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MALPRACTICE DEFENSE
Two keys for preventing a lawsuit

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MONEY
Will satisfaction scores impact your bottom line?

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CAREERS
Can value-based models decrease burnout?

CHRONIC CONDITIONS
Best practices in managing patients with asthma

MedicalEconomics.com
IT’S MORE COMMON THAN YOU MAY THINK

Replication of the HIV-1 virus is error prone, resulting in millions of mutations, like M184V, each day.1-3 Based on reports to the US National HIV Surveillance System, as of 2016, approximately 1 out of 5 treatment-naive patients in the United States had at least one acquired drug-resistant strain of an HIV-1 virus.4*

SERIOUS, IRREVOCABLE IMPLICATIONS

If the virus is resistant to a drug, it may be resistant to other drugs of the same class. HIV drug resistance may result in fewer treatment options for your patients, meaning fewer ways to achieve and maintain viral suppression. Plus, if a patient has a drug-resistant virus, they could pass it to their partner.3,5,6

A TREATMENT WITH A HIGH BARRIER TO RESISTANCE IS IMPORTANT

Treatment regimens with a high barrier to resistance require a greater number of critical mutations to make treatment ineffective. Patients who aren’t on a drug with a high barrier to resistance and have sub-optimal drug levels have a greater chance of developing resistance.7 Factors that contribute to sub-optimal drug levels include poor treatment adherence, food effects, and drug-drug interactions.8-10

WHY HELPING TO PREVENT HIV-1 DRUG RESISTANCE STILL MATTERS

Learn more about HIV-1 resistance at HelpPreventDrugResistance.com

*Data from drug-resistance tests for any transmitted drug-resistance mutation performed within 3 months of HIV diagnosis were analyzed in 36,288 cases that were reported to the US National HIV Surveillance System.


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CHAIRMAN’S LETTER

The best malpractice defense

I

n each issue, Medical Economics covers many challenges that keep physicians up at night. Declining reimbursement, staffing issues, patient adherence—the list appears endless.

But there are few issues that worry physicians more than the prospect of facing a malpractice lawsuit. The data is striking: one out of every three physicians will face a malpractice lawsuit at some point in their career, according to reports published by the AMA’s Division of Economic and Health Policy Research.

But it would be a mistake to consider being sued an inevitability. Our cover story in this issue is all about what physicians can do to prevent a lawsuit. The story focuses on what malpractice experts tell us are the key defenses for every physician—patient communication and proper, timely documentation.

Speaking of issues that keep physicians awake at night: Dealing with payer prior authorizations. One of our practice management experts offers five tips physicians can use right away to help minimize the hassle of prior auths so physicians can concentrate on what they truly care about—helping patients.

A chronic condition that many primary care physicians seek to help their patients with is asthma. CDC data show that 1 in 13 patients suffer from this disease, including nearly 8 percent of all adults. In our coverage, we talked to some of the nation’s leading experts in the treatment of asthma to provide the latest patient management advice so that our physician readers can boost patient adherence, improve their quality scores and get paid what they deserve.

There’s plenty of other great, useful content in this issue: We offer a primer on patient satisfaction scoring, and how it will impact a practice’s bottom line; provide the latest information on telemedicine reimbursement; and interview previously burned out physicians about how they rediscovered the joy of practicing medicine. I hope reading this issue will prove informative and helpful—and maybe help our physicians sleep better at night.

Mike Hennessy, Sr.
Chairman
COVER STORY

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Survey of 1,000 randomly selected primary care physicians by researchers at Johns Hopkins revealed significant gaps in the respondent’s overall knowledge of risk factors, diagnostic criteria and recommended prevention practices for prediabetes.

Survey questions evaluated the physicians’ knowledge in three areas:

- The results revealed substantial gaps in primary care physicians’ knowledge in all three categories measured, according to the study. For example: Only 42 percent of respondents chose the correct values of the fasting glucose and Hb1Ac tests that would identify prediabetes.
- The results suggest that 25 percent of primary care physicians may be identifying people as having prediabetes when they actually have diabetes, which could lead to delays in getting those patients proper care.
- The researchers suggest better educating physicians about diabetes prevention, providing easier access and reimbursement for physicians and their patients to national diabetes prevention lifestyle change programs and offering new tools to improve prediabetes diagnosing.

The board members that contribute expertise and analysis to help shape content of Medical Economics.

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

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

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

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

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

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

Salvatore Volpe, MD
Pediatrics/Internal Medicine / Pediatrics
Staten Island, N.Y.
n response to the letter entitled “Expanding the roles of NPs and PAs will make primary care more desirable” by Dr. Volpintesta (September 10, 2019): The letter argues that the work family physicians do is simple and others with significantly less education can easily replace us. It states that “most of their work includes treating upper respiratory diseases, hypertension, diabetes and coordinating care with specialists.” For a family physician to state this, I surmise that you are either extremely fortunate enough to work in an urban area with healthy, low acuity patients and many specialists to help or you have a very narrow scope of practice.

With all due respect: This is the opposite of both my sentiment and practice.

As a family physician, my scope includes newborns to octogenarians. Clinic, hospital, nursing home, veterans home—I work in all of them full time. Gynecology, pediatrics, palliative care, surgical procedures and mental health—I treat all of them. I do not do this out of choice but because I have to. I live in a poor, underserved community.

NPs and PAs do have a place in our medical system. I supervise two nurse practitioners and have gone to a nurse practitioner for acute medical concerns myself. They can indeed deal with upper respiratory infections, urinary tract infections, pharyngitis, medication refills, and the like. I appreciate their assistance and what they do. No one is disputing this.

For example, my day yesterday was comprised of twelve patients in clinic and ten in hospital. The clinic patients included a 42-year-old woman with a COPD exacerbation unimproved with outpatient treatment prescribed by a neighboring emergency department, severe hypothyroidism, vitamin D deficiency and spousal abuse. The next patient was a 2-year-old girl, again seen both in clinic and the emergency room in the preceding days with persistent unresolved fevers despite being on antibiotics for presumed pharyngitis.

Don’t tell me these are simple and straightforward patients that we are over-trained for.

As a family physician, I am a professional with highly sought-after skills that literally mean the difference between life and death for patients. I can prove this as I was recruited from my previous practice in Arctic Canada to Southern Mississippi. There was no one in the entire country of America that could fill the void despite an extensive recruitment drive. Patients appreciate this and remind me regularly.

As family physicians we have a lot to offer. We treat and manage complicated situations on a daily basis. We should not diminish what we do as it is infinitely more than coughs and colds that we treat.”

Dominika Jegen, MD
WATER VALLEY, MISS.
Doctors frequently worry about getting sued for malpractice, and with good reason. Although the number of lawsuits has been declining in recent years, there were still more than 11,500 filed in 2018, according to data compiled by LeverageRX, an online lending and insurance broker for healthcare. Meanwhile, malpractice payouts rose nearly 3 percent compared to 2017 to about $4 billion.

In spite of those daunting numbers, physicians needn’t think of malpractice suits as inevitable. Understanding the reasons for lawsuits can help doctors minimize the chances of being sued and improve the odds of a favorable outcome if they are.

The main point to remember, experts say, is that most malpractice suits are not really about money. “Any plaintiff’s lawyer will tell you that no patient walks into their office screaming, ‘I want a mil-
lion dollars,” says Richard Boothman, JD, a risk management consultant in Ann Arbor, Mich., and a former trial attorney and chief risk officer for the University of Michigan Health System.

Instead, Boothman says, lawsuits usually are the result of injured patients or their families wanting to find out what went wrong, who was responsible for it, and to see that it doesn’t happen to others.

With that in mind, what can doctors—particularly those in primary care—do to reduce their legal exposure?

**STRIVE FOR TRUSTING, OPEN RELATIONSHIPS**

A good place to start, according to those with experience in malpractice cases, is to establish trusting and open relationships with patients. That, in turn, requires two things: good communication skills, and lots of face time with patients.

Fred Cummings, JD, a malpractice attorney with Dickinson Wright in Phoenix, Ariz., says that a significant motivator among many of his clients is the feeling that their doctor didn’t spend enough time with them, or wasn’t really listening when they described their health problems.

Moreover, without a trusting relationship patients are less likely to reveal personal information, such as drug use or sexual activity, that their doctor needs to properly diagnose and treat them, says Darrell Ranum, JD, vice president of patient safety and risk management for The Doctors Company, a medical malpractice insurer. Ranum adds that patients who trust their doctor are more likely to adhere to a medication regimen and obtain recommended follow-up tests and procedures.

Cummings acknowledges the difficulties most primary care doctors face in spending as much time with patients as they—or patients—would like. That challenge makes it vital to find ways of maximizing the limited time they do have, such as by using scribes to record and enter data for patient visits, thereby allowing the doctor to focus entirely on the patient.

**GOOD COMMUNICATION IS KEY**

In addition to spending time with patients, Cummings and others emphasize the importance of effective communications—oral and written—for heading off malpractice suits, and bolstering a doctor’s case if they are sued. “It’s not enough just to be a brilliant diagnostician, you’ve got to be able to communicate your diagnosis to the patient and have that patient feel confident that you know what you’re doing,” Cummings notes.

His observation is supported by data from The Doctors Company. “We find that one of the key factors [behind malpractice suits], appearing in 21 percent of our claims, is a lack of communication between the patient or their family and the physician,” says Ranum.

Effective written communication covers areas such as explanations for referrals, interpreting lab results, and clear and contemporaneous documentation of patient visits.

“In my experience, the number one reason for a successful malpractice suit lies in the charting. ... So the more accurate your charting, the better.”

—FRED CUMMINGS, JD, MALPRACTICE ATTORNEY, DICKINSON WRIGHT, PHOENIX, ARIZ.,

**DOCUMENT PATIENT VISITS ASAP**

Boothman agrees, and emphasizes the importance for malpractice defense of documenting a patient visit as soon as possible. “When my clients were sued, one of
The first things that I needed to do was to recreate the circumstances,” he explains. “I can’t do that if they don’t have a note with enough detail so that years later, if a lawsuit does arise, we can recreate what happened at that visit.”

Accurately diagnosing a patient can be especially challenging for primary care doctors because of the wide range of medical problems they encounter, Ranum says.

The largest category of patient allegations in The Doctors Company study—39 percent—were diagnosis-related. That means physicians have to be careful to follow a differential diagnosis process, and document that they have done so.

“If the physician’s diagnosis is questioned at some point in the future, and the documentation reflects a thoughtful and systemic approach to arriving at a diagnosis, then the doctor is more likely to be seen as being reasonable in their approach rather than negligent for missing a diagnosis,” Ranum says.

THE ROLE OF PRACTICE CULTURE
Boothman notes that a practice or organization’s culture plays an important role in ensuring patient safety and thus the frequency of malpractice suits. “In workplaces where the physician is regarded as captain of the ship and the people around him don’t feel empowered to raise concerns about a patient’s treatment, that culture can create a higher medical malpractice risk,” he says.

Conversely, he adds, when physicians treat other members of the care team as equals and welcome their questions and suggestions, “Then you know the patient is going to get the benefit of many sets of eyes and lots of brains thinking about that patient, and it creates a much safer situation for everyone concerned.”

Another essential aspect of practice culture for minimizing malpractice risk is creating, and adhering to, protocols for ensuring patient safety and maintaining good communication, such as training receptionists and other staff members to know when they can respond to a patient’s question and when to refer it to a doctor.

Similarly, Ranum says, primary care practices need systems for confirming that patients follow through on referrals and recommended procedures. He cites the example of a patient referred for a chest x-ray for pneumonia, the radiologist identifies a possibly cancerous lung nodule, but forgets to send the results to the primary care doctor.

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“So the physician never follows up on that lung nodule and a few years later the patient has worsening symptoms and is identified with lung cancer,” he says.

DON’T BE AFRAID TO REFER
A further area where primary care doctors can get into legal trouble is failing to make referrals when they are warranted. “Sometimes primary care docs can get in over their head if they don’t seek assistance,” Ranum says, such as when a patient repeatedly sees their primary care physician for the same symptoms.

“If all the standard remedies are not working, then it’s time to move that patient on to a specialist who can maybe identify the real cause of the problem,” he advises.

But from a legal standpoint, merely referring the patient isn’t enough. Primary care doctors also have to document that they made the referral and followed up with the patient. “I will tell you that unless confronted with some documentation that they were given a referral slip, every patient [in a malpractice suit] will say they don’t remember getting a referral,” Cummings says.

Moreover, he adds, under some circumstances primary care doctors who continue treating a patient for the problem for which they referred the patient to a specialist can be held to the medical standard of the specialist in a malpractice suit, even if the patient doesn’t see the specialist.

“So refer often, but if the patient doesn’t go, make sure you document that,” Cummings advises. “And at some point you need to send the patient something in writing about their non-compliance and what it might mean for them medically.”

In the end, Boothman says, the best way for doctors to avoid getting sued for malpractice is by putting the patient at the center of everything they do. And while that may sound obvious, it is often difficult given the many pressures, from seeing additional patients to improving quality ratings, that can pull them away from patient care. Nevertheless, he says: “Doctors always need to remind themselves what a remarkable statement of trust it is that patients put their well-being in the physician’s hands and do the things doctors do to patients. It’s a staggering privilege.”

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

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

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

Should doctors apologize for mistakes?

How to thread the needle when talking to patients about medical mistakes

by Jeffrey Bendix Senior Editor

It used to be that when a patient experienced a bad outcome from a treatment or procedure, doctors were advised not to apologize, or even express sympathy to the patient or their family, lest something they said be used against them in the event of a malpractice suit.

But the conventional wisdom regarding apologies has started to change. Now, experts say, the answer to the question “Should you apologize?” is “it depends.” In part, that has been driven by the growing number of states passing so-called “I’m sorry” laws, which say that doctors’ apologies to patients can’t be used as an admission of guilt, says Fred Cummings, JD, a malpractice attorney with Dickinson Wright in Phoenix, Ariz.

But even without such laws, Cummings says, there are ways for doctors to apologize and express empathy without saying they are to blame. gestures, according to the National Council of State Legislatures.

By late 2018, 39 states and the District of Columbia had enacted laws regarding medical professionals making apologies or sympathetic gestures, according to the National Council of State Legislatures.

But even without such laws, Cummings says, there are ways for doctors to apologize and express empathy without saying they are to blame. gestures, according to the National Council of State Legislatures.

“Sometimes doctors have to make judgment calls, and even if it doesn’t turn out the right way, it doesn’t mean making the judgment was wrong,” he adds. “Talking about that with the patient and regretting the situation doesn’t necessarily get the doctor in trouble with the patient.”

Richard Boothman, JD, a healthcare risk management consultant in Ann Arbor, Mich., and a former trial attorney and chief risk officer for the University of Michigan Health Systems, favors apologies under some circumstances. “The standard of care is not to be perfect or clairvoyant, it’s to be reasonable,” he notes. “But there are times when a physician just drops the ball and makes a mistake. And at that point an apology can be healing for both the physician and patient.”

But if an apology is offered, he cautions, it has to be sincere and viewed in the larger context of the trusting doctor-patient relationship. “You can’t look at it as some risk management strategy that you just roll out and hope the patient or their family satisfied, then walk away,” he says.

The drawback of apologizing is that “you can’t unring that bell once you do it, so you have to be darn sure you know what you’re talking about,” Boothman says. While at the University of Michigan Health Systems he told doctors, “It’s always fine to so say to a patient, ‘I’m sorry this happened, it’s not what any of us planned, and we’ll get to the bottom of it. But let’s take care of your immediate medical needs and we’ll have another conversation about this later.’ That’s what we wanted.”

“You can’t unring that bell once you [apologize], so you have to be darn sure you know what you’re talking about.”

—RICHARD BOOTHMAN, JD, HEALTHCARE RISK MANAGEMENT CONSULTANT, ANN ARBOR, MICH.
Many physicians are familiar with what is known as the Physician Self-Referral Law, or the Stark laws, but they often assume they do not apply to them or that they are in compliance.

The truth is that Stark laws are a complicated statute supported by thousands of pages of regulations, guidance, case law and other interpretations that can make the laws challenging—even for a seasoned lawyer—to fully understand.

Stark generally prohibits a physician from referring a Medicare and/or Medicaid patient for a designated health service (DHS) to an entity with which the physician, or an immediate family member, has a financial relationship, such as through ownership or compensation. Although I always recommend that physician practices work with experienced health law counsel, I understand this is not always something in which a practice is willing to invest.

However, if certain facts are present, it is unreasonable for a physician practice to not seek proper legal guidance. These facts include:

- The practice bills Medicare or Medicaid and
- The practice offers DHS covered by Stark.

Stark includes the general categories of items such as home health, DME, diagnostic services and physical therapy and many others. AND

- Physicians refer within the practice or physicians refer to another entity with which they, or their family member, maintain an ownership interest or compensation arrangement.

An example includes referring patients to another physician practice for DHS when that company leases space to/from the practice. There are various solutions the practice can employ when Stark is implicated. For referrals made by physicians within the practice, the most common approach is to make sure the practice is properly structured as a group practice, which is specifically defined under Stark, and meets certain supervision, location and billing rules. Among other requirements, the group practice definition requires that physician compensation be structured in a specific way that generally does not allow physicians in the practice to be directly compensated based on the volume or value of their referrals for DHS. For example, a practice that offers X-rays cannot track the X-rays ordered by each physician and credit the referring physician with the technical component paid for that service. I have come across many practices that are simply unaware of this requirement and may have compensated their physicians in such manner for many years.

In a recent Qui Tam lawsuit and federal investigation published by the Department of Justice U.S. Attorneys’ Office for the Southern District of Alabama in August, an orthopedic physician practice was investigated for, among other issues, violation of Stark. The government alleged that the practice had a compensation arrangement among the shareholder-physicians where the compensation was paid directly or indirectly related to the volume of each shareholder-physician’s referrals for DHS.

It is unclear whether this is an area that the government intends any heightened scrutiny in the future, but practices currently noncompliant with Stark laws should pay attention to this case and seek advice accordingly.

Stark laws are a strict liability statute and compliance is mandatory. It does not matter whether physicians are aware of the laws or not, or whether they intended to violate the law. Among other negative outcomes, sanctions for violation of Stark laws can include civil monetary penalties and exclusion from participating in the Medicare and Medicaid programs. Additionally, violation of Stark laws can trigger violation of other laws as well, such as the False Claims Act.

Stark is a complex set of laws and regulations that are often difficult to interpret and understand. Given the potential consequences of a Stark violation, it is important for practices to see the value in engaging experienced healthcare counsel early on to avoid future legal and financial complications.

Ericka L. Adler, JD, has practiced in the area of regulatory and transactional healthcare law for more than 20 years. Send your legal questions to medec@mmhgroup.com
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The nation’s largest physician-owned insurer is now expanding in New York.
Many practices are adopting an all-hands-on-deck approach to deliver the suite of services required to achieve comprehensive patient care. Experts say medical assistants (MAs) can be cost-effective contributors to these emerging care models.

MAs work under the oversight of physicians, physician assistants, or nurse practitioners in outpatient settings. Their duties range from clinical work, such as recording blood pressure readings, to administrative tasks, such as scheduling patients.

According to the Bureau of Labor Statistics, the median wage for an MA in 2018 was about $16 per hour, or $33,610 per year. There were more than 634,000 MAs in the field in 2016 with job growth expected to be substantial, increasing 29 percent over the next decade.

Practices looking to hire medical assistants should consider each candidate’s education and certification, as well as past medical and administrative work experience. MA positions typically don’t require college degrees.

While there is no licensing for MAs, the two most common credentials are Certified Medical Assistant, which is earned through the American Association of Medical Assistants (AAMA), and Registered Medical Assistant, earned through the American Medical Technologists (AMT) agency.

“It’s important for physicians to understand that certified MAs can have a variety of training experiences,” says Marie Brown, MD, MACP, an internist at Rush University Medical Center in Chicago. Her practice includes three certified MAs, supporting two internists. One of Brown’s MAs completed some nursing classes plus several years of on-the-job training—rather than a structured MA education program—and passed the AMT certification exam with a near-perfect score.

Beyond that, practices should also consider a prospective hire’s interpersonal skills to understand how the candidate would support the daily objectives of patient care. Brown suggests, for instance, that MAs should be comfortable enough to ask questions when they need more information.

**EMERGING ROLES FOR MAs**

MAs are equipped to manage some of the new practice responsibilities that have emerged under value-based care initiatives, according to Donald Balasa, JD, MBA, CEO and legal counsel for the AAMA.
Patient-centered medical homes are especially well suited to make use of MAs, who can carry out a number of health management strategies, he says.

Emerging roles for MAs include:

- **Prevention outreach specialist or panel manager**—identifies patients with care gaps and communicates with them to encourage adherence to recommended care;
- **Patient navigator or patient advocate**—acts as a liaison between the patient and the healthcare system in an effort to reduce barriers to care;
- **Clinician**—qualified to deliver certain services under Medicare’s Chronic Care Management and Transitional Care Management programs.

MAs acting as prevention outreach specialists can enhance quality scores, which can translate into bonus payments for the practice. For example, medical assistants can review patient records to identify those overdue for preventive screenings, then follow up with reminders and scheduling.

Balasa says the supervising physician sets the criteria for the targeted populations, indicating who should receive which preventive screenings and when.

At Brown’s practice, MAs review records for patients on the next day’s schedule to identify gaps in preventive care such as immunizations, mammograms, or colonoscopies. When a gap is found, the MA prepares the order for the physician and makes it available in the EHR.

“When the patient comes in the next day, the doctor knows the care gaps have been evaluated, the orders are queued, and the doctor just needs to sign off,” Brown says. “It has tremendously increased our percentage of patients who have those gaps met.”

Research shows employing MAs as panel managers is especially effective at increasing colonoscopies, Balasa says. About 37 percent of individuals age 50 and older have not received the recommended colorectal cancer screenings, according to the American Cancer Society, so there’s ample opportunity for panel managers to make a positive impact.

A 2017 study published in Preventing Chronic Disease demonstrated that MAs working in federally qualified health centers in North Carolina were able to increase the percentage of patients up-to-date with colorectal cancer screening from 23 percent to 34 percent. Another study published in *Quality & Safety in Health Care* in 2009 showed the expanded MA role was associated with a 123 percent improvement in colonoscopy referrals among seven practices in Utah.

**CONSIDER THE PATIENT’S NEEDS**

As a patient navigator, the MA takes on a communications role, advocating for the patient with sensitivity to cultural, socioeconomic, age, gender, or other personal characteristics. It’s a valuable asset for practices that are eligible for bonus payments based on patient satisfaction scores.

In this position, a medical assistant would need well-developed interpersonal skills. An MA who is bilingual, for example, might act as a translator in the exam room or at the reception desk to ensure a patient with language barriers can adhere to care plans.

“Being bilingual is important, but it extends beyond that to include familiarity with the customs of certain ethnic or cultural groups,” Balasa says.

He adds that in some Islamic and Hmong communities, female patients want to be treated only by female clinicians. In those...
cases, culturally sensitive patient navigators can manage the appointments in a way that works for the patient and the practice. "It makes it easier for the patient to function within the health system," Balasa says. "It's a relatively new role for the MA that's tied into quality."

**MEDICARE REIMBURSEMENT**

Under Medicare's Chronic Care Management and Transitional Care Management programs, certain services performed by MAs can be billed as "incident to" the services of the overseeing physician or advanced practice provider (chronic care, non-face-to-face service code CPT 99490 and transitional care management codes CPT 99495 and CPT 99496). In other words, practices participating in the two programs can get paid for work performed by MAs.

Some examples of chronic care management duties for MAs include recording patient health information and keeping comprehensive care plans up to date electronically.

Transitional care management services include providing education about available community resources as well as communication with service providers to support the patient's transitions from one care setting to another.

"Even if that information is conveyed by telephone or electronic means, those services are billable under these two programs as incident to the services of the delegating physician," Balasa says. "This is a new area in which medical assistants are getting involved in chronic care management."

Balasa says the contributions of MAs in the team-based care environment are making a difference in how practices function. And when an MA's work has a positive effect on a patient's health—such as when a reminder call leads to a mammogram that detects cancer—Brown believes the physician should commend the MA.

"This is hard work, and they enter into it to help people," she says. "Highlighting the importance of their role in health coaching and adherence is key."

**EASE PHYSICIAN BURNOUT**

In May, the *Annals of Internal Medicine* reported that a significant number of physicians are experiencing burnout, with the economic cost resulting from the associated turnover and reduced clinical time estimated at about $7,600 per physician per year.

In response, many practices are hiring greater numbers of non-physician providers. Medical assistants can be among the most cost-effective additions to practices' staff because of their lower pay relative to nurses or physician assistants. Ideally, a practice would aim for two MAs for each physician, according to Brown.

Paula Lozano, MD, MPH, a pediatrician and researcher with the Kaiser Permanente Washington Health Research Institute in Seattle, says there's a payoff when practices employ well-trained MAs and allow them to take on a range of duties. However, physician leaders might need to get comfortable with delegating tasks to MAs.

"Primary care is a team sport," Lozano says, because the sheer volume of data-gathering, care-planning and care-coordinating is too much for a physician to manage while also trying to care for patients. Although it seems obvious, Lozano says, the relationship between the physician and the MA must be built on mutual trust so the team can function effectively.

"The days are gone when care was a doctor-centric model, where the doctor does everything and makes all the decisions, while the other staff members around the doctor do the stuff at the margins," she says.

Lozano has conducted research demonstrating best practices in team-based care, and she recommends an approach that allows MAs to take ownership of care-management tasks. However, with many markets experiencing labor shortages, practices should also consider enhanced compensation packages for MAs—not just in terms of wages, but also training and career advancement opportunities—to recruit and retain the best assistants.

"Remember MAs are among the lowest paid health workers," Lozano says. "To the extent that we take work off the physicians and give it to the MAs, it's only fair that we reflect that in the compensation."
PRACTICAL MATTERS

5 ways to make prior auths less burdensome

According to the Medical Economics 90th Annual Physicians Report, the biggest complaint physicians have about prior authorizations is the sheer amount of time they take, for physicians and staff.

Brennan Cantrell, commercial health insurance strategist for the AAFP, offers five tips for making the process of prior authorizations a little bit easier.

Know your triggers
Cantrell suggests avoiding the problem if at all possible. Each practice will have some commonly used medications or procedures that are likely to trigger prior authorization requirements. “Be aware of what drugs and procedures you frequently use that are likely to require pre-authorizations and have options ready,” he says.

If a particular medication is causing problems, take a look at the formulary and see if there is an adequate substitute that will not require pre-authorization. “You might be able to use a generic drug or another alternative,” Cantrell says. Having a list of drug options at the ready may mean you can avoid the pre-authorizations process altogether.

Have a designated hitter
Smart use of staffing can help, too. “I’d recommend designating someone in the practice who understands the rules to take care of this,” Cantrell says. Because the processes and rules can vary from payer to payer, if the person dealing with prior authorizations is up to date on these, you won’t be reinventing the wheel each time you have to submit a prior authorization. This can save time as well as prevent mistakes. In a larger practice, you might even have a small team assigned to this.

Go electronic
Some practices keep pre-written templates on hand for commonly used drugs or procedures, and that can save a lot of time. However, electronic authorizations can save even more time.

Sadely, that is not always an option. “Often the portals [for submitting pre-authorization forms] are outside the EHR,” Cantrell says. “You have to log out and back in. The AAFP advocates that the pre-authorization process be in the workflow.”

Some insurance companies are working with EHR vendors to make that happen, but getting those changes made will take some time. However, your EHR may already be optimized for pre-authorizations. Make sure you are aware of your EHR’s functionality around pre-authorizations. If your system does have these features, get your staff trained to make the most efficient use of it.

Customize your EHR

Some EHR software can even alert you when a drug or procedure is likely to require a pre-authorization and suggest alternatives, Cantrell says. If possible, configure your system not only to send alerts but generate a report listing what information the payer will need and other details. Not having to track down what each payer requires will save your staff time when moving through the process.

Keep patients in the loop
Pre-authorizations are stressful for you, and they’re stressful for your patients, too. Patients waiting for medications or procedures may not understand what’s causing the delay. Keep your patients in the loop with a quick phone call or note via your patient portal. They will certainly appreciate your thoughtfulness and will be less likely to blame you for the delay.

Avery Hurt is a contributing author. Send your practice management questions to medec@mmhgroup.com
was at a conference recently, which always helps me reset professionally. One quote shared by a plenary speaker was from Patch Adams: “You treat a disease, you win, you lose. You treat a person, I guarantee you, you’ll win, no matter what the outcome.” As I saw patients in clinic today, I thought about things differently—what if I did treat Mary, Stuart, Lee, and Pamela rather than CHF, Diabetes, Asthma, and Depression?

One of my patients has an emotional sickness that manifests all over her body. She has experienced one blow after another and now finds herself racked with pain. Another patient has intolerable back pain because of her job. If she wants to alleviate the back pain, she needs to find another job, but this is not easy. One young patient who is essentially homeless and uninsured despite working full time needs a generic antibiotic but cannot afford the $12 co-pay. A patient with many chronic medical problems skipped an important diagnostic test because the co-pay was too high.

The treatment these patients need cannot be packaged in a pill form. True treatment of the person involves much more.

However, those are the moments that make me feel incapable and impotent. I can be a sympathetic ear, but I can’t solve these problems. The myriad complexities, inequity, and instability in our current healthcare system seem to be unsolvable. Homelessness, poverty, and broken relationships haunt my patients and are the true health concerns they face. Yet these are the problems I have few resources to address.

Caring, being empathic, and even being mindfully present can alleviate some of the suffering my patients experience. However, the human, rather than the distant professional, side of me wants to step into some of these spaces and help in a different way. I know that I can’t cover every co-pay a patient can’t afford, but I could’ve covered this one today. I’m not in the vocational rehab business, but I know of some job openings that may benefit my patient. That instinct to help has been trained out of me, and I recognize that this is for some good reasons. Saving everyone would surely crush me under the weight of unmet social and societal needs. Maintaining objectivity does allow a physician to make certain decisions that are necessary and hard.

So, I’m left wondering how to best treat my patients—how to balance the medical with the “other.” I may have found success with a lovely patient who is battling depression. At our last visit, he bowed under the weight of his life. I adjusted one medication, made some recommendations about his work environment, and encouraged time in nature. The medication change didn’t work—too many side effects. However, the changes to his work environment and spending time outside helped immensely. I need more treatment plans like this one.

Jennifer Frank, MD, is a family physician and physician leader in Northeastern Wisconsin.
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Money

How patient satisfaction scores are changing medicine

by JORDAN ROSENFELD Contributing author

Healthcare organizations have been using patient satisfaction scores since the late 1980s to improve care delivery and calculate physician and staff bonuses, among other purposes. Now, in the shift toward value-based care, such scoring is playing an even greater role in determining physician reimbursement and helping patients choose a physician.

But is it also changing the way physicians practice medicine?

Physicians, frustrated with feelings of powerlessness over how the scores are determined, fear that they give patients too much influence. Experts say the scores are here to stay, and offer suggestions for ways to approach them in the future.

"Physician reviews threaten the core values of medicine," says Dana Corriel, MD, an internist based in Pearl River,
N.Y. "Medicine is inherently built on the beauty of a patient-physician relationship. To add a review system into it almost makes it dirty."

Patient satisfaction scores may make patients feel better by providing an outlet for their frustrations, but a 2014 study in Patient Preference and Adherence shows they may promote job dissatisfaction, attrition and even inappropriate clinical care among some physicians. Not only are scores not necessarily accurate at identifying negligent or incompetent physicians, according to the American Journal of Medicine, they do not correlate with better patient outcomes.

However, since patient evaluations aren't going away, there are steps physicians can take to adapt to this reality.

PLEASING VS. CARING

Corriel fears that these scores cause physicians to prioritize pleasing patients over doing what they feel is medically correct. "We run into a problem, because healthcare isn't always about pleasing. It's about making decisions that are evidence-based," she says.

She feels that patient scoring can, essentially, be weaponized to manipulate doctors. She points out that, as many patients turn to the internet to research their medical issues, they also come in with preconceived notions of their problems, a particular prescription they think they should receive, or how they want to be treated.

"If you're a physician and you deviate from that, the worry is that it's not going to be acceptable and then the patient has the [score] to fall back on if the physician doesn't do what the patient wants," she says.

In a group practice where she formerly worked, a patient left a terrible review of the entire office and medical staff. "It turned out he hadn't even seen me, nor had he seen any of my partners. He had seen a primary care provider from the floor above," she recalls.

In her experience, patients also expect physicians to know everything, then react negatively when they don't. "I know a little bit about a lot of things—that's what an internist does," Corriel says. "If someone asks me a question that's very deep into the specifics about an organ system, I may not know it. That doesn't make me a bad doctor. Patients don't realize that we're not superhuman."

SCORING IS BIASED AGAINST WOMEN AND MINORITIES

Another problem, research finds, is that patients are more likely to give negative reviews to women and minorities, particularly African-American physicians.

Natasha Sriraman, MD, MPH, FAAP, associate professor of pediatrics at Eastern Virginia Medical School, in Norfolk, Va., says she has experienced such discrimination as an Indian woman, and has seen it among colleagues who are also minorities.

"I'm a woman and a minority. I'm basically [zero] for two," she says. "When I bring up [bias against minorities] in meetings, even with doctors and administrators, everyone is shocked."

She cites another example of a fellow woman doctor who is also Indian. "She saved a man's life and he told the male nurse, 'I don't want that woman taking care of me.'" Sriraman adds, "[Patient satisfaction scores] put a lot of power in patients' hands who may not deserve the power to trash somebody who's working really hard."

"We doctors have to use our voices. We need to make waves."

—NATASHA SRIRAMAN, MD, MPH, FAAP, ASSOCIATE PROFESSOR OF PEDIATRICS, EASTERN VIRGINIA MEDICAL SCHOOL, NORFOLK, VA.

GIVE PHYSICIANS A VOICE

Sriraman grew weary of feeling that she and other physicians had no say in how patient scoring decisions are made, especially when they're tied to bonuses and salaries. So she joined the board of her hospital and spoke to the CEO about what she sees as the unfairness of tying bonus and salary to reviews, over which physicians have little control.

"We doctors have to use our voices," Sriram says. "We need to make waves." She feels that the responsibility for patient satisfaction should fall more on the practice managers or the hospital CEOs.

She adds that physician autonomy is being stripped away, and having a voice is one way
Physician reimbursement is being increasingly impacted by patient satisfaction scores. Once, this was something only hospitals had to worry about, but now it’s affecting practices of all sizes.

Unfortunately, getting good scores is becoming harder. Patients are comparing their healthcare experience against the experiences they have in retail and the service sector. And, let’s face it, healthcare hasn’t been known for providing modern, super engaging, seamless experiences. Still, one study showed that about half of patients expect the same customer service experience in healthcare that they get in retail.

This trend shows it’s more important than ever to be able to track and monitor patient satisfaction and take steps to make improvements to meet the changing expectations of patients.

To effectively gauge what patients think and identify areas for improvement, here are four best practices to follow:

1. Keep it simple
You can’t do anything about a pre-set CAHPS survey, but you can control the length and complexity of a patient survey you send out. It shouldn’t take more than five minutes to complete and should focus on a single topic, like their recent visit or changes you’ve made like new technology or services. Don’t try to do it all in one survey.

2. Be timely
For a post-visit patient survey, send it out within 24 to 48 hours. The sooner the better. You want to do it while patients remember their experience.

3. Get hard data
Avoid creating open-ended survey questions. It’s appropriate to have a spot at the end for additional comments, but you want to be able to easily analyze the data. Use multiple choice and yes or no questions. For example, don’t use, “Tell us what you thought of the wait time.” Instead, ask, “Was the wait time reasonable, yes or no.”

4. Go digital
Create and send your surveys electronically. People prefer online surveys 30 times more than paper ones. Using a digital platform also allows you to automate the sending of surveys, personalize them to the patient, and easily see the results.

5. Problem areas to focus on
There are a few key areas patients focus on when it comes to satisfaction. These include:
- Poor experience with office staff
- Feeling more like a number than a person
- Difficulty scheduling (both wait times and availability of methods for scheduling)
- Poor communication with the office

6. What to ask in the survey
Take the opportunity to ask if:
- Staff were friendly,
- Patients found it easy to schedule an appointment,
- Patients received communications from the practice through their preferred method (i.e., text or email).

If scores are low for friendliness, then you know this is an area for improvement. If lots of patients say they’d like to get communication via text and you aren’t offering that, then you know that is something to change.

7. Make the changes
Take this simple feedback and make a list of areas to work on. Then you can begin to tackle improvements. Some tips for making that process more successful include:
- Group potential improvements into small changes and big changes. A small change might be something like temperature control and a big change might be staff service training.
- Tackle bigger changes one at a time. The little things like adding a coffee station to the waiting room can quickly be ticked off the list.
- Get as much buy-in on the big changes as possible. Share the feedback from patients and ask for input on how to improve. Get the staff involved and engaged.
- Be open to changes or upgrades in technology and processes to help address problems.

8. Follow up
Make sure that as you implement changes and settle into new ways of doing things that you follow up to see what patients think. Surveys should not be static. If you’ve made changes, then change your post-visit survey or send out a single survey specifically about those changes.

Following up shows patients you are committed to improving their experience and continues to engage them in the process. These types of ongoing interactions and engagement are a key way to build loyalty at a time when patients are more likely than ever to go elsewhere when they are dissatisfied.

Josh Weiner is the president and chief operating officer of Solutionreach.
to get it back, by sitting on a local hospital, regional, or a health insurance company board.

“We need to groom physicians to become leaders. Because you have people who have never been to medical school, never seen a patient die, have never had to tell a parent their child has cancer, making these decisions,” Sriraman says.

**EMPOWER FRONT DESK AND SERVICE STAFF**

Perhaps the most frustrating part of patient evaluations is that, “Patient complaints are rarely about physicians,” says Guillaume de Zwirik, CEO and Founder of Well Health, a healthcare software company in Santa Barbara, Calif. “About 96 percent of complaints are related to bad customer service. Insurance didn’t cover it and no one communicated it to the patient, or the wait time was long, for example,” he says.

He points out that most of a patient’s healthcare interactions are not even with the physician, but with the front office, the billing team, the care coordinator, the pharmacy and so on.

“Communication is the problem in the vast majority of complaints, and it’s hard for patients to be heard,” de Zwirik says.

He says the best way to handle these common complaints is to empower all non-physician staff members to handle patient concerns in the moment. He believes that giving the administrative and front desk staff the training and tools to do so will give them greater autonomy, which can improve patient satisfaction, as well.

He suggests a variety of ways to do this including through improved technology, compensation bonuses and small thank-yous, or even appreciation days. “These people are super important, and what makes the engine run. When they feel valued, they deliver better results.”

Sriraman also believes that patients often leave negative scores out of frustration and because they don’t know where else to take their complaints. She says that a lot of patient frustrations can be resolved at the practice management level. “Practice managers have to be our advocate and our ally. They should be the ones addressing negative reviews or scores with the patients,” she says.

**USE SCORES TO IMPROVE COMMUNICATION**

Regardless of these frustrations, patient scores, in some form or another, are likely here to stay.

“We should all be nice to our patients, listen to them, and treat them with respect,” Corriel says. “I think [patient satisfaction scoring] sets out to achieve that, and in that sense I do think there’s pros to it,” Corriel says.

Moreover, there is value in having satisfied patients, says Josh Johnson, Ed.D, PA-C, a physician assistant at Ali’i Health Center in Kailua Kona, Hawaii. "Based on journal studies, patients who are satisfied are more likely to follow through with their treatment plans and to recommend their provider. They’re more likely to go back to that provider to seek medical care in the future.”

Johnson says that taking the time to communicate to patients that physicians are open to resolving problems along the way may also help improve scores later. "It’s about being proactive and educating patients.”

He says physicians can also get in front of scoring by talking to a patient before a survey is sent home. For example, as a patient is discharged from the hospital, or at the end of a clinical encounter, ask, “Is there anything that we could have done better that would’ve improved your experience here?”

Johnson accepts that scoring isn’t going away. Instead, he tries to use it as a motivation to improve. "If I know my scores in one quarter, I ask myself: ‘How am I going to implement change?’ That’s what medicine is, right? It’s looking at something wrong and asking what I can do to improve it.”
Cyberattacks pose a clear and present danger to all healthcare stakeholders, including physician practices. These days, cyberthreats are so common that the question is no longer if an attack will occur, but when.

A 2018 cybersecurity survey by Black Book Market Research found that 90 percent of healthcare organizations have experienced a data breach since the third quarter of 2016, and nearly 50 percent reported more than five breaches. In 2017, a task force working under the U.S. Department of Health and Human Services deemed cybersecurity in healthcare to be in “critical condition,” a claim that was followed by many sizable breaches in 2018.

The outlook is indeed sobering and likely to leave the average resource-strapped physician’s practice feeling helpless. How do small- to mid-sized healthcare operations tackle this mammoth challenge when most physician practices lack IT departments and in-house cybersecurity experts?

Every practice environment faces different threats, so it’s important to understand your own unique situation and plan your approach accordingly. Outlined below are three key steps physician practices should take to gain a better understanding of their cybersecurity needs and determine their next steps.

1. **Recognize trends and challenges**

   Current reports suggest that ransomware and other cyberattacks are on the rise. Notably, ransomware attacks are expected to quadruple in healthcare by 2020. Meanwhile, Gartner, a leading industry research and advisory firm, expects the global cloud services market to grow by 17.3 percent in 2019, opening the door to new vulnerabilities and threats online.

   The industry is also witnessing growing threats related to advanced phishing and password spraying and stuffing—dangers that often get little attention. Phishing tricks users into giving away sensitive information by posing as a legitimate person, usually through an email that appears to be from someone they trust.

   Password spraying occurs when an attacker obtains a list of emails and usernames from an organization, usually through scripts that crawl Google and
LinkedIn, and then attempts to gain access to accounts through commonly used passwords. Password stuffing is even easier, since the hacker gains access to username and password pairs and then applies them to large numbers of accounts until they gain access to the network.

“CEO fraud” is also on the rise in healthcare. In these instances, criminals impersonate an executive as part of an email scam. Using similar writing styles and email signatures, the sender will request the recipient to perform a certain action. For example, a criminal posing as an HR executive may ask an employee to change payroll accounts or to wire certain transactions to different account numbers.

2 Conduct a vulnerability assessment
Many physician practices have not taken the critical step of conducting regular vulnerability assessments because they believe their organization is too small to attract an attacker. But not knowing your vulnerabilities can hurt you, since both large and small organizations are exploited continually.

A comprehensive assessment will simulate potential attacks and test infrastructures to identify weaknesses and risks. That gives practices a complete picture of their environment from an attacker’s perspective.

Quarterly vulnerability assessments are recommended not only to test for new risks, but to ensure that previous weaknesses were fully addressed. When deployed properly, these analyses should provide practices with information on which devices and applications are vulnerable along with possible risks.

It’s important that all key stakeholders come away from these assessments with a full understanding of each vulnerability, its perceived risk level and its potential solution.

In addition to vulnerability assessments, a penetration test should be conducted annually. This technique produces a more in-depth examination of security controls by employing a cybersecurity professional to conduct a “test hack” by attempting to find ways to breach an organization’s network.

3 RemEDIATE your vulnerabilities wisely
Once a practice’s weaknesses are identified, the next step is remediation. Far too often, healthcare organizations make less-than-optimal choices because they react out of fear or they choose the most affordable solution as a band-aid approach.

That response is understandable on one level. Most small- to mid-sized physician practices are not in a position to purchase an expensive and comprehensive cybersecurity platform to address every angle of the security landscape.

A better approach begins with understanding that there is no cookie-cutter solution to cybersecurity. More than ever, healthcare executives, owners and administrators need customized strategies that provide practice-specific tools and filter out unnecessary elements that can keep physician practices from addressing their own unique security situations.

The right partner can help you identify where to start by focusing on priority areas that represent the most bang for your cybersecurity buck. Perhaps the first goal is optimizing firewall management.

Alternatively, the greatest need could be to strengthen the security of appliances and devices such as phone systems, Wi-Fi, email gateways or network access control. Expert guidance is critical to defining and developing a practice’s cybersecurity strategies at the right time and with the right tools to minimize the potential for breaches and ensure the most cost-effective solution.

Physician practices face unprecedented demands on their time and resources. While current trends demand that organizations prioritize cybersecurity, it’s important to remember that the best approach does not generally take a linear path.

Sean Nobles is president of NaviSec, an IT security firm. He holds OSCP, NSE4 and CCNP certifications in network security and has spent more than 20 years in the service provider, military, financial services, value added reseller and call center industries.
TECH TALK

Telehealth reimbursement trends: What doctors need to know

There are a few developments that will fuel the use of telemedicine technology in helping more patients receive care easily and quickly. But in order to effectively move past reimbursement fears and confusion, physicians will need to acquaint themselves with Medicare’s coverage changes. Knowing what’s covered and what isn’t can help physicians and the organizations they work for find the best ways to incorporate telehealth into their daily workflows.

Changes to Medicare Advantage (MA)

For providers, the changes to MA offer an opportunity to appeal to new patients who are approaching enrollment in MA plans by emphasizing the convenience of accessing high-quality care from any location—whether it’s their home, the physician’s office or another originating site.

Previously, MA plans tended to only offer telehealth services as a supplemental benefit. With the Final Rule, MA plans will offer additional telehealth benefits as part of patients’ regular coverage, which opens the door for providers to offer more telehealth services without fear of going broke.

As private payers nearly always follow Medicare’s lead, it’s likely physician practices will have to worry less about whether they’ll be reimbursed for telehealth consultations with private-pay patients.

Medicare Physician Fee Schedule’s Virtual Check-in Code

Changes to the 2019 Medicare Physician Fee Schedule offer providers an opportunity to provide better care to patients through the use of telehealth. Specifically, CMS will now pay separately for two newly-defined physicians’ services furnished using communication technology:

- Brief communication through a technology-based service (HCPCS code G2012); and
- remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010).

These changes expand on CMS’s existing Chronic Care Management (CCM) benefit, which reimburses physicians for non-face-to-face visits with patients who have two or more chronic conditions.

And the timeliness of this new provision is ideal: Chronic disease expenditures account for 90 percent of the U.S. health system’s costs, according to the Centers for Disease Control and Prevention (CDC). With 52 percent of Medicare beneficiaries willing to use telehealth, according to a 2019 senior consumer survey from American Well, offering virtual check-ins can help a practice differentiate itself by offering immediate access to expert advice. When patients can avoid unnecessary visits to doctor offices, urgent care or the emergency department, everyone wins.

However, it’s important to note that the virtual check-in benefit has a few restrictions in its initial form: Check-ins are meant to be for current patients concerning chronic care issues and for overall health management/wellness. They can be provided only to established patients who have seen the provider they are checking in with at least once in the preceding three years. Additionally, virtual check-ins may not be related to a service provided within the past seven days, nor may they lead to a service or procedure within the next 24 hours or during the soonest available appointment.

Physicians already using a telehealth platform should make sure their vendor’s most current software update enables easy code mapping and documentation of the virtual experience within the EHR.
Asthma not only impairs the breathing and quality of life of more than 25 million people who live with it, it poses an immense financial burden to the U.S. healthcare system. The Centers for Disease Control and Prevention (CDC) estimate asthma’s costs in the U.S. at over $80 billion per year.

While physicians often struggle to keep their asthmatic patients in good health, experts say that new treatment approaches and medications may be able to reduce these costs and improve quality of life for asthma patients.

“This is a very exciting time for asthma management and treatment,” says Fernando Holguin, MD, MPH, director of the asthma program at University of Col-

Best practices in managing asthma patients

by JORDAN ROSENFELD Contributing author
Managing asthma

Chronic Conditions

oroado’s pulmonary sciences and critical care division.

Holguin is particularly enthusiastic about the field’s move toward personalized and precision medicine, where each patient’s individual needs can be assessed and treated.

For example, even a few years ago, most asthmatics were treated mainly with corticosteroids and bronchodilators, he says. Now, for those patients with especially severe symptoms—and for whom the usual drugs fail—doctors can use blood work and skin testing to determine the patient’s phenotype and allergic profile. Those whose asthma is affiliated with high eosinophils, an allergic cell, may qualify for biologic drugs.

In addition to the biologics, those with severe, hard-to-treat asthma may benefit from the macrolides family of antibiotics, which includes azithromycin. These drugs can act as a powerful anti-inflammatory in the airways for people with severe asthma. “Studies have shown that using azithromycin two times weekly can reduce the rate of exacerbations by as much as 25 to 30 percent,” Holguin says.

While these won’t work for everyone, they can offer relief for people who struggle with severe illness.

Another technique for severe asthma is called bronchial thermoplasty, where a small catheter in the airway emits radiofrequency heat into the smooth muscle, according to Laran Tan, MD, FACCP, the director of Loma Linda University Health’s Comprehensive Program for Obstructive Airway Disease in Loma Linda, Calif.

The radiofrequency heat treats asthma’s chronic inflammation by reducing the airway smooth muscle so it doesn’t constrict so tightly, Tan says. Studies find the treatment may reduce exacerbations for up to five years after treatment.

“Anxiety and depression exacerbate asthma and asthma exacerbates anxiety and depression. So you have to manage all the co-morbidities.”

— FERNANDO HOLGUIN, MD, MPH, DIRECTOR OF THE ASTHMA PROGRAM, UNIVERSITY OF COLORADO’S PULMONARY SCIENCES AND CRITICAL CARE DIVISION

While new treatments are promising, before trying any remedy physicians should determine if patients really have asthma, says Holguin. “Roughly 30 percent of people that are labeled as having asthma by their providers do not have the disease.”

The confusion often results from the fact that asthma is not just one disease, says Alex McDonald, MD, CAQSM, a family physician with Kaiser Permanente in Fontana, Calif. It’s a set of diseases characterized by chronic inflammation in the airways that creates obstruction, as well as coughing, wheezing, and shortness of breath, he explains. It’s easy to misdiagnose asthma when a patient has just been exposed to an environmental allergen, or is having trouble getting over a respiratory virus.

In order to diagnose asthma, physicians should do a pulmonary function test, using a spirometer, McDonald says. The machine measures the amount of air the patient can exhale over several rounds. Then the patient takes a dose of a bronchodilator to determine if that improves airflow.

But that may not be enough, says Tan, since “asthma tends to be related to allergies and the environment.” Phenotyping through blood work and skin testing can allow physicians to target medications tailored to patients with more severe forms of the disease, he says.

“We’ve realized that a lot of patients with severe allergies have elevated IgE [immunoglobulin E]. Now we have biologic therapies that can specifically target the inflammatory response in these patients’ blood,” Tan says.

Phenotyping typically breaks down asthma into three primary categories, McDonald says:

- Mild, intermittent, which is the easiest to treat, most commonly with a "rescue" bronchodilator inhaler
Managing asthma

**Chronic Conditions**

- Mild, persistent, which requires a controller medication of some kind in addition to a rescue inhaler
- Moderate to severe, persistent asthma, which may require corticosteroids, long acting beta agonists and potentially more complex treatments such as biologics, macrolides antibiotics or bronchial thermoplasty.

However, treatments may not be effective if physicians haven’t helped the patient determine the root allergens causing their exacerbations, McDonald says.

Many patients aren’t aware of the environmental triggers causing their attacks, Tan says, such as cutting the grass, or snuggling with their cats and dogs.

He says that often when taking histories he learns that a patient has lived with asthma their entire life and accepted the impairments that come with it as normal.

It’s the job of physicians to help these patients understand that an impaired life isn’t normal or necessary, Tan says.

“Then we have to try to show them how that better life could be obtained through regularly using inhalers, avoiding specific allergens, etc.”

Additionally, about one third of asthma patients are known as poor perceivers, says Kathleen Dass, MD, FACP, a member of the American Academy of Allergies, Asthma and Immunology. “That means they feel good until they really don’t feel good, so basically they end up in the hospital or just drop dead.”

She stresses to primary care physicians that most of these exacerbations are preventable with the right diagnosis and treatment plan.

**WAYS TO ENCOURAGE ADHERENCE**

Even after diagnosis, it can be challenging for physicians to get patient adherence in order to reduce the severity of illness and encourage (or promote) use of healthcare services. Experts agree that developing a strong relationship

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**Asthma ICD-10 Codes**

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<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.21</td>
<td>Mild intermittent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.22</td>
<td>Mild intermittent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.30</td>
<td>Mild persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.31</td>
<td>Mild persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.32</td>
<td>Mild persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.40</td>
<td>Moderate persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.41</td>
<td>Moderate persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.42</td>
<td>Moderate persistent asthma with status asthmaticus</td>
</tr>
<tr>
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</tr>
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<td>J45.51</td>
<td>Severe persistent asthma with (acute) exacerbation</td>
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<td>J45.52</td>
<td>Severe persistent asthma with status asthmaticus</td>
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<td>J45.901</td>
<td>Unspecified asthma with (acute) exacerbation</td>
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<td>J45.902</td>
<td>Unspecified asthma with status asthmaticus</td>
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<td>J45.909</td>
<td>Unspecified asthma, uncomplicated</td>
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<td>J45.990</td>
<td>Exercise induced bronchospasm</td>
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<td>J45.991</td>
<td>Cough variant asthma</td>
</tr>
<tr>
<td>J45.998</td>
<td>Other asthma</td>
</tr>
</tbody>
</table>
Managing asthma

Chronic Conditions

with patients and being proactive in asking questions can help to achieve both aims.

McDonald takes a lack of patient adherence as a sign that something is wrong and he needs to find out what. “I hate the term noncompliant. That’s medical jargon. I always ask, ‘what’s happening?’”

He says reasons can range from a patient being unable to afford their medicine, to a bad reaction to a medication, to the patient’s pharmacy not stocking the right medication. Sometimes they’ve simply never been asked why they struggle to take their medications, he says.

For issues related to cost, McDonald points patients to a program called Good RX, which helps them find lower-cost medications.

“I hate the term noncompliant. That’s medical jargon. I always ask, ‘what’s happening?’”
— ALEX MCDONALD, MD, CAQSM, FAMILY PHYSICIAN, KAISER PERMANENTE, FONTANA, CA

Dass, who sees a lot of low-income patients, always asks patients if they can afford a medication at the time she is ready to prescribe. She then makes it clear that she will offer them resources if they cannot. She also encourages patients to put their inhalers beside their toothbrushes, as that makes it more likely they’ll use them both morning and night.

Holguin accepts that patients will not always going be able to make dramatic changes to their work or home environments, where they are often exposed to allergens, so he focuses on positive gains to encourage them toward healthy behaviors.

Rather than chiding a patient for smoking, for example, he’s more likely to guide them toward steps they can take to feel better.

He uses the metaphor of treating a wound with a Band-Aid versus antibiotics to help them understand the severity of their disease. “When you put a Band-Aid on a cut, it looks better, but if it gets infected and festers, and you keep slapping a Band-Aid on it, it doesn’t actually fix the problem,” he says.

Holguin finds that patients can relate to that analogy, and he bolsters it with printed information they can read at home to better understand their disease.

The more physicians learn about their patients’ barriers to treatment, the more likely they are to find a treatment that works, Tan says. He uses the example of a single mother who’s going back to school.

“She can’t come in every month to get her injections, maybe she can’t find a ride or doesn’t have childcare. For her, maybe home therapy of bronchial thermoplasty is better than injections. These kinds of discussions need to be had with the patients, rather than just looking at their labs,” he says.

THE MENTAL HEALTH CONNECTION

Along with the physical symptoms of asthma, Holguin says, physicians should be aware of asthma’s impact on mental health. “Anxiety and depression exacerbate asthma and asthma exacerbates anxiety and depression. So you have to manage all the co-morbidities.”

This means developing and maintaining a strong referral network with mental health providers. If providers don’t already have such referrals, they can direct patients to resources such as the National Alliance on Mental Illness; the National Institute of Mental Health; ask patients to contact their insurer for a list of providers, or recommend they see a mental health professional with whom they already have a relationship.

Holguin keeps an open line of communication with his patients. Many of them have his cell phone number and email address and he checks in with them frequently. “Having patients contact me is not a burden. I’d rather have a conversation with someone about what’s going on than them rushing to the emergency room,” he says.

McDonald says that diagnosing and treating a patient is just the beginning of the physician’s job. “Now we start to educate our patients and reinforce that we have to live a healthy lifestyle in order to continue that momentum of good lung health.”

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Physician burnout is a problem that has many causes—excessive documentation and technology headaches chief among them—but a recent Medical Economics physician survey included a less-scrutinized source: Patient needs that sometimes overwhelm their doctors.

Through my own experiences and conversations with colleagues, I’ve come to believe that one of the chief reasons primary care physicians feel overwhelmed by patient needs is that too many still practice under the fee-for-service model. As both a workflow and financial model, it simply does not support the effort required to manage complex cases nor is it conducive to strengthening the physician-patient relationship.

That the U.S. health system is finally realizing its long-overdue opportunity to overcome the limits of fee-for-service is one of the most encouraging trends in medicine today. To replace this outmoded model that has failed too many physicians, more practices are transitioning to value-based contracting arrangements in which providers are rewarded for quality over volume.

However, the challenge that many primary care providers face in shifting to value-based care is that their practices are often not equipped with the tools needed to succeed under value-based models. It is a preventive, multidisciplinary approach to care that places a premium on care coordination. In turn, this requires technology that stratifies and prioritizes care opportunities for at-risk populations and helps providers maximize incentives tied to performance-based contracts.

NEW PRACTICE MODELS FOR PRIMARY CARE

The lack of necessary tools may be changing, though, in part due to the new federal program called CMS Primary Cares. The program offers five financial models, including one based on risk-adjusted per-member, per-month payment. This arrangement in particular will deliver greater financial certainty to practices, providing the funds to invest more heavily in tools that support the delivery of advanced primary care.

Importantly, upfront payments for each patient is a significant and predictable
revenue source. By investing a portion of these upfront payments in new tools to help their practices manage populations based on risk and urgent needs, primary care providers can set themselves on a path to success in the shift to value-based care.

It should be understood that transitioning to value-based care won’t be an easy shift. To achieve true transformation, practices will require not only new financial models, but new technology, new workflows, additional staff training and lots of support.

VALUE-BASED CARE GAINING TRACTION IN ARIZONA

As chief medical officer at Phoenix-based integrated delivery system Equality Health, I am part of a team that provides tools to our primary care provider network to aid the delivery of proactive, value-based care. The provider practices in our network receive specialized training that assists them in assessing patients for behavioral, social and cultural risk factors that could hinder even the most carefully designed care-coordination plans.

As a result of our health system’s significant Latino patient population, for example, our curriculum for providers emphasizes the incorporation of values and cultural beliefs that have significant meaning to this population.

We also know firsthand that our providers need real-time visibility of at-risk patients. We’ve developed a proprietary care coordination response that delivers this insight at micro and population-sized levels. At the micro-level, for example, physicians can identify care gaps for individual patients, while also having access to macro-level information such as our overall population health management performance for various conditions.

These insights are fueled by a diverse and consolidated set of data sources in our care coordination platform. It is this aggregated and structured set of data that provide a comprehensive view of patient health that expedites risk stratification, enabling physicians and staff to assemble and review lists of patients—by condition or gap—who are due to obtain specific services. To improve outcomes, it is critical to track at-risk patients and coordinate their care among all key stakeholders.

It is also crucial for primary care providers to receive real-time alerts for important care events such as admission, discharge and transfer. These alerts inform prompt follow-up, which is key to reducing readmissions. As such, this is a feature we embedded early on in our care coordination platform.

Our frontline position helps us see with our own eyes how unified collaboration and a full picture of patient health are integral to value-based care. Primary care providers see it, too, and collectively are using the platform to deliver risk-based care within five Medicaid health plans in the state. Thousands more clinical sites across the country have also deployed the platform.

It’s critical that all primary care practices have this kind of support, and the new Primary Cares reimbursement model can help them pay for it.

Of course, reimbursement reform won’t solve every problem in healthcare. But payment reform is a move in the right direction. By transitioning to new financial models that reward value and quality of care as opposed to volume, primary care practices can escape the fee-for-service hamster wheel and practice medicine in a way that prioritizes the doctor-patient relationship.

Mark Stephan, MD, is a physician leader who practiced family medicine for 19 years. He is currently chief medical officer at Equality Health, a Phoenix-based integrated delivery system that delivers care through a social-cultural lens.

“I’ve come to believe that one of the chief reasons primary care physicians feel overwhelmed by patient needs is that too many still practice under the fee-for-service model.”
his month, I celebrate the 10-year anniversary of opening my own practice. Wow. Ten years. It hardly seems like it could be true.

Much as I prepared for the transition from being an employed physician to a practice owner, not everything went as planned, and I learned a lot along the way. I frequently wrote about the trials and tribulations of starting my own practice, so I wanted to write about what I’ve learned over the last decade—and what has changed.

Let me start by telling you what things did, and did not, go according to my business plans. I wrote out a well-thought-out 5-year plan. I computed start-up costs—everything from computers and exam tables to paper towels and hand soap. Seeing this document again for the first time in years, I can’t believe I actually created this.

A glaring difference in my plan versus what happened in reality is my current solo practice situation. The plan had been to start solo, add a nurse practitioner (NP) midway through the first year, then add a second physician and NP in year two. In reality, I was solo until I hired a second physician in year two, then we briefly had a NP. We never did hire another one, and the other physician left last year, so I am back to solo practice.

“I It is still my intent to provide quality care and a friendly work environment while trying to remain financially successful.”

I had been spending less on payroll than planned, though I did not take into account making contributions to employees’ retirement accounts. Given the busy nature of our practice, I am not spending on marketing. Since I use call forwarding after-hours, I do not pay an answering service. Medical waste disposal costs less than anticipated. And because of my busy schedule, I generally don’t travel for medical education.

I am, however, paying more than anticipated for telephone, internet and network support. Malpractice insurance costs a lot less for endocrinology than I thought, but other kinds of insurance all cost more.

One of my objectives was to have an average of 450-500 patient visits per month within the first six months of operation and more than 700 patients by the beginning of the second year. I just looked at March 2010’s schedule, and I was seeing maybe half my target. That was a result of having a schedule that was mainly new patients. Now that I see only follow-up patients, I am seeing about 400-450 patients a month.

In a future column I’ll talk about what changed over the years. One thing that hasn’t is the mission statement I wrote in 2009. It reads:

“The Mission is to provide comprehensive diabetes and endocrine healthcare to our patients that meets or exceeds national standards. (The practice) is committed to providing services that result in high patient satisfaction, a professionally fulfilled staff and a consequently successful and profitable business.”

Not everything has gone according to plan, but the practice has been successful, and I’ve learned that success comes in many forms.

Melissa Young, MD, FACE, FACP, is owner of Mid Atlantic Diabetes and Endocrinology Associates, LLC.
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“Well, I’m afraid the outlook is dire, Mr. Simmons. Not for you — I’m just looking at my portfolio performance this quarter.”

Why private equity is coming for healthcare

When it comes to buying medical practices, hospitals and health systems aren’t the only ones writing checks. In recent years, the number of private equity firms looking to purchase practices has continued to increase. In light of these developments, practices need to understand private equity, both as a possible source of expansion capital and as a potential owner of the local competition.