retail and urgent care clinics can refer patients who need more extensive diagnosis and treatment to primary care offices.

Patient convenience is king. Post prices, reach out on social media and offer same-day appointments.
Money

Retail clinics

standalone ERs, which charge close to what hospital emergency departments do, but they charge more than physician practices do, on average. And, among physical sites, retail clinics charge the least for primary care.

FAIR Health's analysis of a large national claims database, for example, found that median charges for a CPT 99202 visit ranged from $160 in an urgent center to $138 in an office to $104 in a retail clinic. Median allowed amounts for CPT 99202 were $93 for urgent care centers, $66 for offices, and $73 for retail clinics. CPT 99203 median charges were $213, $207 and $129, respectively. Urgent care centers were allowed $114, offices, $92, and retail clinics, $85, for CPT 99203. According to other reports, a telehealth visit may cost $50 to $80.

Considering that primary care offices must also see patients with chronic conditions and cope with an ever-increasing, complex blizzard of rules and regulations, the lower or similar payments to primary care offices place them at a disadvantage, Boles notes.

"The expectations on primary care are so overwhelming," he says. "Then you throw on top of that a walk-in clinic right down the street that doesn’t deal with any of those things and sees this person for a minor problem and gets paid similar to what we do for an office visit. They get the icing, and the real meat of the issue is left to us."

Seeing mainly complex patients is a losing proposition for an independent family physician, explains Richard Young, MD, who works for a safety-net hospital in Fort Worth, Tex., and who researches the local market for an affiliated family practice residency. "If I take care of four problems in a visit—say a patient has high blood pressure, diabetes, back pain and a rash—I’ve given away half my services, because the CPT coding system quits paying me after I’ve seen two things."

What can primary care practices do to meet this competition? Schneider urges them, first of all, to investigate the possibility of collaborating with alternative care sites. Retail and urgent care clinics can refer patients who need more extensive diagnosis and treatment to primary care offices, she says, and primary care

Retail pharmacies moving hard into primary care

The leading retail pharmacy chains, Walgreens and CVS, are aggressively expanding the healthcare services they offer to customers. Here’s a roundup of their latest moves.

CVS

CVS announced plans earlier this year to open 1,500 “HealthHUB” locations across the country in the next three years, another major move that shows that traditional physicians practices will face further competition from mega corporations.

CVS already has more than 1,000 MinuteClinics in the United States, in which non-physician providers, usually a nurse practitioner, provides acute care for minor illnesses and injuries, along with basic screening services.

The HealthHUB concept goes beyond that, and represents “a powerful example of how CVS Health can provide consumers with convenient, personalized and integrated access to local healthcare,” according to a CVS press release.

Each HealthHUB has a “care concierge team” that works with customers to guide them through various services, including acute care, nutrition counseling, and chronic disease management for high blood pressure, high cholesterol, and type 2 diabetes.

CVS already has HealthHUBs as pilot programs in a handful of Houston-area stores. The plan is to convert about 50 CVS locations in 2019 in Houston, Atlanta, Philadelphia, and Tampa. The rest of the expansion will occur during the following two years.

“Going forward, we also have truly exciting opportunities to introduce programs and products that will change the way people think of and address their health,” said CVS Health Chief Financial Officer Eva Boratto, in a news release.

CVS competitor Walgreens also is planning healthcare pilot programs in Houston, partnering with VillageMD to open primary care clinics adjacent to five Walgreens stores before the end of 2019.

CVS is also seeking a merger with insurer Aetna, a multi-billion-dollar deal that would reshape
providers can advise patients to go to certain walk-in clinics when their offices are closed. Of course, the alternative care sites must agree to send documentation of each encounter to the patient’s primary care physician.

**EXTEND HOURS**

Practices should also extend their hours, Schneider says, even if it’s only on certain days of the week and/or selected weekends each month. Practices should plan their extended hours to meet the particular needs of their patient population, Cullen advises. On different days, for example, Jeff Pearson, DO, a family doctor in Carlsbad, Calif., has early morning and evening hours designed for patients who are on various schedules, he says.

Kohl agrees extended hours are important, but notes that they can create staff scheduling challenges. When he was in private practice, he recalls, he and his nurse practitioner were on staggered schedules: he handled the early hours and she covered the evenings, and the staff schedules were staggered to match.

“The expectations on primary care are so overwhelming. Then you throw on top of that a walk-in clinic right down the street that doesn’t deal with any of those things and sees this person for a minor problem and gets paid similar to what we do for an office visit. They get the icing, and the real meat of the issue is left to us.”

—DAVID BOLES, DO, OWNER, COVENANTCARE, CLARKSVILLE, TENN.

**OPEN SCHEDULES**

The vast majority of FPs offer some version of same-day scheduling, another technique that increases access. Not too many doctors open up their entire schedules to whomever happens to walk in or call in. But a generous number of open slots can help patients get

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the healthcare landscape. The proposed merger has faced increase scrutiny, however, as the federal judge tasked with signing off on the deal said on June 4 that he had anti-trust concerns regarding the merger.

**Walgreens**

Walgreens, the national drugstore chain, is launching a primary care service for adults starting with the Houston market and possibly expanding into other cities at a later date.

Walgreens is partnering with VillageMD, a provider of tools and support to primary care physicians, to open clinics adjacent to five Walgreens stores in the Houston area, with the first locations scheduled to open by the end of 2019. Unlike many clinics in drugstore chains, this venture will focus primarily on the use of physician providers. Operating under the “Village Medical at Walgreens” moniker, the 2,500-square-foot clinics will provide primary care services from VillageMD doctors who are integrated with pharmacists, nurses, and social workers to meet patient needs. VillageMD will use its docOS system, which integrates data and technology to get a 360-degree view of patients’ health needs, according to a press release from Walgreens. The software helps identify missing diagnoses and gaps in health, allowing doctors and patients to better manage chronic conditions that impede health and increase costs. The technology includes check-ins via phone, kiosk, home-based monitoring, and telemedicine.

“This collaboration with VillageMD demonstrates our ongoing commitment to create neighborhood health destinations that bring affordable healthcare services to customers and provide differentiat-ed patient experience to the communities we serve,” said Pat Carroll, MD, Walgreens chief medical officer and group vice president, in a release. “VillageMD has a strong track record nationally of improving outcomes and reducing the cost of healthcare through their transformative primary care model. With more than 120 primary care physicians in their medical group in Houston, we look forward to working with them as we focus on the health and well-being of the community.”

Walgreens operates 9,560 drugstores in the United States, Puerto Rico, and the U.S. Virgin Islands. Approximately 400 of its stores offer some form of a healthcare clinic for patients. VillageMD has more than 2,500 physicians across eight markets and is responsible for $2.8 billion in healthcare spending.
in when they need to be seen. In his former practice, Kohl kept all of his afternoon appointments open, and they all filled up.

Similarly, Robert S. Kaufmann, MD, a general internist in Atlanta, says that his five-doctor group has regular walk-in slots for patients with low-acuity problems.

**POST PRICES**

Schneider also suggests that practices post the prices for their most common services, just as the alternative care settings do. Even though a provider’s charges may not equate to what the patient will pay out of pocket, she says, “People want to know what’s going to hit their pocketbooks.” If practices want to give patients a better idea of out of pocket costs, she adds, they can ask their major payers what their allowed charges are on the most common services.

Pearson says he’s been posting his prices ever since he started out in practice. Today, all of his charges are on his website.

**BUILD A DIGITAL PLATFORM**

In today’s world, Cullen says, it’s essential for a primary care practice to have a digital platform. Primary care physicians must be able to interact with patients online, not only to give advice, but to set up appointments, deliver test results, and provide educational materials.

These online activities, as well as secure video visits, depend on patient portals. Not many patients, however, take advantage of these sites, according to a 2018 Government Accountability Office’s study that shows only 30% of Medicare patients used them. Cullen says the more value patient portals deliver, the more they’ll be used. Schneider urges practices to promote their portal to patients, talking about it at every visit and providing handouts on how to use it. In a clinic she used to manage, she says, staff would show patients how to log onto the portal on a computer in the waiting room.

It’s also essential to use social media, Schneider says. This is particularly true if practices hope to reach the millennials who are among the biggest customers of retail and urgent care clinics. Practices can employ Facebook, Twitter and Instagram to get out the word about their services and hours of operation, she notes.

**OFFER TELEMEDICINE**

E-consults and video visits represent another promising avenue to connect with younger patients. One Tulsa practice that recently started offering e-visits for 10 minor acute conditions has seen quite a bit of patient uptake, Schneider says.

According to ACP’s telehealth survey, the majority of practices that have the technology aren’t using it. Now that reimbursement for telehealth is widely available, Schneider says, the main barrier is lack of training. EHR vendors who license video visit modules are not training providers on how to use them, and physicians also have to teach their patients how to use the technology.

Kaufmann’s telemedicine vendor provided the hands-on training that the physicians and staff needed to feel comfortable with virtual care. When the group’s doctors are busy, they do audio-video consults on minor acute problems so that patients don’t have to come into the office. “We can provide service without making them wait,” Kaufmann says. At the same time, telemedicine has added a new profit center for the practice, he adds.

**PRIMARY CARE’S ADVANTAGES**

Kohl says the AAFP is less concerned about the competition from alternative care settings than about the fragmentation of care that can result. At least in one respect, that problem is diminishing, he says: Recently, he has seen more retail and urgent care clinics send information about patients’ visits to their regular family physicians.

Still, he says, alternative care settings “represent a misunderstanding of the value of comprehensive, continuous care.” Patients at walk-in clinics don’t receive the same type of attention to all of their risk factors and current conditions.

Pearson recently restarted a cash-only solo practice after several years working for a large group, and this has turned out to be an effective way to compete with alternative care sites, since he can provide more personalized care.

“I don’t have a seven-minute window,” he points out. “They get better service. Also, when they go to urgent care, they’re being seen by a PA a lot of the time. When they come to me, they’re seeing a seasoned doctor with 35 years’ experience.”

———JEFF PEARSON, DO, FAMILY PHYSICIAN, CARLSBAD, CALIF.
How to add more care to your treatment

Physicians are by nature compassionate people. But sometimes life can get in the way of the ability to consistently exhibit care, candor, and concern.

Every component of day-to-day life is interrelated, which is why it’s essential to pay equal attention to your personal, professional, and public priorities. Here are five categories of care that will ultimately enhance the treatment you provide to your patients.

1. Care for yourself
Your personal wellness impacts your patients’ treatment and your staff members’ productivity. If you’re emotionally spent, physically sick, or psychologically stressed, your patients and colleagues will probably suffer some kind of consequence. Though the effects may be subtle, like having them feeling rushed or unheard, your attitude can infect their experience.

The first order of business is to manage your physical and mental health. Make sensible dietary choices, schedule time for pleasure and exercise, and unwind every day through meditation, reading, music, or a hobby. Patients and staff see you as a role model, which is why it’s vital for you to demonstrate healthy habits.

2. Care for family and friends
The people you surround yourself with need you to be present and pleasant. Even though your hours may be long and unpredictable, choose to participate fully when you’re in the company of those who matter most.

Sadly, the busier we are the more likely it is that our family and friends take a back seat. Your loved ones need your support and care as much as you need theirs. Do what you must to carve out time to honor and enrich your personal relationships.

3. Care for your staff
Everyone who works in your practice, from your booking clerk to your physician assistant, benefits from your care and attention. They are, after all, the people who keep you organized and able to cope.

Ensuring job satisfaction for them guarantees a healthy practice for you. It’s up to you to establish the tone of your workplace. When cultivating the character of your practice, start with a foundation consisting of these four elements: inclusivity, positivity, efficiency, and civility. Have open, multilateral lines of communication and be fair when offering feedback to your staff.

If you want to see real change, start sharing three sincere compliments per day and watch the attitude among your colleagues shift.

4. Care for your workplace
The environment you work in plays a huge role in your career contentment. If worn-out furniture, outdated equipment, peeling paint, and close quarters surround you, consider modernizing the office. A few simple décor updates can make all the difference in how everyone feels when they enter the space.

If you’ve outgrown your current office, either physically or mentally, it may be time for a change. Sometimes moving on is the only way to answer your soul’s call for calm over the chaos you may be experiencing at your present place of work. Pay attention to your yearnings.

5. Care for your patients
Now that you, your people, and your atmosphere have been attended to, you’re in the perfect position to offer the best treatment for your patients. Not only are you better able to provide your full attention, but having your core needs and responsibilities managed means you’re much better able to help manage theirs.

Regular patients will notice even the smallest improvements in attitude and design. And when you take the time to focus on self-care, patients new and old are sure to realize they’re in good hands.

Never underestimate the value of tending to your own care first. When you do, your family, friends, colleagues, and patients will thank you for it.

Sue Jacques is a professionalism expert, keynote speaker, consultant, and author who specializes in medical and corporate civility. Send your practice management questions to medec@mmhgroup.com.
March 23, 2019, marked the ninth anniversary of the Affordable Care Act (ACA) being signed into law. These past nine years have been a continuing debate regarding the various aspects of health insurance reform contained in the ACA.

The most fundamental of reforms arose out of the simple definition of “essential health benefits.” For the first time in our nation’s history, health insurance plans were obligated to include “mental health and substance use disorder services, including behavioral health treatment” as covered benefits in their policies.

Behavioral health (BH) providers, who previously had very little exposure prior to the ACA, have been on a sharp learning curve when it comes to dealing with payers. However, much to the surprise of the BH community, payers are running toward alternative payment models that have been commonly utilized in BH for decades. Capitation and risk arrangements are a way of life for BH providers. Capitalizing on this knowledge is critical for any primary care physician (PCP) looking to integrate BH.

Beyond gaining a working knowledge of managing a patient under alternative payment models, what makes the case for integration? Simply put, BH conditions generally go undiagnosed and untreated.

The following list of statistics published by the Patient-Centered Primary Care Collaborative demonstrate precisely why outcomes can be so dramatically improved among patient populations when BH is integrated into primary care. They further demonstrate why integration of BH is the secret to bending the cost curve:

- 80 percent of individuals with a BH disorder will visit a PCP at least once a year.
- 50 percent of all BH disorders are treated in primary care.
- 67 percent of those with a BH disorder do not get BH treatment.
- As much as 50 percent of referrals to BH outpatient do not make their first appointment.

So, what can a practice do to integrate BH? Here are three practical steps to consider:

**START USING CPT CODES**

In January 2018, CPT added codes for BH integration. CPT 99484 can be used with at least 20 minutes of clinical staff time, directed by a physician or other qualified healthcare professional (e.g., physician assistant; nurse practitioner; or specialist such as cardiologist or oncologist), per calendar month with the following required elements:

- initial assessment or follow-up monitoring, including the use of applicable validated rating scales, such as PHQ-9
- behavioral healthcare planning, including revision for patients not progressing or with status changes
- facilitation or coordination of treatment, such as psychotherapy, counseling and psychiatric consult
- continuity of care with a designated member of the care team

Money

Boost revenue with behavioral health

by GREGORY W. MOORE, JD, and RUSSELL A. KOLSRUD, JD Contributing authors
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BH integrated services that are not provided personally by the billing practitioner are provided by other members of the care team under the direction of the billing practitioner on an “incident to” basis.

ENTER A COLLABORATION

Beyond the general BH integration code, three additional codes are available with a psychiatric consultant. These codes are for the PCP. The psychiatric consultant bills separately for his/her services.

CPT 99492 is used for initial care management (the first 70 minutes in the first month of behavioral healthcare management activities) in consultation with a psychiatric consultant and directed by the treating physician or other qualified healthcare professional.

CPT 99493 is used for subsequent collaborative care management, and CPT 99494 is used for each additional 30 minutes in a calendar month for initial or subsequent collaborative care management. Thus, CPT 99494 would be listed separately but in conjunction with CPT codes 99492/3.

A BH integration fact sheet issued by CMS that lays out these psychiatric collaborative care codes does not dictate the appropriate business model. Several business models exist with varying degrees of success. Traditional referral relationships are not as effective as co-location, direct staffing or participation in a BH provider driven clinically integrated network (CIN).

JOIN A CIN

There are CINs of all types emerging in the market as providers begin to collaborate over care management, best practices and outcome measures. The most successful are those led by BH providers who are driving collaborative care centered around BH integration into a primary care.

In essence, these BH focused CINs take a Patient-Centered Medical Home and/or a Certified Community Behavioral Health Clinic to the next level by structuring collaboration/integration in a way that keeps patients engaged and creates metric measurements that attract payers.

As PCPs continue to see their fee-for-service revenue decline while their patient engagement time increases, they should consider offering BH services. BH integration will increase practice revenue, improve patients’ overall health and create the measurable data and outcomes necessary to put PCPs back in the driver’s seat during payer negotiations.

Why more patients are seeking behavioral health

By Jeffrey Bendix, Senior Editor

A new study shows growing numbers of Americans grappling with behavioral health issues.

The study, published by the New York-based nonprofit organization FAIR Health, analyzes data from more than 28 billion insurance claims submitted to commercial payers between 2007 and 2017. Among its findings:

Claims that included behavioral health diagnoses rose from 1.3 percent to 2.7 percent of all claims submitted during the period, an increase of nearly 108 percent.

Claims relating to substance abuse and dependence, a component of behavioral health, grew from .1 percent to .3 percent of all medical claims, a 405 percent increase.

Within the substance abuse and dependence category, opioid dependence surpassed alcohol dependence as the biggest source of claims, growing by nearly 1,200 percent from .016 percent to .252 percent of all claims.

Claims for adjustment disorders—emotional or behavioral disturbances brought on by stress—among those age 19 to 30 increased from .35 percent to .62 percent of all claims. This was the largest increase among any age group.

Claims for generalized anxiety disorder, another subcategory of behavioral health, rose among the age 14 to 17 cohort from .4 percent to 1.77 percent of all claims submitted for that cohort, an increase of 389 percent. Among the age 19 to 22 cohort, the increase was 441 percent.

For claims related to use of stimulants other than cocaine, women outpaced men by 56 percent to 44 percent in the age 23 to 30 cohort. This finding runs counter to the usual pattern of men having higher rates of use or dependence on illicit drugs than women.

The study notes that some of the growth in behavioral health diagnoses could result from better access to mental health services made possible by the 2008 Mental Health Parity Act, which forced most commercial insurers to increase their reimbursements for behavioral health treatment.

Russell A. Kolsrud, JD, and Gregory W. Moore, JD, are members at Dickinson Wright PLLC. Together they created a behavior health care law practice group.

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From the publishers of Medical Economics®
Managing cardiometabolic syndrome: An incremental approach to improving outcomes

by JORDAN ROSENFELD Contributing author

Heart disease and cardiometabolic syndrome, a combination of metabolic dysfunctions characterized by insulin resistance, impaired glucose tolerance, dyslipidemia, hypertension, and central adiposity have become global epidemics. An estimated 47 million people in the U.S. live with these disorders, which place a huge financial burden on the U.S. healthcare system and on the practices of physicians trying to manage these patients. A 2015 study in the *Journal of Diabetes and Metabolism* found that in 2014, national medical expenditures attributable to cardiometabolic risk factor clusters in the U.S. totaled $80 billion, with $27 billion of that spent on prescription drugs.

“The impact [of cardiometabolic syndrome] on the healthcare system is massive because it branches out in every direction. Inability to work, immobility. It has an impact on the workforce, on insurance costs, on hospitalizations. I think we need to really act quickly if we want to stop it,” says Jennifer Haythe, MD, a cardiologist with the Center for Advanced Cardiac Care at Columbia University Medical Center in N.Y.

While many patients manage cardiometabolic syndrome and heart disease with medications, physicians find that a combination of lifestyle changes, including dietary and behavioral changes, are key to keeping these patients healthy.

**GET TO KNOW YOUR PATIENTS**

It’s important for physicians to get to know these patients’ unique needs in order to personalize a treatment approach that will work, says Mark Menolascino, MD, medical director of the Meno Clinic in Jackson Hole, Wy.

“You need to know what’s important to people. Do they want to live a long life, or an optimal life?” he says. “Take a few minutes to understand their goals and health wishes and then try to come up with strategies of lifestyle that fit those goals,” he says. For example, there’s no use suggesting a patient take up bicycling if they live in a place with no safe bike trails or lanes, he says.

In addition, it’s important for physicians to inspire change through positive reinforcement and avoid shaming or blaming the patient, says Lucienne Ide, MD, Ph.D., founder of Atlanta-based Rimidi, a cloud-based software that supports clinical workflows around cardiometabolic disease management.

“Patients should feel that the physician is here to support them on their journey and to see that they are making progress, be that a blood glucose goal, a lipid goal, or a weight loss goal,” Ide says.

**START SMALL**

Patients with cardiometabolic syndrome usually are starting out at a deficit of health, nutrition and physical activity. Big changes are just not realistic, Ide says.

“I’m a big fan of the tiny changes move-
ment,” Ide says. “Just [tell patients to] start with something small that is attainable that they can feel good about.”

Menolascino encourages patients to add more activity incrementally to their existing routines. This can include such steps as parking farther from the store and doing several laps around the parking lot before going in or walking up and down stairs at work several times on a break.

“As doctors we have to pick one thing that fits [patients] belief systems that they can be successful at,” he says.

For patients who are motivated by wanting to take fewer medications, Haythe reinforces that lifestyle changes can enable reductions in, and even stopping, some medications altogether.

For those patients who opt for medication over lifestyle changes, she tries to empathize but still encourage change. “I’ll say things like, ‘It’s very hard to get to middle age. Everybody’s body changes. But you could become much healthier and feel much better if you make real changes to your life.’”

She also offers patients a success story about someone who has made these changes and feels better. “I try to empower them to have confidence that it can be done and it’s not hopeless,” she says.

Though lifestyle changes should take priority, for some patients medication and even surgery (gastric bypass or gastric sleeves) may be the necessary starting point, Ide says, and shouldn’t be seen as a sign of failure. “If a patient is just not in a place where they can make a substantial change, a medical intervention may be what they need to move down that pathway and get stability,” she says.

THE NECESSITY OF EXERCISE

Physical activity is one of the most important steps a person with CMS and heart disease can take for their health, says Chetan Khamare, MD, FACC, a cardiologist at the Premier Heart and Vascular Center in Tampa, Fla. He says the American College of Cardiology (ACC) used to recommend 30 minutes of continuous cardiovascular exercise five days a week, but now they’ve found that just adding an extra ten minutes daily, up to 40 minutes per day, leads to a 25 to 30 percent additional reduction in cardiovascular events.

He also points his patients to an online risk calculator provided by the ACC, which helps establish a baseline of risk for such conditions as heart attack and stroke, and offers physicians a starting point for interventions. He finds that when patients take the agency to use the calculator they’re more likely to commit to healthy behaviors, especially since it’s scientifically validated.

Peer support is also useful in getting patients to be more active, Haythe says. “Tell patients to find a friend to go walking with. Start with just ten minutes outside every day.”

“If your friends aren’t healthy, there’s data to show you probably aren’t either,” Menolascino points out, so he encourages patients to find a group that can help them make healthy choices. He cites the example of a church group that added nutritional lessons to Bible study classes and motivated its members to eat healthier.

DIETARY CHANGES

Most patients with cardiometabolic syndrome and heart disease need to make fairly drastic dietary changes, says Pilar Stevens-Haynes, MD, director of non-invasive imaging at South Nassau Community Hospital in Oceanside, N.Y. But few patients will make all the changes overnight, she says, and physicians need to be encouraging but patient.

Stevens-Haynes sends patients home with a food diary to help them pay attention to what and how they’re eating. Then she’ll encourage them to start with cutting or lowering one thing: canned or boxed food, for example, which is high in salt, or replacing juice or soda with water, or avoiding bread. She then sets a follow-up appointment in three months to see if there have been improvements, such as losing a few pounds, or lower blood pressure, which might enable them to reduce a medication.

Khamare puts eating into a simple set of
Recognize all risk factors. A wide range of traditional and newly recognized risk factors contribute to cardiometabolic disease, and it is important to review all of them during a patient examination.

Traditional cardiometabolic risk factors:
- Age
- Sex
- Family history
- Hypertension
- Dysglycemia
- Dyslipidemia
- Smoking

Newer cardiometabolic risk factors:
- Abdominal obesity (measured by waist circumference)
- Insulin resistance
- Inflammation (measured by high-sensitivity C-reactive protein levels)
- Lack of consumption of fruits and vegetables
- Sedentary lifestyle
- Psychosocial stress

When clusters of these risk factors are identified, a management plan should be promptly put into place to delay or prevent future complications.

Communicate conscientiously. Because patients with cardiometabolic risk factors may be asymptomatic or have no existing conditions, they may not understand the serious risks associated with cardiometabolic syndrome. Primary care physicians must explain the importance of early risk factor control and stress that cardiac disease and diabetes are harder to treat once they are established. However, clinicians must also be cautious not to label patients in a way that makes them feel self-conscious or guilty for their health-related behaviors. Instead, reinforce the concept that lifestyle change, good nutrition, and increased physical activity can substantially reduce their cardiometabolic risk and improve their quality of life overall.

Focus on lifestyle modification. Lifestyle modification is the primary management strategy for cardiometabolic syndrome. This can be challenging to implement in a primary care practice because it requires simultaneous counseling on physical activity, diet, and smoking cessation with regular follow-up over a long period of time. Clinical guidelines recommend that lifestyle modifications be continued for 3 to 6 months before considering pharmacotherapy unless patients are at high risk. The importance of continuous, lifelong behavior change should be communicated to patients, even if they receive pharmacotherapy.

Address both weight and waist. Obesity—defined as body mass index (BMI) ≥30 kg/m²—is a regularly measured cardiometabolic risk factor, but body fat distribution is also an important consideration that should be addressed in a patient’s exam. Excess abdominal fat is associated with increased incidence of cardiometabolic disease, and waist circumference measurements of >40 inches in men and >35 inches in women place patients at higher risk. Adding waist circumference measurements to a patient’s chart can help assess body fat and subsequent risk in ways that BMI alone does not allow. It also provides a measurable goal for patients who are tracking their weight loss.

Build a care team. Because successful patient lifestyle modification requires long-term support, work to build a care team that can commit to being available to the patient over time. In addition to in-office support staff such as nurses and patient educators, it may be appropriate to refer patients to exercise specialists, registered dieticians, counselors or social workers, commercial weight-loss programs, and online or in-person support groups. Individual case managers or coaches can conduct weekly or bimonthly follow-up with patients via phone or email to provide ongoing motivation and reduce the need for office visits. Alternatively, patients within a practice can be organized into small groups that meet with a case manager or coach at regular intervals to discuss their challenges, share their stories, and support each other. Patients at high risk of cardiac disease or diabetes may also require referral to a cardiologist or endocrinologist.

Facilitate self-monitoring. Successful lifestyle modification requires self-monitoring by patients. When patients accurately track their food intake, exercise, weight loss, and change in waist circumference, they can provide valuable information to be discussed during office visits. Reinforce the importance of regular self-monitoring through a written diary, web-based program, or phone app.
Operations

Contributer: Stock.Adobe.com

Cardiometabolic syndrome parameters: “I tell patients if you can grow it in your garden or if you can kill it—with- in certain parameters—you can eat it. Don’t unwrap it, don’t unbox it. Don’t order it at a drive through.”

However, he recognizes that patients will not follow his recommendations immediately, saying that many patients are in a state of denial about their habits. “I’ll give patients one simple goal so that it’s achievable, realistically, and tell them to have a cheat day once a week.”

If the patient can meet that one goal, then at the follow up appointment he sets another goal, and so on.

TECHNICAL SUPPORT

Stevens-Haynes says her patients have more success when they use apps and tracking devices like Fitbits and smartwatches. Her patients rave about an app called My Fitness Pal, which allows patients to track calories and macronutrients, and can even scan products in the store and easily input nutritional data.

These devices and apps can also reveal just how active or inactive a person really is. “The perception in general is that we’re much more active than what we really are,” Stevens-Haynes says.

Haythe has learned that the patients who really commit to these changes feel better, reduce or come off medications more quickly, and see increased self-esteem.

USE OTHER PROFESSIONALS

Getting patients to make lifestyle changes doesn’t have to be solely the job of the physician, says Menolascino. “A lot of doctors don’t really know about the psychology of eating and the psychology of behavioral change,” he says. “That’s what health coaches are for.” He thinks physicians should either have an in-house nutritionist/dietician or health coach or develop a strong referral base for them.

Haythe adds that nurses and nurse practitioners can also be helpful. “A diabetes nurse practitioner can do education and pre-

for example. I recommend having those people in [physician] practices.”

ANALYTICS & REMOTE MONITORING

Tracking key health indicators is an important part of helping patients stay healthy. Khamare says. He recommends that every practice track such indicators as hypertension, uncontrolled cholesterol, and weight. While every EHR is different, there are ways to set up analytics to track this data.

Ide also promotes the idea of remote patient monitoring from home, via a Fitbit, electronic scale, or a Wi-Fi-enabled blood pressure cuff that sends real time data directly to a physician’s EHR. This allows the physician to stay abreast of health changes between office visits. “Physicians might see a patient four times per year, but [patients] are living with their disease every day of the year,” she says.

With remote patient monitoring, not only does the physician gain valuable data, they can communicate support via electronic messages. “Then maybe I could message a patient after a month and say ‘hey, I see you’ve lost two pounds, great job.” She says that creates a positive feedback loop that might otherwise be missing, and helps patients feel that their doctors care.

Even better, Medicare now reimburses for some remote patient monitoring and for time physicians spend reviewing data under chronic care management codes.

“It’s important for physicians to know there’s a lot happening in tech that is designed to support them,” Ide says.
Machine learning: Will it revolutionize healthcare?

by LINDA WILSON Contributing author

To take advantage of emerging software tools that incorporate artificial intelligence, healthcare organizations first need to overcome a variety of challenges.

Some leading-edge organizations are beginning to do just that, focusing on machine learning, a subset of artificial intelligence (AI) that encompasses statistical methods in which computer systems recognize patterns or correlations in data by ingesting large sets of training data. They improve their performance, or “learn,” over time as they incorporate new data; revising their approach as needed without human programmers updating the rules.

In the healthcare industry, most machine learning applications are in the research stage. “There is not a ton of clinical use,” according to Brian Edwards, independent validation consultant for AI vendors.

One area with a lot of research activity is radiology, where the industry is investigating how to use machine learning to detect signs of disease from digital images. “Whenever you have crisp clean data is where you should start. Images are the highest quality data that you have in a health system in terms of reliability,” Edwards says.

Machine learning has been applied to other areas, such as assessing patients’ risk of a hospital readmission, exacerbation of a chronic medical condition, or coming down with sepsis during a hospital stay.

PREPARING FOR MACHINE LEARNING

“I think planning is where it starts,” says Bob Fuller, managing partner for healthcare at Clarity Insights, an information technology consulting firm focused on data analytics. Fuller says healthcare organizations should assess their overall business strategy and how AI could be deployed to solve specific problems, such as hospital readmissions or claims fraud. The next step is to allocate financial resources to transition the information technology infrastructure, so it becomes AI-ready, Fuller says.

This includes a large and diverse set of reliable data to train the machine learning models—whether they are developed internally or purchased from AI software vendors.

“In every situation, it is necessary to train the AI,” Edwards says. “That knowledge is really institution specific. The heterogeneity of data makes it very difficult, if not impossible, to take something from one organization—or a generic packaged product—and implement it widely. It really is implemented one-at-a-time in an almost ala carte type of way, where you need to customize it,” Edwards says.

Another barrier to implementing machine learning in healthcare organizations is access to high-quality data. Healthcare organizations need to have rigorous processes in place to ensure they have clean and well-defined data, Fuller says. While this has always been true, it becomes even
more important as the volume and types of data that healthcare organizations capture continues to grow, he adds.

REAL-WORLD DATA

Geisinger Health—an integrated delivery network with 13 hospital campuses and a nearly 600,000-member health plan—has tapped into its vast store of diverse datasets to develop machine learning applications internally.

It has data on 2 million patients in its electronic health-records system. It also has a stable patient population in Pennsylvania and New Jersey, which allows it to build longitudinal datasets, spanning 20 years.

In its digital imaging system, it has two petabytes of data, which it accumulated over 19 years. Most of this data is from radiology, but some is from other medical disciplines, such as cardiology. “The ability to have that data and to use if for machine learning is one of our strengths,” says Aalpen Patel, MD, chairman of radiology at Geisinger.

Some applications are in daily clinical use already, including a machine learning model that detects intracranial hemorrhage, or bleeding in the brain, from CT scans. Geisinger uses the model in daily operations to read CT scans of the brain taken in the outpatient setting. If the algorithm detects bleeding, the case is automatically reprioritized as a STAT case in radiologists’ work queue.

While all CT brain scans from hospital units or emergency departments are considered STAT and read within 30 minutes, similar scans taken in the outpatient setting are read within 12 hours. By sending those cases from the outpatient setting through the machine learning model, Geisinger reduces diagnosis times significantly for critical cases coming from the outpatient setting.

“We don’t take on problems that we don’t think are relevant,” says Brandon Fornwalt, MD, PhD, chairman of the department of imaging science and innovation at Geisinger. The integrated delivery network’s goal is to move from the research phase to implementation in clinical workflows quickly, he says.

In addition to large datasets, ample processing speed is necessary for machine learning. Geisinger solved this problem for its first machine learning application in imaging by purchasing a GPU (graphics processing unit), which accelerates the processing of computational workloads. Since then, it has upgraded its architecture to include multiple GPUs because its need for processing power has grown.

Fuller says accessing cloud options—such as from Amazon Web Services, Microsoft Azure, or Google Cloud—might be more cost effective for many healthcare organizations than building the required infrastructure internally because the cloud allows you scale computing resources up and down to match current needs.

Having a plan to evaluate machine learning products on the market today also is important. Salt Lake City-based Intermountain Healthcare, which has 23 hospitals and more than 170 clinics focuses its efforts on purchasing commercially available software, has investigated many more products than it has purchased, according to Lonny Northrup, senior health informaticist at Intermountain.

Northrup says Intermountain typically won’t move forward with a tool unless the vendor can point to clinical improvements and cost reductions that occurred at another health system.

After analyzing the results the platform achieved elsewhere, Intermountain assesses how well a product works with Intermountain’s patient data. To do this, the health system feeds the product a set of training data—such as on colon surgery—that the health system has already studied, allowing it to verify the insights that the tool derives.

The next step is a pilot test. For example, Intermountain is working with a vendor of patient engagement software on a clinical trial using the product to encourage patients with complex cases of congestive heart failure to follow their medication regimens. Using machine learning methods, the software platform personalizes the recommendations it makes about how to prod patients to behave in ways that improve their health. As part of the project, Intermountain provides 24/7 availability of clinical personnel to respond to these patients’ needs, Northrup says.

“In every situation, it is necessary to train the AI. That knowledge is really institution specific. The heterogeneity of data makes it very difficult, if not impossible, to take something from one organization—or a generic packaged product—and implement it widely.”

—BRIAN EDWARDS, INDEPENDENT VALIDATION CONSULTANT FOR AI VENDORS
Who are your role models?

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

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

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

“My family doctor growing up.”

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

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

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

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

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

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

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

 “[Neurologist] David Perlmutter, MD.”

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

“My parents.”

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Supercharge your practice’s efficiency
Primary care practices deal with numerous challenges that make it difficult to grow. The good news, according to practice management experts, is that practices can find ways to grow revenue and reduce costs. But it requires planning and sometimes making difficult changes. Our cover story walks through some potential strategies to boost practice growth.

“The microscope helps me to see the ever-shrinking reimbursements we’re getting.”