PRIVATE EQUITY IS COMING

- Why investors target medical practices
- The pros and cons of taking an offer

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Build an efficient vaccine program

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Best practices in treating migraines

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Here’s a scenario: Representatives of a private equity firm come knocking on your door, looking to buy your practice. What do you do?

Physicians are no strangers to such purchase offers. For years, hospitals and larger health systems have been buying independent practices. But private equity is a relatively new player on this stage, and when they ask you to sign on the dotted line, the potential benefits and risks are a bit different. For this issue’s cover story, we interviewed experts about what private equity’s move into healthcare means, and what questions physicians should ask before agreeing to a deal.

There’s also some news to cover: For the first time in decades, the federal government has proposed loosening the physician self-referral law, known as the Stark Law, and the Anti-Kickback Statute. Two healthcare attorneys sort out what might be changing, and what it means to physicians.

It’s also flu season, and many experts are predicting it could be a difficult one for patients. That means physicians need to have their vaccine program humming efficiently, and we have a feature exploring how physicians can make sure their practices can manage their program effectively—and increase revenue in the process.

There’s other great content in the pages of this issue of Medical Economics, including coding guidance from the experts, three tips to improve cybersecurity, and strategies for physicians to help patients with chronic migraines manage their symptoms.

And—saving the best for last—Medical Economics is proud to unveil the First Place winning essay from the 2019 Physician Writing Contest. We received more than 300 entries on the topic of “How I became a better doctor,” and we found the essays to be smart, insightful, emotional and inspiring. After presenting our winner, we’ll be unveiling the runners-up before the end of the year. I hope you enjoy them, and they help you to remember why you became a physician in the first place.

Mike Hennessy, Sr.
Chairman and Founder
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Patients want easy billing

A new survey of patients finds they want physicians to adopt billing practices that are both modern and transparent—and they will change providers to find the experience they are looking for.

The 2019 Healthcare Consumer Study was commissioned by Cedar and conducted by independent research firm Surveyata between August 27 and September 1. It includes information from 1,607 online respondents over the age of 18 who paid a medical bill in the last 12 months.

Of those patients surveyed, 49 percent said they were frustrated with their physician’s hesitation in adopting digital administrative processes like online bill paying or access to insurance information, and one in three say physicians have not done enough to improve billing and payment processes.

More than one-third of the patient respondents (34 percent) have had a healthcare bill go to collections in the past year. The top three reported reasons were:

- inability to pay full amount (60 percent)
- confusion about bill amount (43 percent), and
- outdated billing and notification processes (26 percent).

The majority of those frustrated with their physician’s lack of digital patient administrative practices (66 percent) were between the ages of 18 and 24, while 29 percent were older than 65. One in five patients said they have dropped a physician due to poor digital experience and 41 percent said they’d consider switching to a doctor who offered a better experience.

To read more, visit MedicalEconomics.com/news
PRIVATE EQUITY IS COMING

What it is, what these firms want and why your practice might be a target

by TODD SHRYOCK
Managing Editor
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.

There were $15 billion in deals in 2017, $22.3 billion in 2018 and there is well over $60 billion so far this year, according to the Medical Group Management Association (MGMA). “I don’t see it slowing down,” says Halee Fischer-Wright, MD, president and CEO of MGMA. “Last year, there were 200 private equity deals closed, and as we entered October, we are looking at about 250 to 300 deals this year.”

The first wave of private equity investment hit specialties like orthopedics, dermatology, urology and gastroenterology, where potential profits were highest, but the firms are now expanding their targets. “I do see private equity drifting into primary care practices,” says Fischer-Wright. “They aren’t necessarily looking at buying small ones, but networks so they can control a region and have groups large enough to compete for contracts or drive rates.”

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.

HOW PRIVATE EQUITY WORKS
Private equity firms work by pooling money from investors that they use to buy businesses, create value beyond the purchase price, then sell off the combined portfolio company and return the profits to the investors, says William Spratt Jr., JD, partner, healthcare, for the law firm of Akerman LLP in Miami.

Often, the strategy in healthcare is to either combine multiple practices of the same type to dominate a market, or create a large multispecialty practice.

“ar many are looking to acquire primary care practices, because they are recognizing that’s where all care starts,” says Spratt, who adds that the shift to value-based care is a major driver in this. “They recognize that primary care practices that have assumed risk-based contracts with third-party payers are attractive targets.”

Spratt explains that if a private equity firm can aggregate, say, 10 primary care clinics in a market, and each has full risk contracts and is good at managing its patient population, that puts the combined company in a good position to negotiate more favorable rates with payers.

The larger patient population also spreads the private equity firm’s risk, because the more patients under their control, the less likely one or two catastrophic cases will affect their quality ratings.

“What a lot of private equity firms like to do is find a ‘platform’ practice—one that has demonstrated the ability to be successful in the market and in its specialty,” says Richard Zall, JD, chair of law firm Proskauer Rose’s healthcare group.

This practice will usually have around a dozen physicians and two to four sites, with at least $5 million to $10 million in earnings before interest, taxes, depreciation and amortization (EBITDA). The firm then adds services to the platform practice or combines it with other practices.

Target platform practices are mostly identified by the equity firms’ business development people. Zall says they attend physician conferences and talk to people in the market to learn who the high-quality practices are and what payers think of them.

Private equity is not a long-term owner in the practice. Physicians with an ownership stake in the acquired practice get an initial buyout plus some equity in the new private-equity controlled company, but investors are looking to get their money back usually in three to five years, says Fischer-Wright. “What we’ve seen is private equity is looking to get three to five times return on investment over that time,” she says.

THE PROS AND CONS OF SELLING TO PRIVATE EQUITY FIRMS
An offer from a private equity firm can be appealing to a primary care practice that wants to grow or is struggling to find the capital for the investments needed to succeed in value-based care.

But for the deal to be successful, experts say, physicians must understand the goals...
Orthopedic practices were some of the early targets of both private equity firms and hospitals looking to expand their reach. Nicholas Grosso, MD, an orthopedic surgeon and president of The Centers for Advanced Orthopaedics in Bethesda, Md., didn’t want to give up private practice because he believed that it was the best way to deliver quality care, but knew something had to change to survive.

“We had to get bigger for a lot of reasons,” says Grosso. “Reimbursement rates were falling, we had no negotiating power and costs were going up. That’s why a lot of practices were being sold.”

He began to search for a business model that would help his practice survive a rapidly consolidating healthcare market and found one that would allow participating practices a high level of autonomy. It also provided the support and negotiating leverage they needed to survive.

Practices in the group function under the same tax ID number, and what started as 24 practices is now up to 160, with each practice allowed a great deal of autonomy. The advantage lies in leveraging the scale of the group to negotiate better reimbursements and vendor prices.

“We have also been able to save a lot of money on malpractice insurance, and we’ve gone self-insured for our own health insurance,” says Grosso. “With our volume, we’ve also done well with purchasing basic stuff, like exam paper and supplies.”

As the group has grown, its members have opted to consolidate to one EHR. Corporate employees have been added for compliance, data analysis, human resources and a comptroller, as finances allow, taking these burdens off individual practices.

Physicians pay dues based on their investment level and each owner gets one vote with their ownership share. Grosso says keeping their autonomy and financial control of their practices has been attractive to members. “When you sell to private equity, eventually the private equity firm is in charge,” he says. “Most private equity firms want to name a CEO or negotiate the rights so they are calling the shots. We didn’t want to avoid being owned by a hospital only to end up owned by Wall Street,” Grosso adds.

Grosso says physicians need to research the private equity firm interested in their practice and make sure they understand what they are giving up for the money. “Most sound good up front, but you are giving away a portion of your income going forward,” he says. “The income recovery has rarely materialized the way they said it would.”

He says creating a larger group may not work for everyone, but says it’s one way to avoid losing control of your practice. “There are different people out there with different models, but it has to be good for everyone,” he says. “It has to be a win for everyone. No one is joining to take a big cut in salary and to give up complete control.”
of the private equity firm and be comfortable with its leadership team, because the practice will go through many changes.

“When you sell to a private equity firm, you may have a physician or two that sits on the board of the new corporate entity, but it won’t be the physicians driving the major decisions,” says Fischer-Wright. “What the selling physicians often don’t think about is that if the private equity firm is successful and the practice gets sold to a second firm after five years, the physicians won’t have any say in the new company.”

Spratt says most firms will pay 75 percent of the practice’s valuation at closing with physician owners receiving 25 percent in equity in the new holding company that is created. Physicians typically receive the same deal as the private equity firm for their 25 percent when the investors cash out by selling the holding company.

As minority owners, however, they will have little to no say in how the new deal is structured or to whom the practice is sold. Some buyers are health systems and hospitals, so physicians trying to stay independent by selling to private equity may end up being owned by the very entities they were trying to avoid in the first place, experts say.

There may also be a compensation cut for the physician-owners selling the practice. The private equity firm typically compares the median compensation for physicians in that region with what the physicians in the targeted practice are making.

“Traditionally, what happens is physician compensation decreases 30 percent,” says Fischer-Wright. She adds that doctors need to study the numbers to make sure the deal works for them in the long term. “The decrease in compensation may actually wipe out the value of the seven-figure check from private equity over their career.”

If the right private equity partner can be found and physician owners understand the details, it does provide an option for sustainable growth. “To compete in healthcare in 2020, you need that investment in the EHR, the technology platform and more business management,” says Fischer-Wright. “I have yet to meet a physician who wants to spend more time on the business aspect of medicine. For more proactive practices, this is a funding source to become a sustainable practice.”

In most cases, the private equity firm focuses on the business side of medicine and leaves the clinical decisions to the doctors. “For the best private equity firms, they understand that from a clinical perspective, they aren’t professional clinicians,” says Zall. “They are looking for partners on the clinical side that deliver high quality. They know that providing better patient care and delivering higher quality service will make them more successful and more likely to grow.”

“I do see private equity drifting into primary care practices. They aren’t necessarily looking at buying small ones, but networks so they can control a region and have groups large enough to compete for contracts or drive rates.”

— HALEE FISCHER-WRIGHT, MD, PRESIDENT AND CEO, MGMA

Instead, the equity firm usually focuses on streamlining administrative tasks, using economies of scale for purchasing, improving billing practices, bringing in new vendors and providing experienced executive leadership.

“There are different models—some are more interested in physician leadership and directed growth while others might be just interested in taking over the platform and have the physicians be employees,” says Zall. “There is not just one size of private equity firm out there.”

Understanding the culture of the private equity firm and how it operates are crucial to the deal succeeding for everyone in the long term, experts say. “Smaller practices don’t think about culture as a major driver of success,” says Fischer-Wright. “Where we’ve seen success, the cultures are complementary. It’s like dating: you really have to get to know your partner.”
Private equity

Zall advises looking at their track record with similar practices to see if they understand the specialty and the geographic region, and what kind of return on investment they achieved with past deals. The objective measures are important, but so is the interpersonal dynamic.

“Are these people you want to be meeting with early in the morning or late at night and making important decisions with?” says Zall. “Most successful deals have good chemistry. It works more often than you might think it would.”

“The need to derive a large financial return on investment that private equity firms might face when acquiring medical practices could create pressure to change practice patterns. . . . It could change the way patients are diagnosed or treated if those decisions are influenced by the need to generate a financial return.”

— ZIRUI SONG, MD, PHD, ASSISTANT PROFESSOR OF HEALTHCARE POLICY, HARVARD MEDICAL SCHOOL

DOES PRIVATE EQUITY INVESTMENT AFFECT CARE QUALITY?

As the number of private equity deals for medical practices increases, some questions have been raised about its potential effect on the quality and delivery of care. Zirui Song, MD, Ph.D., assistant professor of healthcare policy at Harvard Medical School, says that not enough studies have been done to know for sure, but the fears from doctors about private equity’s influence are logical.

“The need to derive a large financial return on investment that private equity firms might face when acquiring medical practices could create pressure to change practice patterns,” says Song. “It could mean increased utilization of certain services, it could change the way patients are diagnosed or treated if those decisions are influenced by the need to generate a financial return.”

Song says he’s heard reports of physicians being concerned about utilization goals or to push certain products. There may be incentives for doctors to use certain services that are costlier or to refer to providers or labs that are also owned by the private equity firm. But he says there is no evidence of this beyond anecdotal accounts, because no studies have been done on the issue.

In some cases, just combining practices can lead to higher insurance premiums for patients, as private equity firms use their leverage to negotiate better rates with payers, and if insurers pass along the price increase. However, physicians may benefit through increased profits, Zall says.

“I think most of the successful private equity firms realize that to be successful, they have to deliver a better product,” he says. “It has to be more accessible, quality at least as good or better than what is in the market, and pricing has to be competitive because consumers are paying more of the bill.

“Some firms may want to do a land grab and do a quick flip, but the better ones realize that if all they are doing is earning money through increased pricing, they will not be successful,” he says.

Song says patients could benefit as well. “We know there is a lot of evidence that the U.S. healthcare system has a substantial amount of low-value care or wasteful care that is delivered,” he says. “To the extent that private equity can help provider practices be more efficient, cut down on unnecessary costs of production, that will help them be more lean in the delivery of healthcare services.”

In the end, physicians have to decide whether the tradeoffs, including some loss of autonomy and compensation to the private equity firm is worth it to them and their patients.

“We should not forget that delivery of healthcare is about the health of the patient and welfare of the patient population,” says Song. “The considerations of private equity ought to take into account the impact on patient well-being.”
Doctors often have opportunities to gain nonpublic, insider knowledge about new drugs, devices, and other healthcare innovations being developed by publicly-traded companies. A doctor may acquire such information by sitting on a firm’s board of directors, serving as an expert consultant, or helping to run clinical trials whose outcomes can affect the value of a company’s stock.

Insider trading occurs when an individual possessing such information makes investment decisions based on it, explains Michael S. Sinha, MD, JD, a research fellow in therapeutic science at the Harvard-MIT Center for Regulatory Science at Harvard Medical School. It’s important to know how to avoid it.

The authors note that temporary insiders are subject to the same rules as company management and full-time employees.

There are two basic traps that people fall into with insider trading, explains Steven W. Schuster, JD, a partner at McLaughlin & Stearn, a New York-based law firm.

The first trap consists of an officer, director, or employee of a company taking advantage of knowledge they have obtained through their position with that company. For example, a physician might observe that a new drug they have been given to test is either a success or failure. These results amount to material inside information and trading on it would be illegal, says Schuster. Or a doctor might know that a certain drug or device is about to be approved or disapproved by the FDA. These kinds of situations are what people traditionally think of as insider trading, Schuster explains.

The second trap involves a person with inside information tipping off somebody else who then trades in the shares, says Schuster. In some cases, the person receiving inside information will share their monetary gains with the person providing the tip. However, such sharing of the illegal profits does not have to occur for insider trading to occur, says Schuster.

Insider trading can result in both civil and criminal charges. Often, people convicted of insider trading are required to return any profits accrued in the 12 months prior to their prosecution, wrote Kesselheim’s team. The penalties depend upon the extent of the transgression and...
Money

Insider trading

the amount of illegal gains, and can include imprisonment, Sinha says.

What’s more, a person need not actually profit from insider trading in order to be guilty of committing securities fraud and liable to prosecution, according to Kesselheim.

Ways to avoid insider trading

Follow these guidelines:

- Read the fine print:
  As described above, physicians often engage with publicly-traded companies in various ways, such as serving on boards or as expert advisers.
  “In these cases, the physician is almost always asked to sign confidentiality or nondisclosure agreements before serving in such roles. Carefully read and then reread the terms of such agreements before you sign them,” says Sinha.

  If you don’t understand aspects of the agreements, seek immediate clarification from a representative of the company asking you to sign, Sinha adds.

- Before you buy or sell stock,
  consider the source of the information prompting the trade: When a doctor receives information about a public company through their professional activities, they have an obligation to consider the source of the information and whether it has already been made public before trading on it, says Sinha.

  “There is a big difference between ‘I read it in Bloomberg Businessweek’ and ‘I heard it during a company board meeting,’” he says. When in doubt, he advises, do not trade in a stock, even if the information came to you from family or friends.

- The rules apply everywhere and anywhere: Schuster gives this example: A doctor might socialize with an old friend who works for Disney, and the friend might mention that visitors to the theme parks are up 30 percent for the current year.

  The doctor must determine if that information has already been made public. If the information is not yet widely available, the friend may expect the doctor to refrain from trading on the basis of it.

  If the doctor did buy or sell Disney stock after that conversation, both he or she and the friend may have broken the law.

  “Information received in a social setting is a gray area, but when in doubt, don’t trade on it,” says Schuster. The friend may not be guilty if he expected the visiting physician to keep the information on attendance confidential.

- Do trade freely on insights and ideas you develop yourself. A physician may have extensive knowledge of a particular illness or a certain type of surgery. He or she may then read in the paper that a certain company is about to invest heavily in an approach that the doctor thinks is going to work or is not going to work, says Schuster. In that case, the physician is free to trade and to advise others to trade in the stock, he says. “You’re using your knowledge and public information. There’s no expectation of confidentiality.”

  A doctor would also have the green light to trade, he says, based on clinical observations, insights and intuitions. “Say you’re using a device and it’s just not working well. Or maybe you observe how patients react to a new medication. Trade on it. Tell people about it,” says Schuster. “You’re not getting those ideas from anyone at the company.”

  But if a doctor learns about the underperforming device or the fantastic new drug from someone who has a relationship with the company making the device or drug, he or she must not trade on that information or reveal it to anyone else, says Schuster.

“There is a big difference between ‘I read it in Bloomberg Businessweek’ and ‘I heard it during a company board meeting.’”

— Michael S. Sinha, MD, JD, Research Fellow, The Harvard-MIT Center for Regulatory Science, Harvard Medical School

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Physicians can adopt administrative and care management processes to deliver cost-effective vaccination services that simultaneously provide highest-quality patient care. While vaccination is mostly identified with immunizing children against diseases, providing vaccination services in a clinically and economically efficient way is foundational to the health of all patients and can add to a practice’s income stream.

“Adults need to be vaccinated; that’s a starting point,” says Jesse Hackell, MD, FAAP, who has led Pomona Pediatrics, in Pomona, N.Y., since founding it in 1987. “It’s not just against immunococcal disease; it’s shingles, chicken pox, measles and HPV. Just because you’re older doesn’t mean that you don’t need vaccines.”

Hackell adds that providing vaccinations can net a fair return. “Vaccine administration can be a profit center for a practice if it’s done correctly. It’s not a huge profit center but it’s possible to provide a margin.”

A VACCINE CHAMPION
Successful vaccination programs require buy-in from the entire practice staff and a smooth-running operation where all the details are handled properly. Doing so requires a “vaccine champion,” says Hackell.

The champion is the advocate who persuades everybody in the practice, clinicians and office staff alike, to embrace and promote the goal of vaccination. “Even the folks answering the phones must tell people ‘If you’re coming in for a well visit, we’re going to give you some vaccinations, too, if you need them, so bring your records,” says Hackell.

The champion also serves as the knowledge resource for the practice—the person who knows what the vaccines are for, their indications, recommendations, and schedules. In a practice with multiple physicians the champion usually is a clinician, who could be a nurse, a physician or even a physician’s assistant.

Running the program on a day-to-day basis requires a second essential person: a vaccination coordinator, who centralizes control of all program workflow processes, from ordering and inventory to administration and billing.

Among other responsibilities, the coordinator must properly maintain vaccines, syringes and related supplies; ensure the integrity of the vaccine records system; and
establish protocols for administering and storing the vaccines.

**CREATING REVENUE**

Doctors won’t get rich providing vaccination services, but modest revenue gains are possible. How?

“It comes down to buying them at the lowest possible price, using them expeditiously, and keeping track of them so that you’re not wasting vaccines,” explains Jamie Loehr, MD, FAAFP, owner of Cayuga Family Practice, in Cayuga, N.Y.

Practices can reduce the prices they pay for vaccines when they buy directly from manufacturers or join a vaccine purchasing group, in which independent practices combine to negotiate reduced fees for bulk vaccine purchases.

“There’s a convenience factor if you buy from a supplier, but the prices tend to be a bit higher,” says Loehr. Manufacturer rebates may be available to direct buyers and purchasing group members, too.

Noting that pricing isn’t going to vary much among groups, Jeff Winokur, a vaccine procurement and administration expert and president of Atlantic Health Partners, a Delray Beach, Fla. vaccine purchasing group, suggests that practices look for other ways to determine which purchasing group would be the best fit.

“Is there a cost to join a group program? Do they provide educational information about vaccines, including updates on indication changes and the availability of a vaccine? Do they do any advocacy on your behalf with payers? Do they have expertise for vaccines in the age range that a practice has?”

Since manufacturers have standard policies on replacing expired vaccine stock, “buying groups can help make sure their members understand those policies, as well as return policies, for instance, with flu,” adds Winokur. “Different flu manufacturers have different policy answers to questions like ‘Okay, I have 20 doses left. What do I do with them?’ ”

Practices also can learn when manufacturers are going to raise their prices. Then, depending on what they have in stock and how much they’ll be using in the short term, they can decide whether to buy more during the period between the announcement and the effective date of the price hike.

What’s critical financially is for the practice to get a decent return on the cost of the vaccines. “They should look at their major insurers to see what the payments are for the vaccines, and if they’re not making a significant margin on the vaccine product, they need to renegotiate that,” Hackell advises. “If you’re not getting 25 per cent above the private sector cost, you’re going to lose money.”

Buying online directly from the manufacturer keeps the balance sheet in the black for Loehr, who notes that the savviest insurance companies pay $2 to $3 more than the lowest market prices they can find for vaccines. Accordingly, he says, he’ll make $2.50 if he buys the vaccine for $50 direct from the manufacturer, but lose that same amount if he buys it from a retailer.

**TIMELY REMINDERS**

Helping patients stay current on their vaccinations not only keeps them healthy but produces a steady source of revenue. Immunize.org, a website that provides information on starting and operating a vaccination program, shows how to make this an efficient, labor-saving workflow process (and a subtle marketing tool) for physicians. The site provides templates for standing orders, which lets staff take a general policy rule and apply it to specific patients, so the doctor doesn’t have to be present for a vaccine administration.

“With a standing order you can tell them, ‘You’re due for a vaccination today. Would you like to have it?’ And if they say ‘yes’, you give it to them without needing an individ-
ual patient order from the physician,” says Loehr. “The site has a bunch of different standing orders in different languages for different vaccines.”

Practices also can install alerts in their EHR when a patient is due for a vaccination or provide phone call reminders for that purpose.

Doctors can compete with the convenience of pharmacy and retail clinic vaccinations by holding in-and-out vaccination clinics – especially for flu shots – where patients can get vaccinated within minutes without having to complete paperwork or schedule appointments.

Winokur suggests letting patients know about this service before the flu season begins, and designate certain days and/or times that make it easy for patients to take advantage of these streamlined services.

**KEEPING THE PRODUCT SAFE**

As important as profitability and patient participation is having protocols for safely storing and handling vaccines.

The CDC’s best practice guidance specifies a few essential steps for safe storage: immediately checking newly-delivered vaccine packages for damage by examining and documenting the condition of the vaccine and its shipping container; comparing the amounts, lot numbers and expiration dates of the vaccines against the packing invoice to see that they match; and accurately monitoring and recording vaccine temperatures.

If there’s no package temperature indicator, the coordinator should check that the packaging has enough insulation and refrigerant to chill vaccines to the correct temperature. In either case, it’s necessary to ensure that inactivated vaccines are unfrozen.

Vaccines should be stored in a refrigerator designated just for that purpose, with a built-in temperature indicator. They should be kept on the middle shelf, with older vaccines in front, and none of them touching the refrigerator sides or the freezer. The practice must keep daily temperature records and save them for at least three years.

“You need to have a process in place that tracks what expires first so that you use that first,” says Good. “But you also need to keep track of your supply and demand, so that you don’t stock up vaccines at the wrong time of the year or the season.”

Government agencies such as the CDC help practices plan for these needs by issuing alerts about when a flu or other disease outbreak has begun. Analytics-based EHR programs that leverage population health data also can guide practices in anticipating what amounts and types of vaccines they’ll need at a given time.

Other workflow aids with robust predictive logic are state immunization registries, which contain patient vaccine records and tell when patients are due for immunizations.

Recordkeeping should include lot numbers, too. “It’s important to track those lot numbers in your EHR because if there’s ever a recall, you’ll need to pull out a list of patients who received [vaccines from] that lot number,” says Good. Additionally, doctors should make sure their purchasing contracts with vaccine manufacturers tell them if recalled products yield a refund or credit.

The coordinator also should do a weekly inventory to track expiration dates so that soon-to-expire vaccines aren’t wasted. (Most expired doses of vaccines can be returned for credit.)

“You need to have a process in place that tracks what expires first so that you use that first,” says Good. “But you also need to keep track of your supply and demand, so that you don’t stock up vaccines at the wrong time of the year or the season.”

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— JESSE HACKELL, MD, POMONA PEDIATRICS, POMONA, N.Y.

Consistently emphasizing the necessity of vaccines, exercising diligent inventory and storage control and making price-conscious vaccine purchases are integral to a vaccination program that provides needed care for your patients while enhancing practice revenue. And don’t forget common-sense efficiency.

“You can’t afford to have wasted doses,” Hackell says.
Getting the most from patient family members

by JOHN CAMPANELLI Contributing author

Nitin S. Damle, MD, FACP, recently saw one of his favorite patients, an elderly woman who had always been active and independent. Yet this time, her daughter and son-in-law came to the appointment with her. They said she was forgetting things, becoming disoriented and even getting violent with her husband.

As he initially examined her, he didn’t notice much of a change in her condition. She seemed to be the same highly functioning woman he’d known for years. Yet because the woman’s daughter and son-in-law had come into the office and spoken up, Damle was able to perform an exhaustive examination, get the woman admitted and then into assisted living, saving her and her husband from a dangerous situation at home.

"Clearly, without the family bringing this to my attention, it could have gone on for quite a lot longer," says Damle, a practitioner in an eight-physician group in Wakefield, Rhode Island. "But having family members in the mix can also create anxiety, introduce the toxins of family dynamics, suck up a physician’s time and create privacy concerns.

Family members can be a physician’s extra eyes and ears. They can boost patient adherence. They know more about a patient than a doctor ever will. As a result, they can provide crucial information. And they can advocate for their loved ones, advising and steering them toward healing.

"I can’t think of any reasons not to involve a family member," he says. "They can really enrich the conversation. We welcome them, and the more information we can get, the better job we can do.”

—NITIN DAMLE, MD, FACP, WAKEFIELD, RHODE ISLAND

Establish open communications

If a family member is present, it’s crucial for the physician to set the stage and a tone of honesty and open communication, says Bernard M. Bandman, Ph.D., executive director of the Center for Communication in Medicine in Bennington, Vermont.

"Good communication is good medicine," he says. "It leads to more effective care. It leads to strengthening relationships between the physician, the healthcare team, the patient and the family.”

Doctors need to use that honest and open communication to see how the patient feels about having company during the appointment, Bandman adds. "It’s a delicate matter. So it’s really incumbent upon the physicians to say, ‘I see you brought your wife. Would you like her to stay or would you like to have a little time for just the..."
two of us to talk and then we can invite her to come in later?’”

How the patient answers, including through body language, may help the physician understand whether any problematic family issues exist. Chances are, the patient will welcome the opportunity to have the family member close by.

Even with a helpful family member in attendance, physicians should still spend some time alone with a patient, allowing the patient the opportunity to share private concerns or ask confidential questions.

“I’ll ask a family member to leave so I can properly do a physical examination,” says Damle. “During the exam, I’ll query the patient on what’s going on, how they see things and what their perspective is. Once it’s all done, I’ll bring the family member back into the room.”

Privacy concerns are essential, but HIPAA provides some flexibility when it comes to family and friends. The U.S. Department of Health & Human Services’ Office of Civil Rights says physicians are permitted to share information that is “directly relevant to the involvement” of family and friends who help provide a patient’s care or the payment of care. Information can also be shared if the patient is present and gives consent or if the patient, “when given the opportunity, does not object.”

In other words, a signature on a written release is not necessary. However, physicians should always document any verbal consent on the patient’s chart.

With patient and a family member together, physicians should start a conversation about the role of the family member, says Bandman. He suggests that physicians briefly share their own experiences.

“It’s really humanizing when a doctor says, ‘You know, from my experience, I’ve seen family members play different kinds of roles in caring for their loved ones,’” says Bandman. Next, he says, physicians should ask the patient direct questions: Whom do you look to for help? What do they do for you? What would you like them to do for you?

Advocate for family help

Also, realize the traditional definition of “family member” no longer applies. “A family member does not have to be somebody who is related by blood,” says Myra Glajchen, DSW, director of medical education at MUHS Institute for Innovation in Palliative Care in New York, where she mentors and trains young doctors.

What if family members are disruptive?

By Steph Weber Contributing author

What if a patient’s family member’s behavior presents as aggression, anger, or general disruption? In this circumstance, physicians need to take charge before it impedes their patient’s care. And while there are tips to aid physicians in dealing with this occurrence, proven techniques to defuse the situation and maintain a patient focus exist as well.

Emotions play a significant role in these exchanges. “People often react in a combative, argumentative way when they’re scared, worried, or feeling something difficult to express,” says Lindsey Hoskins, Ph.D., a Maryland-based licensed clinical marriage and family therapist with additional training in medical family therapy. “It’s much easier [for family members] to be defensive and combative. That’s natural.”

Setting the stage for open, inclusive communication with patients and their loved ones is the ideal tactic to minimize troublesome situations. Experts recommend physicians do the following:

- Understand the family dynamic before consulting with the family by reviewing the patient’s history, including work, children, and marriage.
- Ask family members to introduce themselves and specify their relationship to the patient.
- Avoid turning your back to the patient and family members. Consider using a tablet or positioning your computer so that you can make eye contact with everyone in the room.

So consider a family member who is acting out because of their fear, whether that fear originated from their mother’s new diagnosis or from the side effects of an alternative treatment. If the physician rushes through the appointment, ignoring the upset family member and thus failing to acknowledge the fear, it only allows the fear to fester and grow. In turn, it inadvertently creates the breeding ground for even more displaced anger.

“You don’t want to get into a power struggle with the person,” says Hoskins. And it’s best to approach the situation in a way that lowers one’s natural defenses. “Being kind and gentle, but still direct; that’s really the only way you can address it.”
“It is anybody who the patient identifies as helping them cope with or manage their illness. It could be a neighbor, a significant other, a friend from church, whoever the patient decides.”

And realize that these family members, if they aren’t already, will likely become the caregivers of older patients. “They play a huge role,” says Damle. “Consider them to be part of the healthcare team.”

How valuable these “teammates” can become depends largely on the physician and how well he or she can nurture the relationship. Doctors need to be proactive in their potential relationship with a family member, say the experts, starting as soon as a patient walks into the office, either with a family member or without.

Even if a patient, especially an older patient, is alone in the examination room, Glajchen inquires about family, asking, “Did you come here with anyone today?” If there’s a family member in the waiting room, she’ll ask if the patient might want that person in the room.

Using GoToMeeting, Face-time and conference calls. “The physician doesn’t have to feel that it only works if the family member or friend is physically present,” she says.

Understand the family’s role
It’s also important for the physician to query the family member. Glajchen says too many doctors assume that if someone is at an appointment, he or she is ready to take on the responsibilities of caregiving.

Family members might not feel comfortable changing a dressing or lifting a parent out of bed, says Glajchen.

“It behooves the physician to ask the family member if they are prepared and willing—and what we could do to help them feel more prepared to take on those responsibilities,” she says.

These conversations take time, and Bandman knows physicians are hesitant to put even more pressure on their tight schedules. However, an upfront investment in time “saves time down the road in terms of the planning and the execution of the care plan,” he says.

Early, honest conversations with patients and family members not only nurture trust, they give physicians clear knowledge of the patient’s resources and family support. They can also help establish a point person who can communicate with the entire family, saving the physician significant time later.

With a family member engaged and welcomed, the benefits can add up. Physicians will get a deeper, more objective and more reliable family history. They’ll get better descriptions of current conditions and symptoms. They’ll have another set of ears to hear—and later share—information on diagnosis, treatment and medication. The doctor will have a helper to ensure adherence at home. And, of course, the patient gets invaluable emotional support.

“That kind of support, is key to outcomes,” says Bandman.

Promote those benefits,” says Damle. He suggests creating a pamphlet for family members—and displaying it prominently in the office—that tells them how important they are, how their opinions are valued and how they are respected members of a patient’s healthcare team.

“I can’t think of any reasons not to involve a family member,” he says. “They can really enrich the conversation. We welcome them, and the more information we can get, the better job we can do.”

“A family member does not have to be somebody who is related by blood. It is anybody who the patient identifies as helping them cope with or manage their illness.”

—MYRA GLAJCHEN, DSW, DIRECTOR OF MEDICAL EDUCATION, MJHS INSTITUTE FOR INNOVATION IN PALLIATIVE CARE, NEW YORK
FINANCIAL STRATEGIES

Get paid faster
5 ways to improve your accounts receivable turnaround

As soon as your medical practice sends a claim to the payer, you will be counting down the days until you receive the actual payment. Of course, it is a must to ensure that you receive the payment as soon as possible since delays will eventually cost your business.

What increases your payment turnaround time
It is ideal to get the accounts receivable (A/R) cleared in less than 30 days. However, there are cases when payments are delayed. There are several reasons why it takes a long time for a payer to make the payment. Here are some of those reasons:

- Claim errors
- Multiple denial appeal
- Missing the right time for filing

How to reduce A/R turnaround time
Do your best to reduce the A/R turnaround time. Here are some helpful tips for reducing turnaround times:

1. File claims as soon as possible.
The sooner you submit the claims to the payer, the sooner you receive payment. In major hospitals, it may take two weeks more or less to submit claims. Once the payers (Medicaid, Medicare, private insurance, etc.) receive the claim, they will process the payment within 15 days. For your medical practice, improve your claims submission process to improve your cash flow.

2. Pre-empt denials.
Invest in solutions that can help significantly reduce the number of mistakes in submitted claims. When there are mistakes in a submitted claim, the payers may deny it. You will then have to file a denial appeal. The process of clearing the account receivable will take longer than normal then. Thus, it is imperative to submit a clean claim so as to receive payment as soon as possible.

3. If there are denials, work through them immediately.
No matter how much you perfect your process of submitting claims, there may be one or two mistakes that’ll slip through. Once you get the notice for denials, work on them immediately. Don’t allow them to pile up if you don’t want to stunt your cash flow. Remember that payments from appealed denials will take about 90 days and you can’t wait that long to clear your accounts receivables.

4. Check your aged trial balance.
The aged trial balance is the list of all accounts receivable with an outstanding balance. It is highly recommended to check at least once a month to make sure that there are no account receivables that are more than 45 days old.

5. Track your claims denial rate and overall accounts receivable.
Review and analyze your accounts receivable at least once every six months. Specifically, you have to check the denial rate. If it is too high, then consider improving the process for submitting claims.

Alpha B. Journal is founder and CEO of Journal Solutions LLC, a practice management consultancy located in Danbury, Conn. Send your financial questions to medec@mmhgroup.com.
Managing patients with migraines
Tips for primary care

by JORDAN ROSENFELD Contributing author

Migraines are not just bad headaches, they’re the most common severe primary headache disorder, affecting about 12 percent of the population, according to Noah Rosen, MD, director of the Headache Center at the Northwell Institute for Neurology and Neurosurgery in Manhasset, N.Y.

Rosen says that headaches are divided into two basic classifications: primary headaches and secondary headaches.

“Secondary headaches are when a headache is secondary to another condition such as a tumor or a spinal leak,” Rosen says. “A primary headache is where the headache itself is the problem.” Migraines fall into the latter category.

For those who don’t want to turn to medical intervention, physicians can recommend a variety of management strategies that may circumvent or reduce the need for medication:

LIFESTYLE MODIFICATION

“So many headache disorders are triggered events,” Rosen explains. The more researchers learn about migraines, he says, the more they appear to be related to neuro-inflammation, which can be triggered by numerous factors from diet to caffeine withdrawal.

Hence, lifestyle modifications can be very important. “That includes eating regularly, hydrating well, regular sleep and stress reduction,” Rosen says.

Additionally, people with migraines should attempt to track and record their headache triggers, though Rosen says only about 70 percent of migraine patients ever identify a trigger for their headaches.

EXERCISE AND MASSAGE

In the same vein as lifestyle modifications, Rosen points out, “There is some evidence for the preventative benefits of migraine with regular aerobic exercise.” Yoga has also been shown to have some positive effects on migraine.

Additionally, physical therapy, massage, and acupuncture have all been linked to migraine relief, but do not yet have enough consistently validated research behind them to prove their effectiveness. However, all of these modalities are likely to bring temporary relief and while not causing any harm, he says.
**COGNITIVE INTERVENTION**

Other validated treatments include psychological interventions, including cognitive behavioral therapy and biofeedback, which is a form of computer-aided progressive relaxation training, Rosen explains.

Biofeedback often accompanies mindfulness training, in which a person pays very careful, focused attention to a set of stimuli or activities.

**SUPPLEMENTS**

Rosen says that there is also some evidence for the efficacy of several over-the-counter supplements including magnesium, riboflavin, coenzyme Q-10, and feverfew.

“Riboflavin and co-enzyme Q-10 work upon the energy metabolism in the cell, on the mitochondria,” he explains. “There are several mitochondrial diseases that have a high association with headache disorders, so that may be the mechanism by which it has the effect.”

Rosen warns, however, that not all supplements contain the ingredients or dosage levels they claim to, so it might make sense to seek out manufacturers that publish their quality control data.

**MEDICAL DEVICES**

Finally, Rosen says, there are a number of medical devices on the market for migraines and cluster headaches. These include nerve stimulators, electrical TENS units and trans-cranial magnetic stimulators. Clinical evidence varies for each item.

Some items may be cost-prohibitive because they are not covered by insurance.

“You have to take a realistic assessment of what is the cost of this disease to your patient and what are the best options. Even a single lost day [to migraine] can be devastating,” he says.

**WHY JOURNALING IS KEY**

In order to begin to understand the triggers and patterns surrounding patient migraines, headache specialist Stephanie Nahas, MD, MSEd, recommends patients keep a migraine journal or calendar.

Nahas, an associate professor of neurology at Thomas Jefferson University in Philadelphia, and director of the university’s Headache Medicine Fellowship Program for the Jefferson Headache Center, says journals are useful to gauge the actual burden of illness the patient is experiencing.

Writing down the details of a migraine attack can reveal how migraines impair a person’s daily ability to function at home, at work, and in leisure, as well as the frequency of attacks and what medications are required to control them, she says.

Additionally, a migraine journal can help patients distinguish between actual triggers and those that are merely coincidental.

“Many patients may not be sure they have real triggers or not, so keeping track can help to tease out what’s a trigger,” Nahas says.

Triggers can run a wide gamut, including sleep, diet, exercise, dehydration, stress, and hormones.

With a journal, a patient can notice the circumstances surrounding a migraine. “You can take notice of how your sleep was the night before, did you exercise today, how’s your hydration and are you stressed out,” Nahas says.

A journal can also help to track the benefits of what is known as a “protector,” which Nahas calls “the opposite of a trigger.” Protectors are factors that make it less likely that a person will have an attack. This could be a new medication, lifestyle modifications, acupuncture, and so on.

The calendar can also be of great value to the physician. Nahas says, as a way of monitoring acute medication use. “If somebody has headache more than 10 days a month, you need to monitor how often they’re using acute medication to treat attacks because they could get into trouble with rebound headache,” she says.

Rebound headaches are part of a cycle where the patient has to keep taking more and more medication to treat the migraine and the migraines then begin to increase in frequency and intensity.

Migraine journals eventually begin to reveal patterns that can also help patients prepare a pre-emptive strategy, Nahas says.

Additionally, journals enable the patient to express their feelings about migraine’s impact on their lives, and bring it to someone else for validation and help.

If a physician recommends a patient begin using such a journal, physicians must then look at them during the visit. “Because nothing insults somebody more than being told to do something but then the doctor doesn’t care that you did it,” Nahas says.

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**Chronic Conditions**

“You have to take a realistic assessment of what is the cost of this disease to your patient and what are the best options. Even a single lost day [to migraine] can be devastating.”

— NOAH ROSEN, MD, DIRECTOR OF THE HEADACHE CENTER AT THE NORTHWELL INSTITUTE FOR NEUROLOGY AND NEUROSURGERY IN MANHASSET, N.Y.
Even though physicians have been able to bill CCM since 2015, they still run into problems in terms of getting paid, says Kim Garner Huey, CPC, owner of KGG Coding and Reimbursement Consulting in Birmingham, Ala. Here are some common reasons for denials and how to avoid them:

**Reason for denial:** Multiple providers bill CCM for the same patient during the same 30 days.

How to avoid it: Communicate with specialists regarding who will bill for the CCM. “This code was really intended for primary care, but it’s not restricted to primary care,” says Huey.

**Reason for denial:** Physician bills CCM more than once every 30 days.

How to avoid it: Set up an alert in the practice management system that prevents physicians from reporting CCM before 30 days have elapsed, says Huey.

For more information about CCM, including patient and practitioner eligibility as well as the service elements included in the code, visit the CMS website.

### Chronic care codes and what they pay

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2019 national Medicare payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490</td>
<td>CCM, 20 minutes</td>
<td>$42.17</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM, 60 minutes</td>
<td>$92.98</td>
</tr>
<tr>
<td>99489</td>
<td>Each additional 30 minutes</td>
<td>$46.49</td>
</tr>
</tbody>
</table>

### Chronic conditions that qualify for CCM include:

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

Source: CMS

Lisa Eramo is a contributing writer who specializes in coding and documentation. Send your coding questions to medec@mmhgroup.com.
Proposed changes to Stark Law & Anti-Kickback Statute, explained

by KRISTIN M. BOHL, JD and ADETORO T. OLUGBEMI, JD Contributing authors

The proposed rules released by the Department of Health and Human Services Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) in October 2019 include new exceptions and safe harbors, as well as clarifications to the Physician Self-Referral (Stark) Law, the Anti-Kickback Statute and the civil monetary penalty prohibition against beneficiary inducements. These much-anticipated proposed rules aimed at removing regulatory barriers to coordinated care and value-based care provide some of the most extensive changes to these laws in response to the HHS’s “Regulatory Sprint to Coordinated Care.”

ANTI-KICKBACK STATUTE
The OIG proposes new safe harbors and modifications to existing safe harbors to promote outcome-based payment arrangements that reward improvements in patient health. Notably, the OIG’s proposed rule includes three new safe harbors for value-based arrangements protecting arrangements for improved care quality and outcome and efficiency, and arrangements under which the value-based enterprise (VBE) is at substantial or full downside financial risk. The OIG also proposes to expand protections under the Anti-Kickback Statute and the civil monetary penalty law for improved coordination of patient care and health outcomes.

Under the proposed rules, CMS-sponsored models, such as the Innovation Center models, can now operate under a safe harbor which would likely replace the current model-by-model fraud and abuse waiver process. Acknowledging the increased use of technology in patient care and the need for the safe protection of patient information, the OIG’s proposed rule includes a new safe harbor for cybersecurity technology and services donations and modifications to the electronic health records safe harbor. The OIG’s proposed rule also includes modifications to the personal services and management contracts safe harbor to include a change in the requirement for compensation to be set in advance and the protection of outcome-based payment arrangements.

Notably, the OIG states that the proposed protection for outcome-based payment arrangements would not apply to pharmaceutical manufacturers; manufacturers, distributors, and suppliers of durable medical equipment, prosthetics, orthotics or supplies (DMEPOS); and laboratories. Other proposed changes include new protections for bundled warranty arrangements that apply to at least one item and...
10 proposed exceptions

Value-Based Arrangements. Three proposed new safe harbors for certain remuneration exchanged between or among eligible participants in a value-based arrangement that fosters better coordinated and managed patient care:
- Care coordination arrangements to improve quality, health outcomes, and efficiency;
- Value-based arrangements with substantial downside financial risk; and
- Value-based arrangements with full financial risk.

These proposed safe harbors vary by the types of remuneration protected, level of financial risk assumed by the parties, and types of safeguards included as safe harbor conditions.

Patient Engagement. A proposed new safe harbor for certain tools and supports furnished to patients to improve quality, health outcomes, and efficiency.

CMS-Sponsored Models. A proposed new safe harbor for certain remuneration provided in connection with a CMS-sponsored model (as defined in the proposed rule), which should reduce the need for separate and distinct fraud and abuse waivers for new CMS-sponsored models.

Cybersecurity Technology and Services. A proposed new safe harbor for donations of cybersecurity technology and services.

EHR Items and Services. Proposed modifications to the existing safe harbor for electronic health records items and services to add protections for certain related cybersecurity technology, to update provisions regarding interoperability, and to remove the sunset date.

Outcomes-Based Payments and Part-Time Arrangements. Proposed modifications to the existing safe harbor for personal services and management contracts to add flexibility with respect to outcomes-based payments and part-time arrangements.

Warranties. Proposed modifications to the existing safe harbor for warranties to revise the definition of “warranty” and provide protection for bundled warranties for one or more items and related services.

Local Transportation. Proposed modifications to the existing safe harbor for local transportation to expand and modify mileage limits for rural areas and for transportation for patients discharged from inpatient facilities.

Accountable Care Organization (ACO) Beneficiary Incentive Programs. Codification of the statutory exception to the definition of “remuneration” related to ACO Beneficiary Incentive Programs for the Medicare Shared Savings Program.

Telehealth for In-Home Dialysis. A new exception for “telehealth tech” for in-home dialysis patients.

service, a new statutory exception for telehealth technologies furnished to in-home dialysis patients, and modifications to the local transportation exception.

PHYSICIAN SELF-REFERRAL (STARK) LAW

CMS issued its proposed rule focused on modernizing and clarifying the Stark Law. Similar to the OIG’s proposed rule, CMS’s proposed rule creates new and permanent exceptions to the Stark Law for value-based arrangements.

While the OIG’s definition of VBE expressly excludes manufacturers, distributors, and suppliers of DMEPOS, CMS seeks comments on whether or not to exclude DMEPOS providers from the definition of VBE and seeks comments on the roles that DMEPOS providers play in the coordination of care. Noting the continued importance of price transparency and its impact on a patient’s freedom of choice, CMS seeks comments about the role of price transparency in coordinated care – specifically, whether to include a requirement for price transparency in the value-based arrangement exceptions.

CMS proposes new exceptions for cybersecurity donations and for limited renumeration to a physician, as well as modifications to the current electronic health records exception. As expected, CMS also proposes clarifications to definitions and important Stark Law terms that the industry has grappled with for years—including commercial reasonableness, the volume or value standard as well as fair market value.

CMS also discusses the period of disallowance, application of the isolated transaction exceptions and other clarifications to compensation exceptions.

INDUSTRY INPUT AND IMPACT

The proposed rules provide an opportunity to give feedback to CMS and OIG on the expansive modifications to laws that have widespread influence throughout the health care industry. CMS and the OIG consider each comment received in promulgating final rules – and these final rules will have far-reaching impacts for health care as the transition to value-based care continues. The rules are scheduled to be published in the Federal Register on October 17, 2019. Based on the rules being published in the Federal Register October 17, comments will be due by December 31, 2019.

MEDICAL ECONOMICS | NOVEMBER 25, 2019
LEGALLY SPEAKING

Why old computers are a liability risk

One common, recurring seasonal business risk for doctors’ offices is created when businesses take advantage of year-end deals and surplus taxable income to replace computers and other business equipment. Making sure your practice has appropriate amounts of cyber liability insurance as well as sound and enforced policies on how old equipment is stored and disposed of is vital practice risk management.

Wiping data is vital
Taking a tax deduction for donating safe electronic equipment after determining it does not contain confidential information is a relatively standard business practice. Whether your devices are going to be destroyed, donated, or recycled, all data on the computer must be wiped as a minimal first step. Security software available at most office supply stores can help and may already be present in your operating system or anti-virus programs. Remember that “deleted” data on personal computers is not actually “erased” unless the hard drive itself is destroyed.

Beyond “computers”
While computers pose the most obvious threat to legally onerous financial and HIPAA-protected information, they are not your only risk. Other devices, including scanners, printers, and fax machines, can store thousands of images and pages of data. Your practice must securely dispose of a variety of computer and related electronic devices including the following, admittedly incomplete list:

- Computers, tablets, and smartphones that have been used to access or relay protected data
- Networked printers, faxes, scanners, etc.
- Computer servers and arrays
- Devices that combine hardware and software for a specific medical or administrative function
- Networking equipment
- Electronic data storage devices and backups

Professional IT support that includes security software and online security training for your staff should be considered mandatory for business asset protection and risk management. Some IT providers can also help securely dispose of your equipment.

Finally, consider if your business insurance coverage adequately protects you in case of accidents, errors, or breaches. Your practice should have seven figures in data breach/cyber liability insurance, not just a $50K or $100K rider that shares limits with your malpractice policy.

A device security plan

- **Secure all old equipment.** Many practices put outdated equipment into a storage area that no one pays attention to or inventories until something goes missing or a breach occurs.
- **Have a plan and make a specific individual responsible for implementing it.** Create a written chain of custody and educate the person in charge about the risks and gravity of the task at hand.
- **Keep records of all devices,** including the ones being destroyed or donated (make a copy for your accountant including a description, serial numbers, estimated depreciated value, and replacement cost), and where they went or how they were disposed of.
- **Sign out all users and physically disconnect devices from network.** Old machines are often not maintained or updated and may actually create a security risk while still in your office.

Ike Devji, JD, has practiced in the areas of asset protection, risk management, and wealth preservation law exclusively for the last 15 years. Send your legal questions to medec@mmhgroup.com
Despite the large number of doctors and nurses who crowded the operating room, it was eerily quiet. All in attendance stared in silent horror at the large dark-red tumor that protruded from the vagina of the young girl lying anaesthetized on the table under the merciless spotlight.

Just hours earlier, the ten-year-old had been brought into the hospital by her parents for “bleeding.” When the emergency room doctor saw the large lesion he immediately called the gynecologic oncologist. Now in the operating room, two gowned physicians carefully removed the tumor and controlled the bleeding. Afterwards the child was moved to the recovery room, and from there to the gynecological floor.

As a second-year ob/gyn resident, I was on my first gynecologic-oncology rotation, and the girl became one of my patients. Being on the oncology service, I was captivated by the complex operations and enthralled by the surgical skills of the oncologist who, in my opinion, operated like a virtuoso. During surgery, his movements were like those of a gifted musical conductor, lightly moving the tip of his scalpel or scissors as he effortlessly separated tissues, opened surgical planes and exposed blood vessels, nerves and the ureters, all with minimal blood loss. I was fascinated. The operating room was the focus of my attention. I was far more interested in the technical aspects of surgery than in the patients we operated upon. I quickly performed my daily assignments including rounds, patient admissions and discharges, dictations and outpatient clinics, so I could spend as much time as possible at the operating table. I participated in as many surgeries as I could, even when it meant arriving earlier and staying at the hospital after hours when I was not on call. I thought I had found my calling. Learning to operate like this oncologist, I thought, would enable me to save countless lives.

In the weeks that followed, this little girl was to change this naive view. She made me a better physician.

The pathologic result confirmed the worst possible diagnosis—an aggressive sarcoma. After an intense discussion by the oncologic team, I was present when her parents were called in and the aggressive nature of the tumor and the very small likelihood of survival were explained to them. The team recommended the immediate removal of their daughter’s uterus, ovaries,
and as much of the intra-abdominal tumor as possible, to be followed by chemotherapy. The signed consent form was stained with their tears. I was saddened by the need to remove the uterus and ovaries from such a young person, but since I knew the grim prognosis associated with sarcomas, I understood the rationale for radical surgery as the best option.

I had watched as the young girl was brought to the operating room and anesthetized. I was one of the surgeons to operate on her. Unlike the way I had felt during previous surgeries, this time I noticed that I was unable to concentrate on only the technical aspects of the operation. I realized that caring for her before surgery, and seeing her parents grapple with the shocking diagnosis had created in me an unfamiliar level of emotional involvement.

During the child's post-operative course, I found myself spending more time than usual in her room and came to better know her and her family. I sensed that our relationship had changed. She and her parents shared their fears with me and described the details of their lives, as if I were a confidante, a relative, an older brother.

Fortunately, her recovery was uneventful, and she was discharged home.

Three weeks later she returned for her first round of chemotherapy. Just a month before she had been a typical youngster, going to school, doing her homework, and visiting friends. Now she was in a hospital room, surrounded by strangers who poked and prodded her and subjected her to painful treatments. She suffered from vomiting and diarrhea, side effects of the therapy.

Once again, I did my best to help her deal with the pain, fear and anxiety. Her familiarity with me seemed to ease her discomfort. Her parents, who put on a brave face while she was awake, shared their heartache with me while she slept. I watched them tenderly care for her, struggling with the knowledge that she was unlikely to survive while still hoping for a cure.

By the time she returned for her second round of chemotherapy I was no longer on the gynecologic-oncology rotation, but she and her family requested that I continue to be her caregiver. She asked that I be the one to start her IV access and begin the chemotherapy drip. My program director and the oncologist agreed that it would make it easier on her and her family, so I became the resident in charge of her care.

My bond with her and her family grew. It was painful to see her lose her hair and become more and more swollen from the combination of medications and anemia. While her parents hid their agony from her and her younger sister, they continued to share their pain and fears with me.

While I knew my involvement made this awful experience a little easier for them, it was becoming harder for me. I was no longer able to use my white coat as a shield. I lost the ability to dissociate from the suffering of my patient. Watching her vomit again and again despite the medications she received in order to decrease the side effects of the chemotherapy, seeing her become weaker and paler with every passing day, it became impossible for me to leave my feelings behind when I went home. Even more difficult was that while I watched the life slowly leaving her body, my wife and I were expecting our first child.

I was again called upon by her and her parents to participate in her third round of chemotherapy. She looked very different from the girl her parents had brought to the emergency room just three months earlier. Her small frame seemed lost in the big hospital bed. She was pale, bald, swollen and too weak to talk. I sat in her room and held her hand, watching her condition rapidly deteriorate. I saw her family come to accept the failure of modern medicine to save their child. I was there when she passed away.

The death of this little girl and the agony of her family broke my heart. My glorified view of oncologic surgery became more realistic, as did my understanding of the limits of medical therapy. More profoundly, I learned the importance of opening my heart to my patients, making time to listen to their stories and acknowledging their fears and pain. I understood that even when I cannot cure a disease and heal my patients, I must strive to make their experiences better by salving the spirit as well as the body. I learned that I can do this by lowering my personal shield and, when appropriate, not hiding my emotions. I learned to make sure they know that I care.
The 5 elements of physician self-care

by REBEKAH BERNARD, MD Contributing author

Studies show that medical students have a precipitous drop in empathy levels within just months of starting their third-year clinical rotations. While there are a variety of proposed explanations for the transition from naive pre-med idealist to world-weary cynic, one likely culprit is the de-emphasis on self-care which occurs during these rotations.

 Virtually overnight, medical students transition from a routine of regularly scheduled lectures and study periods to a brave new world of 4 AM rounds, overnight shifts, and wolfed-down meals between operating room cases.

And if students dare to express feelings of hunger or fatigue, their senior resident or attending is likely to tell them to “suck it up!” or remind them that “you can sleep when you’re dead.” By the final year of medical school, jaded students are passing on the same “words of wisdom” to the juniors behind them.

The message: Patients’ needs come first. Doctors’ needs (much less those of medical students!) are a mere inconvenience, something to be ignored and overcome. Or worse, something to be proud of. (“You worked with a 103-degree fever? Well, one time I went back to work after giving myself intravenous fluids in the call room from for a stomach flu!”)

While it’s possible to continue this superhuman behavior for a few days, weeks, months, or even years, it’s not good and it’s certainly not healthy. Moreover, doctors develop dangerous habits that are hard to break, following them even after their student and resident days are long gone.

Case in point: Unless there is another doctor present, I’m always the first person done eating at the table, as if some invisible code pager is going to pull me away from my meal at any second.

By continuously deferring our own physiological needs, physicians harm not only ourselves, but also provide a disservice to our patients.

Geni Abraham, MD, an internist and wellness expert, notes that when physicians don’t take care of their own needs, they can’t be “good medicine” to their patients. Abraham compares physicians treating patients while they are physically depleted to “trying to fit a twin-sized sheet onto a king-sized bed”—a futile and impossible task.

“Do as I say, not as I do”

In order to provide the type of care that patients deserve, physicians must prioritize their own needs. “We’ve got to get back to the fundamentals of personal health care,” says Abraham. “We need to be doing exactly the things that we are telling our patients.”

She recommends that doctors start by focusing on the following aspects of self-care:

1. NUTRITION “I don’t care if you want to follow a vegan or a keto diet, as long as you are eating whole foods and a balance of nutrients,” says Abraham. It’s also important for physicians to practice mindful eating—actually tasting and enjoying our food, rather than gulping it down as if we are on 24/7 duty and expecting to be called to a patient’s bedside at any moment.

Abraham notes that eating is a social activity, and great enjoyment can be gained from eating in the company of others. Take time to schedule and plan meals with family and friends, rather than eating over the sink or in your car (guilty on both counts).

2. EXERCISE “Exercise is the cheapest drug for anxiety and mild to moderate depression,” says Abraham. “It’s also one of the best ways to help students and residents learn, as movement has been shown to promote learning.” While physicians certainly understand the benefits of exercise, the challenge is often finding the time to do it.

“You have to find the time,” advises Abraham. Even if you can only do 10 or 15 minutes, schedule...
that time into your week and make it non-negotiable. Consider an app like the “7-Minute Workout,” which gets your heart pounding and can be done in the comfort of your living room. It may also help to find something active that you might enjoy like a sport or dance class.

3. SLEEP “Lack of sleep causes memory loss, irritability, and chaotic thinking,” says Abraham. “And chaotic thinking doesn’t help our patients or ourselves.” Abraham recommends getting enough hours of sleep at night and practicing good sleep hygiene. “Put your phone upside down to avoid the blue light that it emits and avoid watching intense television shows before bedtime.” Instead of looking at screens before bed, Abraham recommends practicing mindful meditation or deep breathing exercises.

If you still feel sleepy even after getting enough hours of sleep, consider getting tested for sleep apnea. Robyn Alley-Hay, MD, a retired ob/gyn who is now a physician coach, notes that starting CPAP for her previously undiagnosed sleep apnea was a life-changer. “I wish I had been tested for sleep apnea years ago,” says Alley-Hay. “I no longer have to start my day exhausted, slow, muddled, and generally grumpy.” Alley-Hay recommends that doctors get tested and treated. “It is hard enough to recover from call nights, irregular shifts, and short nights as a physician. Add sleep apnea on top of that and it’s a recipe for exhaustion, burnout, irritability, and even depression.”

4. NON-TOXIC RELATIONSHIPS Physicians need support from family members, friends, and colleagues. We need to take time to nurture those relationships by scheduling activities like date night with your spouse and lunch with a colleague. Attend medical society meetings and physician socials. Knowing that we are all dealing with similar issues can provide a great deal of support.

On the flip side, extricate yourself from relationships that are toxic or emotionally draining. Say no to people, employers, committees, or memberships that fail to add value to your life.

5. MINDFUL SELF-COMPASSION Abraham suggests that physicians pay attention to how they talk to themselves. She notes that humans are wired to pay more attention to negative thoughts than to positive ones, and that we need to work to counteract negativity in our lives. “It takes five positive thoughts to overcome one negative thought,” says Abraham.

One way to achieve mindful self-compassion is to keep a journal of your emotions, and to take a moment at the end of each day to focus on the things that went well.

3-step plan to protect your practice against hackers

by SEAN NOBLES Contributing author

Cyberattacks pose a clear and present danger to all healthcare stakeholders. These days, cyberthreats are so mainstream 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 was in "critical condition," a claim that was followed by many sizeable 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?

When it comes to securing systems and data, it’s important for organizations to take a step back, start simple and move forward strategically. Cybersecurity is a journey, not a destination — and you don’t always need to tackle everything at once. 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 to 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 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 fly under the radar. Phishing employs social engineering to trick 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 that a certain action be performed. 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, as 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 also to ensure that previous issues were fully remediated. 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 system.

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.

It’s 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. Or, perhaps the greatest need is stronger 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 breach 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, a veteran-owned 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.
Make population health work for your practice

Value-based care requirements are becoming increasingly important for independent medical practices and require a shift in how they think about their patient populations.

No longer is the focus only about treating the sick people in a waiting room; it’s about empowering patients to better manage their health from their homes, both with preventive care and in living well with chronic illness.

No matter the size of the population or organization, population health management (PHM) programs can help to improve outcomes by more effectively addressing patient needs and connecting a practice and its patients to the community.

If independent practices are thinking that a PHM program sounds complicated and expensive, it does not have to be. Using these tips, practices can implement PHM programs that are customized for their patients and continue providing care for their community.

Jump in

There is no need to tackle a practice’s entire population right out of the gate. Instead, break populations into smaller groups, and choose a low-risk population where simple changes are easily implemented. This approach is a good way for practices to dip their toe in the water before diving in and investing substantial resources and time.

Setting specific quality metrics to monitor creates a framework that helps practices determine success. Once practices have achieved their goals with one pilot population, they can expand to others. The key here is to start.

Make a business case

Identifying the potential return on investment (ROI) and proving out that ROI is critical. The physicians making these decisions are directly impacted in the financial risk.

As independent practices plan the change, it’s important to take time to define the benefits and the costs. If the benefits improve a clinical outcome, does it increase pay for performance and how much would that be? If it improves access, does it reduce avoidable emergency department visits or allow clinicians to see more patients?

Leverage relationships

Many independent practices assume that they do not have enough financial and technological resources to make a PHM program work. In reality, small practices often are more aware of the resources available in their community and how to connect with them.

They often contribute to the local business community alongside their own patients, allowing them to tap into what is happening in the community, and leverage existing relationships to help them start PHM programs without investing substantial resources.

These relationships can be utilized to make a significant impact, such as directing patients to local food pantries or coordinating transportation. By leveraging these community relationships, independent practices can make an impact with their PHM pilots without spending a great deal because they do not have to build it themselves.

Fail and learn

Most changes in healthcare come with a learning curve, and PHM pilots are no different. Some initiatives will not work as intended and that is OK. Leaders need to be able to make corrections and adjust, or make the decision to abandon an initiative. It is important to have a few key metrics that practices are tracking to determine success, and to be able to recognize when it is time to move on.

Population health is not a one-and-done program, but is an approach that requires building a series of programs based on the needs of patients. Practices should avoid getting bogged down in the complexities and focus on getting started, one small population at a time.

Cindy Gaines is chief nursing officer for population health management for Philips. Send your tech questions to medec@mnhgroup.com.
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Avoiding bias with patients

While implicit unintended bias affects nearly everyone, its consequences are especially significant in medicine. The unconscious assumptions patients may hold about patients can lead to inappropriate treatment decisions, and on a larger scale, worsen disparities in health outcomes. The good news is that as understanding of implicit bias grows, so do techniques for combatting it.
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