TOP CHALLENGES facing physicians in 2020

MONEY
Getting started with direct pay

LEGAL
Contract advice about termination and productivity

CHRONIC CONDITIONS
Tips for managing pre-diabetes

TECH
The benefits of texting with patients

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very physician has practice challenges that keep them up at night. Maybe your practice is having trouble recruiting retaining quality staff members, or prior authorizations has you clenching your teeth. Perhaps your EHR is giving you fits, you’re worried about how the new urgent care that opened down the street is going to impact revenue.

The good news is that there are solutions to even the most complex challenges that physicians face in their careers, something that a physician can start doing today to improve the practice and the care provided to patients.

Every year, in the last issue of the year, Medical Economics details the top challenges facing physicians in the upcoming year, and provides some tips on how to address them. In this issue, we take a look at the 10 major challenges physicians can expect to encounter in 2020, and what to do about it. Our list is wide-ranging and broad, and encompasses all of the major areas we cover: practice management, money, technology, physician careers, law and malpractice and managing patients with chronic conditions.

In addition to our in-depth review of these challenges, we have other great content in this issue, including:

- The last of three winning essays of our 2019 Physician Writing Contest, featuring a heartbreaking story by Rachel Fleishman, MD;
- A feature on direct pay, one way a growing number of physicians are transforming their practices to improve the time they spend with patients;
- Some quick hits featuring practice advice on contract termination, addressing prediabetes in patients and the benefits of texting directly with your patients.

So if stress over practice challenges is keeping you up at night, take a look at our coverage in this issue. Maybe you’ll find an idea that can help your practice improve, and you to rest easy.
2020’s top challenges
The 10 issues physicians will contend with

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Defining ‘value’
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AMA: Doctors need more health economics training

The American Medical Association (AMA) is calling for medical schools and residency programs to incorporate information on healthcare economics in their programs, according to a news release from the association.

The new policy is built on AMA’s ongoing work to ensure students and residents are trained to practice within the modern health systems. Specifically, it calls for these programs to incorporate information on the organization of healthcare delivery, modes of practice, practice stings, cost effective use of diagnostic and treatment services, practice management, risk management, and quality assurance, according to the release.

Also, the new policy calls on medical student and residency programs to ensure their students and residents are given instruction related to the environment and economics of medical practice in fee-for-service, managed care, and other systems.

“Medical students and residents with a deeper understanding of cost, financing, and medical economics will be better equipped to provide more cost-effective care that will have a positive impact for patients and the health care system as a whole,” says Barbara L. McAneny, MD, former AMA president, in the release. “We will continue working to ensure future physicians are ready on day one to meet the needs of patients in the modern health care environment.”

AMA is also currently working the National Board of Medical Examiners to develop a standardized test to ensure medical and other health profession students are proficient in health systems science. The test is expected to be available later in 2019, according to the release.

The AMA says it will continue efforts to improve training to ensure physicians are equipped to succeed in the changing healthcare environment.

To read more, visit MedicalEconomics.com/news

Slideshow spotlight

The 2019 EHR Scorecard

MedicalEconomics.com/EHR

Topic Resource Center

BURNOUT

- The peril of multitasking
- What is moral injury?
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Too much focus on what doctors don’t do well

Regarding the brief article titled “Study: PCPs deficient in recognizing prediabetes” [Medical Economics, October 25 issue]. The summary of this survey tells us that John Hopkins researchers found that primary care physicians lack overall knowledge of risk factors, diagnostic criteria, and recommended prevention practices for prediabetes.

While this is disturbing news, why do I get the feeling that similar findings of primary care physicians’ ignorance would be found in surveys about countless other conditions? Wouldn’t it be refreshing to report that primary care physicians are doing a remarkable job in at least something or other?

Let’s be honest. Medical journals and pharmaceutical advertisers have a common interest not just in keeping physicians reading the articles and the advertisements, but also—for better or worse, in reinforcing doctors’ insecurity in thinking they might not know enough as for surveys with predictably disturbing results to the purchase of mass media space aimed at better educating the public in disease prevention.

“Wouldn’t it be refreshing to report that primary care physicians are doing a remarkable job in at least something or other?”

Dr. Dominika Jegen is right to suggest that in urban areas where a good supply of specialists exists, family doctors may have a limited scope of practice compared to hers—practicing as she does in an underserved area: (“Family physicians manage complex patients every day”, November 10, 2019).

She has my sincere apologies if my comments that family practitioners are limited to treating common illnesses and coordinating care with specialists (“Expanding the roles of NPs and PAs will make primary care more desirable”, September 10, 2019) have offended her.

Treating patients as she does, in the clinic, in the hospital, in nursing homes and veteran homes; treating newborns and octogenarians; and treating patients with gynecologic, pediatric, and mental health problems as well as providing palliative care is truly a Herculean task and deserving of all physicians’ admiration.

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The benefits of texting with patients

By embracing two-way texting as a communication channel for patient engagement, practices can achieve significant improvements throughout their operations. Here are seven ways that practices can benefit immediately from two-way texting.

1. Generate inbound calls. Not every outbound phone call staff members make is answered, but almost every inbound call to a practice during hours of operation is answered. Texting is a great way to inform patients that they need to call the practice. The text can even put the practice’s phone number at their fingertips.

For example, you can send a text to patients letting them know that their insurance has been verified and that they may have a copay, then ask them to call the practice if they need more information.

2. Provide education and support. Two-way texting is an easy way to put relevant information in patients’ hands before or after appointments. Many patients will lose or discard printed information given or mailed to them, but they will likely read and engage with a text.

Remember, smart phones have access to the internet. If you want patients to look at an online video, read appointment-related instructions or go to a portal to view lab results, just include the link in the text.

3. Increase compliance. Two-way texting also is a great way to ask patients if they are complying with medication and/or care protocols. Consider sending the following reminder tasks:

   a. “Have you weighed yourself today?”
   b. “Are you taking your medication as instructed?”
   c. “Have you completed your knee exercise for 15 minutes today?”
   d. “Have you scheduled your follow-up appointment with us?”

If patients reply via text that they are not in compliance with your instructions, staff can reach out and re-engage the patient.

4. Improve online reputation management. Two-way texting is a very effective way to gauge patient satisfaction following an appointment and steer satisfied patients to leave positive reviews about your practice online.

Furthermore, by asking a patient to text back to share their level of satisfaction with an appointment experience, the practice can receive immediate feedback from the patient and can intervene quickly if an experience was unsatisfactory for any reason.

5. Increase top-line revenue. Using texting for appointment-related messages reduces cancellations and no-shows. Not only can you more effectively identify which patients plan to keep their appointment, but staff also can identify patients who need to cancel or reschedule. That gives staff a chance to fill that appointment slot with other patients.

For practices that provide annual visits, texting is a great way to recall patients or remind them about available services, such as annual wellness visits.

6. Improve payment-related communication. Before mailing out letters to patients regarding overdue payments, you can send a polite text reminding them that payment is due. Include a link to an online bill pay website if you offer such a payment mechanism. This approach to securing payment is familiar to most people, since many other industries already use texting for payment prompts, including most major credit cards and many banks.

7. Provide updates concerning local weather-related and other schedule changes. Texting is a fast and efficient way to update patients about relevant changes to their appointment due to a local weather event, power outage, or physician illness. Sending a text to a group of patients letting them know their appointment needs to be delayed or cancelled and asking them to call the practice to reschedule is much easier than picking up the phone and calling every patient on the schedule for that day or multiple days.

Brandon Daniell is president and co-founder of Dialog Health. Send your technology questions to medec@mmhgroup.com
The TOP CHALLENGES facing physicians in 2020

It has never been such a challenging time to be a physician. Every physician, whether they own their own practice or are employed by a hospital or larger health system, must navigate a host of obstacles each and every day: Payment hassles, staffing issues, patient communication obstacles, technology burdens, long hours and burnout, and much more.

Each December, Medical Economics presents its list of the top challenges facing physicians going into the next year. This year we focused not only on the challenges, but also practical tips physicians can start using right away to make practicing easier.

BY MEDICAL ECONOMICS STAFF

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Physicians are increasingly beset by paperwork, administrative hassles and regulatory burdens—and that trend will not abate in 2020. Prior authorizations, quality metrics and other complex challenges are keeping physicians up at night with worry, reducing the time they spend with patients and leading to a surge in physician dissatisfaction.

In August, Medical Economics asked physicians what issues were affecting their career satisfaction, and more than 37 percent said "too much paperwork and government/payer regulations." That was the most common response, ahead of EHRs, poor work-life balance and declining reimbursement.

“What we hear from doctors repeatedly is, ‘I went into healthcare to help people, but I spend my day typing into a computer or on the phone doing prior authorizations, and I feel like my time is being wasted on all of these things instead of focusing on taking care of my patients,'” says Clif Knight, MD, FAAFP, a board member of the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience, a group fighting burnout in healthcare. “And over time doctors lose that connection of why they went into medicine and start wanting to do something else because they feel like they’re just wasting their time.”

These problems lack easy solutions, but there are strategies physicians can use to lessen the burden. One of physicians’ biggest complaints is how much time prior authorization consume in the daily schedule of the practice. According to the Medical Economics 2019 Physician Report, doctors spend nearly an hour per day on prior authorizations, while staff members spend an additional 12 hours per week dealing with payer approvals.

Red tape and hassles also don’t vanish for employed physicians, who often find they are just trading one type of administrative burden for others.

“When you become part of a large system, you’re no longer a self-employed person who can determine their own work or call schedule,” says Robert McLean, MD, FACP, president of the American College of Physicians. “A lot of those little decisions you used to make [as a practice owner], while they could become headaches, they also contribute to the feeling that you’re a self-actualized person, and that gets lost as an employee.”

Administrative burdens

8 ways to ease the prior authorization burden

1. Be prepared
   Have forms available, either in print or on computers, for the procedures and prescriptions that most commonly require prior auths.

2. Use the Web
   Check the payer’s website for any prior auth criteria they have posted, and submit requests using the site rather than by telephone.

3. Make the patient’s records available
   Be sure the staff member submitting the prior auth request has access to the patient’s chart and any other information needed to justify the request.

4. Document the need
   Note in the patient’s chart why they need a particular procedure, medication or exception to the payer’s requirement.

5. Follow guidelines
   Following recommended treatment guidelines increases the likelihood that a payer will approve the request.

6. Learn what drugs payers will cover
   Knowing which medications all your payers cover for common conditions and prescribing them when appropriate reduces the need for authorizations.

7. Centralize the process
   Designate specific staff members to handle prior authorization requests, even if your practice has more than one site. Then make sure those individuals have access to all patient records and providers’ notes.

8. Do a cost-benefit analysis
   Find out how many prior authorizations each of your biggest payers required over the last year and consider dropping any whose reimbursements don’t justify the time.
Getting paid

Treating patients and managing a practice are challenging enough. But for today’s physicians, simply getting paid is often a struggle. It means navigating an increasingly complex reimbursement landscape marked by myriad programs linked to quality metrics and outcomes. It also means seeing that the practice is documenting and coding accurately so as to avoid denials and ensure proper reimbursement levels. Also, more patients have high-deductible health plans, which means practices are often on the hook for collecting from patients.

Here are some tips from experts for meeting these challenges.

FOCUS ON OUTCOMES

Value-based payment is not going away, so even physicians who are still largely reimbursed via fee-for-service need to learn about quality metrics and the various value-based programs created by both public and private payers.

As Medicare continues to move into value-based care and private payers add more incentives focused on outcomes, data becomes increasingly important for a practice’s reimbursement outlook. Physicians in the MIPS program must track and submit information on a dizzying array of measures, and many private payer contracts have similar metrics that require data as their proof point.

If a practice does not have the data to prove patients are achieving desired outcomes, reimbursement can take a substantial hit—up to 9 percent just from MIPS by 2022. Combine this with private payer contracts that continue to incentivize value-based outcomes, and a substantial part of practice reimbursement could be endangered by a lack of performance data, experts say.

“Carriers are doing deals that gener-

How to avoid E/M denials

1 **Ensure the E/M code supports the specific patient encounter.**

Not every patient with a chronic condition will justify reporting CPT code 99213. Some cases may be exacerbated and/or require medication management and referrals to specialists while others may be relatively straightforward and controlled.

2 **Refer to the E/M guidelines.**

Assigning an E/M code is not a subjective process. Instead, physicians should refer to the 1995 or 1997 E/M guidelines for specific requirements for time-based billing as well as billing based on the three key components: history, exam, and medical decision-making. The most common mistake physicians make when applying these guidelines is under-documenting E/M level 4 and 5 visits for new patients. More specifically, they omit one or more systems in the requisite general multi-system exam or they omit a complete past family and social history.

3 **Be cautious with copy and paste functionality.**

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

4 **Watch out for pre-populated EHR templates.**

Pre-populated templates not only cause up-coding (e.g., if certain body systems are always indicated as having been reviewed even when they’re not relevant to the current encounter), they can also lead to contradictions that raise red flags with payers. For example, if a physician diagnoses a patient with strep throat, and the template defaults to a normal exam for ear, nose, and throat, it could open the door for a post-payment audit. Physicians should ensure their documentation is aligned with the patient’s diagnosis even if it means manually unchecking certain boxes in the template.
ally reward physicians in value-based contracts, but minimize reimburse-ment increases if they are not involved in value-based benefits,” says Ken Gou-let, former executive vice president of Anthem Inc. and current board mem-ber at OODA Health, which focuses on streamlining interactions between payers and providers.

Goulet says that while the fee-for-service model won’t be completely eliminated, doctors will see diminishing reimbursements from it in 2020 and beyond.

**CHANGES COMING IN 2021**
This looks to be a transition year for payments, as many programs and changes expected to go into effect in 2020 have been delayed until 2021. These include new CMS-created primary care models and a streamlining of evaluation and management level-of-care coding.

In October, CMS announced that its newest alternative payment model, Primary Care First, has been delayed until January 2021. Primary Care First is geared toward primary care practices that are ready to accept financial risk (i.e., payment reduction for missing quality goals) in exchange for more flexibility, increased transparency, and performance-based payments that re-ward participants for outcomes.

In addition, CMS will provide higher-than-historical Medicare fee-for-ser-vice payments for practices that care for complex, chronically ill patients.

In terms of E/M changes, CMS is:
- Reducing from five to four the number of levels for office/outpatient E/M visits for new patients
- Revising the code definitions
- Changing the times and medical deci-sion-making process for all the codes,
- Requiring performance of history and exam only as medically appropriate, and
- Allowing clinicians to choose the E/M visit level based on either medical deci-sion-making or time.

**Increased competition**

Will the quest for patient convenience kill the traditional medicine practice?

In the past, a handful of Saturday appointments was about the only con-venience patients expected from their doctor. But patients are now demanding the same conveniences from practices that they get from restaurants or retailers. If they don’t get these conveniences, they will find another doctor.

And patients have a growing number of options for obtaining medical care. Hospitals and retail pharmacies are investing in convenient care clinics where patients can be seen even for acute issues. There are more urgent care centers across the country and they are increasingly being used for primary care by younger and uninsured patients.

“If practices don’t adapt, they will see patients slowly migrate elsewhere,” says Susanne Madden, MBA, president and CEO of The Verden Group, a Nyack, NY-based health-care consulting firm.

Madden says if practices want to survive, they need to cater to consumer behaviors, even if there are no other doctors nearby. “Some rural doctors might get patients not because they are amazing doctors, but because there aren’t many options,” she says. “But the day a competitor moves into town with a higher level of care access and com-munication, they’ll be out of business. They need to up their game.”

“If practices don’t adapt, they will see patients slowly migrate elsewhere. . . .The day a competitor moves into town with a higher level of care access and communication, they’ll be out of business. They need to up their game.”

—SUSANNE MADDEN, MBA, THE VERDEN GROUP, NYACK, N.Y.
Competition is coming from retail clinics and urgent care facilities as much as other medical practices, experts say. The corporations backing them often have the funds and expertise to give consumers exactly what they want and redefine what an appointment with a doctor looks like.

Take GoHealth Urgent Care, of Atlanta, for example. Backed by private equity, its mission is to “redefine the healthcare experience.” It has 125 centers and is opening 30 more in the next year.

GoHealth partners with local health systems and builds facilities they say are based on convenience. Patients can compare wait times for GoHealth facilities online, make an appointment at the one with the shortest wait, and upon arrival, check-in via kiosk. Office designs are bright and open, and patients enter exam rooms where high-tech electrostatic glass walls change from clear to frosted for privacy. All equipment is either in the room or brought to the patient, so no moving about the office if, say, an x-ray is needed. Wall-mounted screens show the patient what the doctor is looking at and entering into the health record, and there is no checkout when the patient is finished—they just leave.

“We compare ourselves to a restaurant, where consumers will not return after one or two poor experiences,” Dev Ashish, CIO of GoHealth, said at HIMSS19, an annual health IT convention. “The same rules apply to healthcare.”

Conveniences patients expect from today’s medical practices

**Easy online appointment-setting**
Patients can order anything from a book to a mattress at any time with a few clicks on their smartphone. They don’t want to spend 15 minutes on hold to make an appointment. Practices need to offer online scheduling to make it easier for patients to book appointments.

**Streamlined paperwork**
Today’s patient expects a smooth and easy visit. The more forms that can be filled out electronically and in advance of an appointment, the better. No one wants to sit in a waiting room filling out forms on a clipboard that could easily have been done the night before. Checkout should be just as easy, with little to no time spent standing in line. Any prescriptions or follow-up appointments should be as automated as possible.

**Minimized wait times**
Patients expect the doctor to see them within about 15 minutes of their appointment time. They have little tolerance in their own busy schedules for physicians who run late or overbook. To minimize the problem, consider implementing a system that texts patients updates on wait times, allowing them to adjust their arrival to reflect the doctor’s current schedule.

**Quick responses to questions**
Patients expect a response to questions posed via email or an EHR portal in 24 hours or less. This timeframe is basic business protocol established by the retail and service industry, and medical practices must embrace it as well. They also expect lab results to be posted online or emailed to them for easy viewing.

**Updated waiting rooms**
Free Wi-Fi, coffee, and water are the minimum. A modern design with comfortable furniture and natural lighting will put patients at ease and make them feel valued. A dingy room plastered with warnings and payment notices isn’t exactly customer-friendly.

**Transparent pricing**
Patients expect guidance on how much services will cost, what will be covered by their insurance and what will not. If a referral is made, the patient should be informed whether it will be in-network or out of network. Any bill sent by the office (or better yet, presented online), should be easy to read and understand.

**Availability**
Patients don’t get sick only during business hours, and offering a few Saturday appointments no longer caters to their busy lifestyles. With urgent care and retail clinics offering extended hours daily, if a practice doesn’t adapt its schedule to its patients, they’ll get their care from a place that does.
EHR usability and interoperability

EHRs remain a significant challenge for physicians, and that shows no signs of changing in 2020. The problems of clunky EHR interfaces and lack of seamless communication between systems are deep-rooted and complex. The result is products that are expensive and, as a growing body of research indicates, contribute to physician burnout and worse health outcomes for patients.

"I’m not surprised at all the physicians find the EHR is not complementary to the care of their patients, and have difficulty in their use," says Andrew Pecora, MD, CEO of Outcomes Matter Innovations, and chairman and founder of COTA Healthcare.

Pecora spoke recently with Medical Economics about the problems with EHRs.

Q: Medical Economics: EHRs were supposed to transform healthcare. But many doctors would say they’ve caused more problems than they fixed. What went wrong? Pecora: EHRs were built to be billing systems. They were built to look at the content of a note, not to care for patients. And that really hasn’t changed. That’s not an absolute statement, because there are now changes being made. But they’re not user-friendly. They’re not intuitive. They don’t complement the way the doctor thinks or approaches seeing a patient, examining a patient, and making a clinical decision on how best to treat the patient. So really, it’s just another thing to do, whereas they used to just write a note.

Q: Medical Economics: How would you assess the state of EHRs today? Pecora: I think EHR vendors in general understand there needs to be an EHR 2.0, that the versions that were built to support billing and coding are a necessary platform but nowhere near sufficient. And when you look at the content and information technology now, we’re talking about machine learning and artificial intelligence, there needs to be add-ons that make the note much more intuitive to the doctor, particularly when it’s doctors in a specialty with decision support with real time analytics to help make a decision that’s best for the patient. Also, there’s way more we can do to make note writing itself easier for the doctors. We pay physicians to make a good decision for their patient. And that has to be the emphasis. Physicians feel like they’ve become glorified note-keepers, and the value of the service they provide has been diminished.

Q: Medical Economics: When physicians say they want usable systems, what are they actually looking for? What capabilities do they need to succeed? Pecora: Well, the biggest enemy to a doctor is time. Patients and physicians both complain that not enough time is spent face-to-face, hands on the patient, sitting there talking to the patient about not just their illness of the moment, but how their life is going. That empathy is so important to being a doctor. Instead, all of that time is sitting by the computer, making sure you get your 10 elements of this note and 15 elements of that note. That should be automated. There is no good purpose for a doctor wasting their time typing or dictating stuff that should just be automated, and a doctor shouldn’t be penalized for that.

Q: Medical Economics: Physicians regularly point to EHRs as a contributor to physician burnout and career dissatisfaction. How did we get here? Pecora: Fundamentally, physicians went into the practice of medicine to care for their patients, not to write notes. Right now the emphasis is on writing the note and less on caring for the patient. It is because the number of patients per hour a doctor needs to see given what has happened to reimbursement has gone up. And the amount of documentation necessary to have the coding for a proper bill has gone up. So when you look at those two things, what has been sacrificed? What has been sacrificed is the very reason doctors went into medicine; the time they get to spend in a caring environment with their patients. That’s been taken away.
Caring for yourself

Physicians are caregivers by nature. But many neglect to care for themselves. Physician burnout is one of the most pressing challenges facing medicine, and there are many reasons for it. But one cause of burnout, many physicians argue, is that they are trained to focus exclusively on the needs of patients. The unintended consequence of this is that physicians neglect themselves, says Rebekah Bernard, MD, a physician and author. That leads to stress, burnout and even a lack of empathy for patients—all of which run counter to the goal of focusing on patients’ needs above all else.

“This starts in medical training, Bernard says. “The message: Patient needs come first. Doctors’ needs are a mere inconvenience, something to be ignored and overcome,” she says.

In order to provide the type of care that patients deserve, physicians must prioritize their own needs, says Geni Abraham, MD, an internist and wellness expert. “We’ve got to get back to the fundamentals of personal healthcare,” 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:

**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 food, rather than gulping it down as if they 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. Schedule and plan meals with family and friends, rather than eating over the sink or in your car.

**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.” But while physicians understand the benefits of exercise, often the challenge is finding the time to do it.

Even if you can only do 10 or 15 minutes, schedule that time into your week and make it non-negotiable. For physicians strapped for time, consider an exercise that can be done quickly at home, Abraham advises.

**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 sleep 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, she recommends practicing mindful meditation or deep breathing exercises.

**NONTOXIC RELATIONSHIPS**

Physicians need support from family, friends, and colleagues. They need to take the time to nurture those relationships by scheduling activities, like date-night with your spouse and lunch with a colleague. Show up for medical society meetings and physician socials. Knowing that we are all dealing with similar issues can provide a great deal of support.

**MINDFUL SELF-COMPASSION**

Abraham suggests that physicians pay attention to how they talk to themselves. She reminds us that humans are wired to pay more attention to negative thoughts than to positive ones, and that we need to practice and work to counteract negativity in our lives. “It takes five positive thoughts to overcome one negative thought,” she says. One way to achieve mindful self-compassion is to keep a journal of emotions, and to take a moment at the end of each day to focus on the things that went well.
The threat of a medical malpractice lawsuit is one of the issues all physicians worry about. And it’s not an overblown threat. Studies from the AMA and others have found that about half of all physicians will face a malpractice suit at some point in their career. But despite those odds, being sued is not inevitable.

In fact, malpractice experts say that there are practical steps physicians can take to prevent lawsuits. They boil down to building meaningful relationships with patients in which communication is open and honest—and documented clearly and comprehensively.

“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,” says Fred Cummings, JD, a malpractice attorney with Dickinson Wright in Phoenix, Ariz.

Despite the time constraints involved in practicing medicine today, building trusting relationships is vital, says Darrell Ranum, JD, vice president of patient safety and risk management for The Doctors Company, a medical malpractice insurer. Ranum says that patients who trust and communicate well with their doctor are more likely to adhere to a medication regimen and obtain recommended follow-up tests and procedures.

The Doctors Company has done extensive research on malpractice claims, and their data show that one of the key factors in 21 percent of malpractice claims is a lack of communication between the patient and their family and the physician, Ranum says. That includes both verbal and written communication.

A physician’s advice for avoiding a lawsuit

Internist George G. Ellis, Jr, MD, has spent time reviewing medical malpractice cases as a consultant. Based on his experience as a practicing physician and reviewing these cases, here are five tips for avoiding a malpractice suit.

1. Document, document, document
   If it isn’t documented, it wasn’t done and there is no going back once that note is closed. So dot your I’s and cross your T’s before you move on to another note. Make sure your documentation is complete and accurate. Avoid cloning notes (i.e. “copy and paste”). It will get you into trouble every time.

2. Review medications
   Do this even if your nurse or medical assistant reviews them. I find more mistakes in the medication section than anywhere else in the medical record. Especially review medications for drug interactions.

3. Follow up on tests
   I set alarms for test orders. If after a week I don’t see that the test is done, I start to make phone calls looking for test results or if the patient actually had the test done.

4. Be humble and compassionate
   If you are wrong, apologize to the patient and be sure it is clear what you are apologizing for. There is a big difference between being sorry out of sympathy for spotting something negative in a test and apologizing because you made an error.

5. Subtle symptoms warrant investigation
   Investigate, investigate and investigate some more. If a patient has a persistent symptom, check all the possible causes and don’t give up. Not only will this prevent litigation, it’s what patients expect of us.
Millions of Americans suffer from complex chronic conditions, which harms their quality of life and shortens their life expectancy while adding costs to the U.S. healthcare system, already the most expensive in the world.

Complex chronic conditions—such as diabetes, obesity, and other cardiometabolic disorders—are at the root of this problem, and often involve difficult treatment regimens that include medication and lifestyle changes. Treatment of these conditions typically falls to busy primary care physicians, who don’t have enough time to provide these patients with the counseling and life coaching that treating these conditions often requires. At the same time, physicians are financially judged on the health outcomes of these patients, leaving physicians in a bind.

At the heart of many of these chronic conditions is obesity. An estimated 39.8 percent of U.S. adults over 20 are obese, with another 31.8 percent considered overweight, according to the 2015-2016 National Health and Nutrition Examination Survey. Obesity increases the risk for many medical issues, including hypertension, diabetes, sleep apnea, cardiac disease, arthritis, hyperlipidemia, and certain cancers. The U.S. spends approximately $190 billion annually, or 21 percent of healthcare dollars, on obesity and related conditions.

“We need to start treating the largest disease in our country, as all other health issues go along with it,” says Craig Primack, MD, co-founder of the Scottsdale Weight Loss Center in Arizona.

What can physicians do to better engage these patients and encourage them to take control of their health? One popular technique is motivational interviewing, which allows physicians to learn what’s going on in their patients’ lives, what motivates them, and other factors. This can help physicians tailor their approach to each patient and find the triggers that motivate that individual, says Damara Gutnick, MD, an internist and the medical director of the Montefiore Hudson Valley Collaborative.

Gutnick uses the acronym CAPE to explain the basics of motivational interviewing:

**COMPASSION.** The entire interaction is driven by the best interest of the patient.

**ACCEPTANCE AND RESPECTING AUTONOMY.** Individuals have the right to change or not change, says Gutnick. “If somebody is not ready, you respect that and you don’t push. You might use some skills to try to guide them toward change, but if you’re hearing a lot of resistance and you have four patients waiting, you don’t push [during] that visit,” she says.

**PARTNERSHIP.** The physician is not telling the patient what to do. Instead, “You’re helping the patient move toward change, but you’re equals,” Gutnick says.

**EVOCATION.** This means pulling ideas for change out of the patient. “As a doctor, I know a lot of reasons why you should quit smoking, but only you know what’s most important to you,” Gutnick says. This mindset can help neutralize patients’ natural reflex to come up with reasons to not do something when it comes in the form of “doctor’s orders.”

“The challenge for physicians and patients is that both need to change their behavior. “Any behavior change is really hard,” Gutnick says. “People might have the desire, but if you don’t have the milieu that allows you to try it, then it’s going to be very hard to implement.”

—DAMARA GUTNICK, MD, INTERNIST, MEDICAL DIRECTOR, MONTEFIORE HUDSON VALLEY COLLABORATIVE
Cybersecurity

More than 32 million patient records were breached in the first half of 2019, and hackers were the culprit in more than half of those incidents, according to the Proteus Breach Barometer.

This threat will not go away in 2020—hackers covet the rich personal data contained in medical records. And while massive hacks of hospitals, payers, and other large corporations get the most news, even the smallest practices are targeted with impunity. More than 83 percent of physician practices report that they have experienced some form of a cyberattack, including phishing, hacking, and even employee theft of electronic protected health information, according to a 2018 study from the American Medical Association and Accenture.

One of the biggest cybersecurity mistakes a practice can make is to assume it won’t be a target because it is too small or has nothing of value, says Kevin Johnson, CEO of Secure Ideas, a Jacksonville, Fla.-based security consulting firm. “Hackers are not going after you specifically, they are going after everybody,” Johnson says. “They target large numbers of victims, because it doesn’t take much more effort to send out millions of attacks versus a hundred, because it is all automated.”

The result is that many physicians feel helpless to defend against a hack, and just keep their fingers crossed that they won’t fall victim. But that’s the wrong mentality, cybersecurity experts say, because there are steps that practices can take to minimize their risks. They include conducting a thorough risk assessment and building a rigorous staff training program.

**RISK ASSESSMENT**

The best way to identify a practice’s key vulnerabilities is by conducting a baseline risk assessment. It’s mandated by HIPAA, and security experts advise conducting such an analysis each year. The analysis both helps a practice learn its vulnerabilities and mitigates financial risk if the practice does experience a breach. The risk assessment is the first thing HIPAA investigators will ask about if a breach occurs, and without one, the financial penalties can be severe, says Matthew Fisher, JD, a partner with Mirick, O’Connell, DeMallie & Lougee LLP, in Massachusetts.

**STAFF TRAINING PROGRAM**

A risk assessment can also provide data on what the practice should focus on in terms of staff training. The truth is that many breaches result from mistakes made within the practice, says Michael Yamamoto, chief information security officer for Beth Israel Deaconess Medical Center in Boston. “The human component is the most difficult to secure,” he says.

Yamamoto recommends that healthcare organizations of all sizes focus cybersecurity training around the basics of everyday work life. “Fundamentally, a lot of security comes down to people’s passwords,” he says. “If somebody gets that password, they’re in.”

Physicians must take cybersecurity training seriously and make sure they keep their knowledge up to date. To keep hackers at bay, Yamamoto recommends using passwords with at least 12 characters, and different passwords for every place a user logs in. Multi-factor authentication should be used wherever possible.

Each practice should develop a protocol that addresses how it will respond to incidents and who should—and shouldn’t—have access to protected health information. It should also include how the practice will encrypt data.

“You have to think more generally about how you, as a physician, are protecting your most important business asset: your practice data.”

—ROBERT TENNANT, DIRECTOR OF HEALTH INFORMATION TECHNOLOGY POLICY, MGMA

MedicalEconomics.com
Physicians need good contracts to survive in practice today. Whether its contracts with payers or an employment contract, many physicians do not negotiate the way they should, or sometimes even know what’s negotiable and what’s not.

Here are tips for physicians to improve their contract negotiation skills in 2020.

**PAYER CONTRACTS**

Commercial payers don’t automatically reward physicians for being loyal members of their networks. Physicians need to ask for higher payment rates, says Marcia Brauchler, MPH, CPC, president and founder of Physicians’ Ally Inc., a healthcare consulting company in Littleton, Colo.

Brauchler provides these five suggestions to help practices negotiate more favorable commercial payer contracts:

1. **FOCUS ON PAYERS THAT CONSISTENTLY PAY BELOW THE MEDICARE FEE SCHEDULE AMOUNT.**
   
   Have some commercial payment rates remained the same over time despite increases in the Medicare fee schedule?
   
   If so, this could be leverage for negotiating higher payment rates, says Brauchler, who poses this hypothetical question: If a payer paid 100 percent of Medicare five years ago, why wouldn’t it pay 100 percent today when that rate is higher?
   
   “If you were worth it then, why aren’t you worth it today?” she says.
   
   “Letting contracts live in perpetuity without negotiating year over year ends up costing your practice.”

2. **CREATE A VALUE PROPOSITION.**
   
   Has your practice opened an addi-
CONTRACTING MISTAKE

THE MOST COMMON CONTRACTING MISTAKE

As more physicians become employed, learning how to successfully negotiate an employment contract becomes a crucial skill to learn. But many physicians don’t negotiate, and just sign what’s put in front of them, says Michael S. Sinha, MD, JD, a Fellow at the Harvard-MIT Center for Regulatory Science.

EMPLOYMENT CONTRACTS

As more physicians become employed, learning how to successfully negotiate an employment contract becomes a crucial skill to learn. But many physicians don’t negotiate, and just sign what’s put in front of them, says Michael S. Sinha, MD, JD, a Fellow at the Harvard-MIT Center for Regulatory Science.

THE MOST COMMON CONTRACTING MISTAKE

Often, physicians will eagerly sign a binding letter of intent or agree to terms of a contract with little or no negotiation—in some cases, they aren’t even aware of what can be negotiated.

GET PROFESSIONAL HELP
Consult a healthcare lawyer early in the process. Find someone who specializes in physician employment contracts in that state. They will have a lot more insight as to what can, and should, be negotiated. "If you don’t negotiate, you’re only cheating yourself," Sinha says.

KEY CONTRACT AREAS TO FOCUS ON

These include:

1. Clearly define the duties and responsibilities in the contract.
2. Get any promises that are important to you in writing. Only when those details have been hammered out can you get an estimate of your true market value.
3. Determine the salary structure that works best for you. Perhaps you have a lot of administrative responsibilities that would cut into meeting pre-defined relative value unit (RVU) thresholds—this may mean you’ll miss out on bonuses under an incentive-based contract, and a fixed salary would make more sense.
4. Flexibility and vacation time may also be up for negotiation, but at the expense of your base pay. Here, an incentive-based contract may mean that, as long as you’ve hit appropriate metrics, you’ll have more time off with no salary repercussions.
5. Be sure that you have access to the performance reviews or quality metrics that are being used to determine bonuses.

WHAT TO KNOW ABOUT NON-COMPETES

State-level legal expertise is particularly important here, Sinha says. An attorney should know the standard for a particular area and can push for compromises in duration and geographic distance.

"That distance can be very important," Sinha says. "For instance, a 20-mile restrictive covenant may be reasonable in rural Tennessee but would be unreasonable in New York City. Negotiate favorable terms for a restrictive covenant prior to signing the contract; if you don’t, disputes over restrictive covenants could take years and several thousand dollars in litigation fees to resolve."

OVERLOOKED ITEMS

Don’t forget to negotiate student loan repayment, Sinha says. Some newly-minted physicians are coming out of residency with $200,000 to $300,000 in student loan debt. There are usually ways to get the hospital to pay some of it off. They may be reluctant to pay a lump sum directly to you, but may be happy to write a check straight to the lender. They’re also less likely to pay any of it up front, but may agree to annual installments, payable after each year of service.
Hiring quality clinical staff

Physician practices need non-physician clinical staff to grow, implement team-based care, and achieve success with quality metrics.

But it’s often extremely difficult for practices to find talented clinical staff, because such individuals often choose to work at larger practices health systems. Experts say it’s often difficult to compete on pay and benefits.

“At a small practice, there’s only so much money that can be spent on compensation, so they have to consider the types of the benefits they can offer, like flexibility and work-life balance. ’Those are big perks that money can’t buy,” says Jillian Schneider, MHA, manager of practice support at the American College of Physicians.

It’s also important to make sure your clinical staff have a chance to grow professionally.

“Not all employees are interested in doing the same job forever; many people are aiming to progress,” says Laurie Morgan, MBA, a practice management consultant and partner at the practice management consulting firm Capko & Morgan. “Enabling employees to pursue more education conveys that your practice is investing in your staff.”

Adding clinical staff can relieve physician burdens and help alleviate feelings of burnout. Medical assistants (MAs) 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, says Marie Brown, MD, MACP, an internist at Rush University Medical Center in Chicago.

According to the Bureau of Labor Statistics, the median wage for a medical assistant in 2018 was about $16 per hour, or $33,610 per year. There were more than 634,000 MAs employed in 2016, with job growth expected to increase by 29 percent over the next decade.

Practices looking to hire MAs should consider each candidate’s education and certification, as well as past medical and administrative work experience. Getting a good read on a prospective hire’s interpersonal skills are key to understanding 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 include:

- Prevention outreach specialist or panel manager—identifies patients with care gaps and communicates with them to encourage adherence to recommended care plans;
- 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.
Tips for hiring clinical staff

**Target the talent**
To attract physicians, independent practices should search for candidates who come from rural areas and are therefore likely familiar with life in those areas, the sense of community they often have and perhaps even how healthcare practices in those areas operate. Practices should use professional networks, medical schools or physician associations to identify clinicians who fit that profile.

**Train future doctors**
Independent practices also should work with medical schools or regional medical associates to attract potential candidates. Reach out and offer the opportunity for students to learn about small-practice medicine, rural medicine, and form a program that exposes them to this environment.

**Budget for competitive compensation**
An attractive compensation package includes a competitive salary and standard benefits, such as health and dental insurance as well as paid time off for vacations, sick days, and bereavement. Small and independent practices don’t often have the money to fund a new position as soon as they recognize the need for more staff, so plan strategically to start budgeting for new positions a year or two in advance of recruiting and hiring.

**Think creatively**
While salary is important, small practices can also attract and retain staff by structuring compensation to reward hard work or finding other ways to boost the total compensation package. Consider creating bonuses for clinicians who meet productivity goals, or establish an employee profit-sharing program.

**Offer growth opportunities**
Practices should determine ways for their physicians, non-physician providers, and support staffers to grow professionally. Enabling employees to pursue more education conveys that your practice is investing in the staff, and can save the practice money in the long run. The cost of the training plus a raise and promotion for the employee could be less than the salary you’d wind up paying an external hire. Don’t forget to use professional development opportunities as a recruitment tool.

**Formalize it**
Although management consultants say small, independent practices should use individualized employment packages as a way to recruit and retain top talent, they advise practice owners to have policies and procedures in place to establish available benefits so that even if employment packages are individualized, they won’t seem capricious. Practice owners who want to recruit and retain skilled professionals need to focus on being good employers—not just good healthcare providers.
PRACTICAL MATTERS

6 ways to motivate your practice team

When it comes to motivating employees, money isn’t everything. Sure, people have to make enough money to pay their bills. But when getting them to put in additional effort for the team, it takes more than a good paycheck.

Fortunately, the best motivators often are relatively easy, inexpensive, and can be a whole lot of fun. Try a few of these ideas at your practice, and see if your team is more willing to go the extra mile.

Name names
It might seem obvious, but many leaders miss it: Know everyone’s name.

“One of the best ways to have a motivated team is when the doctor knows everyone’s name, and says thank you,” says Elizabeth Woodcock, president of Woodcock and Associates, an Atlanta-based physician practice consulting firm.

Stay on mission
“Make sure your team is aware of the mission,” says Cristy Good, CMPE, Senior Industry Advisor at MGMA. “When I worked in a pediatric organization, everyone was dedicated to the mission: making kids better.”

When your team is aware of the larger goal that their work is a part of, they’ll feel an investment in the organization and have a reason to work hard to achieve that organization’s goals.

Pat backs
When your employees do a good job, make sure they know that you know.

“In my experience,” says Good, “nurses, front desk, staff, and back office staff really respond well to being recognized.” You can acknowledge the work of a team or point out individuals who’ve gone above and beyond. Just make sure the message gets through. Don’t assume they know you value them.

Be specific
Acknowledging a job well done is most effective when the acknowledgment is specific.

“I spoke with a doctor recently,” Woodcock recalls, “who went to his scheduler and said, ‘Mr. Jones (not his real name), because you were able to get this patient in today, he will not have to go to the hospital. You helped give excellent care.’” This not only recognized the employee for his work, it recognized his role in the organization and its mission. “This is very powerful,” says Woodcock.

Not just the boss
It’s great to be recognized by the boss, but Good points out that the practice shouldn’t stop at the top.

“Encourage employees to recognize, thank, and support each other,” she says. “Build that culture of support and kindness.”

Have fun
“Work culture is important,” says Woodcock. “People want to work at a place that’s fun.” It’s easier than you might think to make your practice a fun place to work. Good suggests offering simple amenities, such as free snacks and pleasant break rooms. Holiday parties are also a great way to build a welcoming office culture, Good says.

Woodcock suggests things like participating in charity events as an office, having a crazy sweater day, or a dinner swap. “I love this one,” says Woodcock. “Everyone brings a favorite covered dish to trade with another employee. Everyone takes home a ready-made dinner—that someone else cooked for them.” If you try, you can probably think of dozens of fun ideas to boost office culture. “It’s a good idea,” Good says, “to let employees take the lead on this; let them develop their own culture.”

Avery Hurt is a contributing author. Send your practice management questions to medec@mnhgroup.com.

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Recently, I worked with two different physicians who faced termination scenarios. In both instances, my clients were terminated without cause while being compensated based on production and were not permitted to work during the notice period. Many physicians are compensated based on pure production, while others may have a base salary plus some type of bonus based on production. When reviewing a physician contract—or drafting it—there are some key issues to take into account concerning the relationship between productivity compensation and termination.

Although we like to think that both physician and employer will continue to meet their obligations during a notice period, some employers may not be willing to work, perhaps because they wish to reallocate patients, resources, etc. or perhaps for less business-related reasons. However, it is important to understand that during a notice period, the physician is still employed and his or her compensation formula and/or productivity bonus formula is dependent on production.

As a result, not allowing a physician to work during a notice period can cause significant financial harm to the physician. Moreover, during a notice period, the physician also likely cannot work elsewhere due to exclusivity, non-compete and similar provisions.

To address this issue, some contracts will properly include language that states the physician will be paid the same average compensation that the physician was paid in the 90-day period prior to the date the notice period started to run.

Other alternatives might include an average of monthly compensation over the past 12 months, a per diem rate based on the physician’s average production, etc. No matter what approach is used, some mutually agreeable and fair compromise is appropriate.

Unfortunately, contract drafting sometimes can be rather sloppy. Indicating the physician will “continue to receive compensation” does not address the issue. Similarly, stating the physician will continue to be paid “draw” during the notice period is not ideal. Often, a physician’s contract sets a fixed amount called a “draw” which is then reconciled against actual productivity, quarterly or annually, resulting in bonus being paid to the physician when they exceed the “draw.”

Most physicians set their draw fairly low so as not to “overdraw” and be in a deficit situation. When a contract only allows a physician to be paid “draw” during a notice period, this can substantially reduce the compensation the physician could have earned had he or she been allowed to work.

While some employers make it clear a physician is not permitted to work during a notice period, others pretend the physician is welcome to work, while simultaneously sabotaging them. In my recent situation, the employer reassigned patients asking for my client by telling them he was unavailable, retired or planned to leave. Referral sources were told the physician was leaving and referrals needed to go to other physicians. Staff was reassigned away from my client making it hard for him to perform, and his patient’s calls went unanswered and unreturned, causing damage to his reputation.

Most contracts do not go into enough detail to make these clear breaches and the physician’s claims are quickly dismissed. This can be a tough situation to address in a contract, but requiring that both parties continue to perform their normal duties and prohibiting a change in patient and employee assignments during the notice period can help with this situation and allow the physician to be productive.

It’s essential that the employment contract clarify that financial documentation regarding all amounts billed and collected (or RVUs performed) be shared with the physician.
Learning how to listen

BY RACHEL FLEISHMAN, MD

T
here is a point of tension unearthed in the care of a critically ill infant. A visceral, know-it-when-you-see-it feeling that medicine has crossed a line. Textbooks speak of finding balance between fighting diseases to prolong meaningful life and promoting human suffering to preserve the sanctity of life. Within this teeter-totter is the nuanced beauty of neonatology, the raw honesty with which we counsel families. One of the hardest lessons in medicine is that you never can know how things will work out. We don’t always agree: every doctor feels the weight of this ethical seesaw differently. Even harder is learning, really learning, that your own ethical balance, your own vision of humanity, must fall into stride with the beliefs and desires of the parents you counsel.

I remember my first stint in the NICU. A universe where we examined stomach juice in syringes and mucus-tinged, stool-stained diapers by flashlight in the night. There, mixed in between the growing and the gaining, was a baby who lived to have needles jabbed through the muscles between her ribs daily, draining pockets of murky fluid. Chronically high settings on her ventilator hammered the air in to her chest. The pain of every procedure, every day, took its toll on the team. Nurses begged not to care for her. Senior residents pushed the attending to let nature win out. The daily burden of her life felt cruel to me.

This baby’s mother was alone, her husband in Afghanistan or Iraq. The distinction was important at the time but now, all these years later, I only remember that he was at war. She was a brand-new mother, fighting on behalf of her daughter. She drove an hour to visit, often coming at night to avoid the data of daytime. I remember how the attending would sit beside her, chairs nestled alongside the incubator, and emphasize the graphic and painful details of the daily needle sticks.

I remember my internal compass pushing for this mother to just understand her daughter’s reality as I saw it. Each time an attending brought up taking a different, more compassionate path forward, the mother shut it down. She was taking her baby home, she would say. Concretely. And she’d unlatch the flaps that covered the portholes into the incubator and put a hand on her daughter’s head, gently stroking it. I imagine...
her singing in my memory but cannot say whether or not she did. She taught me, then, about hope.

The baby grew, although she did not improve. Each needle left space to inhale. Her father took a brief leave from his service to meet her and we forced him to face a different type of war. The war in our NICU was about the pain of surviving; how much can one tiny baby endure. The pain of needles seemed farcical compared with the pain of severed limbs and shrapnel removal. He was a father; his daughter was a fighter.

I learned that the point of my own compass had to yield to the directions of this infant’s parents. I watched as the team shifted rhetoric to fight with them, to fight for her. We championed the sanctity of life, of family, of survival. We moved her from one hospital to the other. She went from a room with five other babies who all, eventually, went home bottle feeding, to her own hospital room. We cut a hole in her neck once we stopped piercing holes in her sides. Her mother moved from the military base to that room, her days measured by suctioning secretions and pausing alarms. She had no family nearby. No friends came.

Contrary to so many cases that haunt me, this baby did not die. At least, not then. Almost a year after her birth, weaned from needle sticks, with a machine pumping life through a tube in her neck, she went home. She could not smile. She could not sit. Her eyes disorganized in their movements. Child life specialists hung balloons of pink foil from her crib. Her father had come home from war. We had done everything to send this child home, to form a family. Everything. And I had learned the discomfort that comes without paternalism.

Many years later, this time as the attending, I met with a woman several months after the death of her son to review his autopsy. I had done this only a few times before. His mother arrived disheveled, teeth and hair chronically un-brushed. She had gone to his birth hospital just that morning looking for a blue bear she remembered from his time there. It had long been thrown out. She let out a slow trickle of tears. She wanted an answer. Not about his cause of death, but about why this had all befallen her.

This woman taught me about life after the death of a child. The odor of mildew and sweat; she showed me the pervasive despair of waking up every day knowing that you have outlived your offspring. The lost promise of fresh powder-scented diapers and curdled milk and the soft snuggle of heavy head against chest rocking in the grey shadow of night.

We went through his autopsy, and the story of his life. We talked about his heart. The problem, cardiomyopathy, is often genetic. We drew pictures. I implored her to see a geneticist, to have testing done on herself, to learn if this could happen to another one of her children, should she have more. Wallowing in her grief, however, made her feel close to her son. An end to grieving perhaps meant that he was really gone.

I left after the autopsy review thinking of the military mother from years prior, whose daughter would have been a teenager by then if she were still alive. With her life we abated the ache of a loss that never heals. I left this meeting understanding, truly, for the first time how women whose children die will wake up in the middle of the night, pining over the loss of their children, forever.

Compassion is taught to medical students in concrete actions. Sit down, eye contact, talk less, pause, recap. Touch a hand. Cry if you need to. As if these boxes can be checked off, one by one, toward reward. Gravitating toward death, toward social suffering, is a choice. Inserting yourself in the vacuum of need. Listening, truly listening, to find the balance between the meaning and the suffering. And accepting that the teeter-totter may not always tip your way; these are lessons never conquered, but I am learning, daily, how to listen.
At first blush, the shift from volume to value appears progressive, thoughtful and even prescriptive for a healthcare system burdened with treating too many patients in too little time at too high a cost. But appearances can be deceiving, and you don’t need to dig too deeply to uncover the drawbacks of mandated value-based care, and why real value may be found in a much simpler way.

The original intent was sound, aimed at fulfilling the quadruple aim of healthcare and rewarding physicians with incentive payments for quality of care versus quantity of services.

However, the nature of many value-based care models appears to be more about value to the insurer, the employer and the hospital. The physician and patient, who rightfully should be at the forefront, may be at the very end of this line.

The term “value” itself has different meanings to all involved in healthcare, naturally viewed through each individual lens. Patients value compassionate care that decreases suffering and pain and is available at their convenience with minimal out-of-pocket expenses, while payers define value as overall population health at the lowest cost possible. Agreeing on a common value proposition for healthcare becomes almost impossible to achieve, given the diverse goals—quality, service, cost, outcomes, access—of its main stakeholders.

Even the question of who bears primary responsibility for a patient’s health improving is one without consensus as shown in the recent Value in Health Care Survey: physicians overwhelmingly assigned themselves responsibility, patients assigned responsibility equally to themselves and physicians, while employers split accountability among patients, physicians, health system, insurers, and themselves. Value, it seems, is in the eye of the beholder.

So it’s not surprising that the push toward value-based care has met with mixed results. Half of physicians surveyed for a 2018 Future of Healthcare report felt that value-based care and reimbursement will have a negative impact on overall patient care, and 61% said it will also negatively affect their practice, with concerns expressed about decreasing reimbursement rates and resources needed for additional documentation and data collection.

Concierge medicine offers an exceptionally viable solution, simultaneously simplifying and transforming the physician’s practice. Independent physicians remain that way, unfettered by the need for tedious documentation to prove value and achieve financial sustainability. This type of personalized care drives down the need for urgent care and ED visits, and improving outcomes for patients.

Most importantly, physicians are able to fulfill their personal vision for patient care. As one of our clients eloquently sums up: “All those things that we’re not compensated for in traditional primary care medicine are the most essential things.” That’s the real meaning of value-based care.

Terry Bauer is CEO of Specialdocs, a concierge practice transition and management company established in 2002.
Physician burnout is an epidemic that’s rattling the healthcare field as much as any illness, leaving many physicians wondering how they can continue to practice medicine. Practice transformation to a direct pay or concierge model is one solution physicians are taking to deal with burnout, declining revenue and payer hassles.

Direct pay practices charge patients a membership fee to pay for all costs of practicing. Concierge practices also charge a membership fee but bill some services to the patient’s insurance, as well. In both models, physicians tend to have smaller patient panels so they can give more time and attention to their patients.

For the physician with little or no experience in either model, getting started can

by JORDAN ROSENFELD

Getting started with a direct pay practice

MedicalEconomics.com
be daunting, but experts who have already forged the path offer reassurance that transitioning to these models is a realistic goal, though it means learning to practice medicine in a new way.

WHEN TO LEAP

The biggest hurdle in the transition to direct pay practice may just be getting started, says Matthew Mintz, MD, FACP, a clinical associate professor at George Washington School of Medicine in Bethesda, Md. Mintz left a hospital two years ago to start his own direct pay practice after he ran the numbers and determined that he would need only 200 to 300 patients (of a panel of over 2,000) to follow him to be able to afford to make the leap.

“A good rule of thumb is that about ten percent of patients will follow you,” he says, and that was true for him.

By the time a physician is thinking of starting a direct pay practice, Mintz says, there’s very little point in waiting from a psychological standpoint. “It’s not worth it to stick around for another few years and be miserable trying to save up a few pennies. You’re better off making a clean break and taking out a loan, investing in yourself, essentially.”

He acknowledges that making such a choice is a leap of faith for many physicians, and that the comfort of a solid paycheck often leads people to stay in a traditional fee-for-service, insurance-based practice, even when they are miserable.

“The systems that we work for tend to de-value physicians, and the physicians then internalize that and de-value themselves. The one piece of advice I have is for physicians to know they are of value, and that people are going to be willing to pay for those services even without insurance,” Mintz says.

He charges his patients an annual membership fee that they can pay all at once, monthly or quarterly. It covers basic primary care services such as physicals, EKGs, and blood draws. For services beyond basic care, patients can bill their insurance, but he does not bill any insurance directly.

Erin Jackson, JD, a healthcare lawyer with Jackson LLP in Chicago, who helps physicians make the transition to concierge care, urges physicians to be aware of their patient demographics before the practice transition, and to plan about six to nine months in advance. “Not only do you need to determine if there are patients there to support your practice, but can your patients afford a direct pay model?”

An additional $50 to $100 per month may be more than some patients can afford, she cautions. Alternatively, a physician may be aware of a need or gap in healthcare in their community that they can fill for patients who are already paying high deductibles and often have to wait months to see their physicians.

Jackson also encourages physicians to evaluate their personal motivation for setting up a direct pay practice. “I start the conversation about what you are hoping your life’s going to look like,” she says. She helps her clients make sure that they are getting into concierge/direct pay for the right reasons—usually to focus more on patient care and to spend less time on paperwork.

GETTING HELP IN THE PROCESS

Starting a direct pay practice can mean leaving behind much of the staff of a traditional practice, including medical assistants, scribes, billers and coders, Dan Wohgelernter, MD, a cardiologist in Santa Monica, Calif., did not try to go it entirely alone. He contracted with a third-party organization called Concierge Choice Physicians that helps set up the administrative aspects and address any legal concerns. “Just like I think patients shouldn’t be their own doctors, doctors shouldn’t be their own lawyers,” Wohgelernter says.

Under this arrangement, Concierge Choice takes a fee. They were especially useful helping him transition away from a hybrid model, where he charged an annual fee, but still billed patients’ insurance, which eventually met with limitations, to a completely direct pay model.

His hybrid model recruited those patients he treats frequently, or ongoing, who had greater need for intervention into the concierge side, where they would pay an annual membership fee and gain access to him 24/7, with few exceptions.
“This entitled patients to have this type of enhanced relationship with me.” For hospital visits, procedures and diagnostic tests, he still billed their insurance.

But eventually, the hybrid model began to fail. “The disadvantage of the hybrid model is that you are creating an exit ramp for patients who might otherwise want to stay with you,” Wohgelernter says. “And the patients who were paying the extra fee often resented me seeing other patients who weren’t signed up.”

He soon made the decision to get rid of insurance and go completely direct pay. While it was hard to say goodbye to some patients, the new model has changed his life and how he practices. He spends between 30 and 60 minutes with each patient instead of 10 to 15. “You are really able to fulfill the requirements of the art of medicine,” he says. “Patients love it, and I feel that I’m fulfilling what I always envisioned in my role as a doctor.”

Jackson also favors a direct pay or concierge model over hybrid because it’s more streamlined and easier to navigate from a legal and financial standpoint. “Hybrid models raise more red flags. And traipsing through the regulations can be extremely tedious. There’s a lot more opportunity for messing up if you’re taking insurance,” Jackson says.

She reminds physicians that there are legal gray areas in matters such as marketing and fundraising that it’s useful to engage a lawyer on, no matter whether they enter a hybrid or complete direct pay model. “So long as you practice medicine you cannot escape the legal restrictions upon your license,” Jackson says.

Unlike Wohgelernter, who relies upon the support of a third-party organization, Daniel Paul, MD, an orthopedic surgeon and founder of Easy Orthopedics in Colorado Springs, Colo. found that setting up a concierge practice did not require much outside expertise and allowed him to simplify processes because he does not have to seek reimbursement from insurance companies. He uses a HIPAA-compliant Google Drive in place of an EHR and acts as his own receptionist. “You save so much time in administrative junk,” Paul says. “My notes are basically just a narrative. You don’t have to pre-authorize or anything.”

Moreover, changing to concierge is not so much about administrative functions, as it is personal ones. “You can’t just take your existing practice and strip out all the insurance and expect it to work, because it won’t. A concierge practice is relationship-based medicine, which means spending more time with people,” Paul says.

Paul also points out that the transition might involve rethinking finances and lifestyle altogether. “If you’ve got a super expensive house and car and all your kids are in private school, you might have locked yourself into your job. The first step is downsizing yourself to prepare for this period of not making a lot of money.”

However, he says that these sorts of life changes are worth the results. “I will bet you money that [physicians who transition to concierge] will be happier than they were before.”

HOW TO TALK TO PATIENTS ABOUT THE TRANSITION
Perhaps the scariest part of the transition to direct pay is letting patients know and hoping they will follow. “It takes convincing patients at first,” Paul says. “But if you have established relationships with these patients you can explain, ‘Now I can practice how I want, and provide you with better patient care.’”

Erin Jackson says that physicians who want to thrive in this model need to educate their patients on the benefits. Since overhead costs will go down, physicians should budget more money for reaching out to patients to discuss the value of the model.

“Patients feel like they’re paying cash anyway with these massive deductibles. So they get to cut through all of the red tape and have access to a physician 24/7. I think it allows the patient to feel much more content with their relationship with their physician,” Jackson says.

Wohgelernter agrees that patients benefit as much as physicians. “There are so many aspects of the concierge relationship that not only improve the quality of patient care but also actually reduce costs for the patient and the system,” he says.
How do we bill situations when a patient comes in for a preventive visit and, once in the exam room, informs the physician of additional issues? Does it matter if the conditions are stable? Also, when can we bill an E/M when these types of issues are presented in addition to a procedure performed at that visit?

A 44-year-old established patient presents for her annual well-woman exam. A complete review of systems is obtained, and an interval past, family and social history is reviewed and updated. A neck-to-groin exam is performed, including a pelvic exam, and a Pap smear is taken. Counseling is given on diet and exercise. Appropriate labs are ordered.

The following situations would not be significant enough to warrant billing a separate E/M service:

1. The patient also complains of vaginal dryness, and her prescriptions for oral contraception and chronic allergy medication are renewed. This additional work would be considered part of the preventive service, and the prescription renewal would not be considered significant.

2. The patient also requests advice on hormone replacement therapy. She is anticipating menopause but is currently asymptomatic. This would not be considered significant because the patient is asymptomatic and preventive medicine services include counseling or guidance on issues common to the patient’s age group.

Preventive medicine service with E/M service

The following examples might help clarify the difference between “significant” and “insignificant” services performed in addition to a preventive medicine visit.

Many times a patient’s “Oh, by the way …” comment turns an encounter that was scheduled as a preventive medicine visit or a minor office surgery into something more. We always need to keep in mind the patient’s expectations for the visit. According to CPT®, separate, significant physician evaluation and management (E/M) work that goes above and beyond the physician work normally associated with a preventive medicine service or a minor surgical procedure is additionally billable. The code that tells the insurer you should be paid for both services is modifier -25. Used correctly, it can generate extra revenue.

The key is recognizing when your extra work is “significant” and, therefore, additionally billable. While CPT® does not define “significant,” asking yourself the following questions should help lead you to the answer:

- Did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?
- Could the complaint or problem stand alone as a billable service?
- Is there a different diagnosis for this portion of the visit? Or, if the diagnosis is the same, did you perform extra physician work that went above and beyond the typical pre- or post-operative work associated with the procedure code?

If your answers to each of these questions is yes, then you should report the appropriate E/M code with modifier -25 attached as well as the preventive medicine service code or minor procedure code. You can increase the likelihood that the insurer will pay for both services by organizing your note so that documentation for the problem-oriented E/M service is separate from documentation for the preventive service or procedure. You may even want to use headers or a phrase such as “A significant, separate E/M service was performed to evaluate …”
The following situations would be considered significant enough to warrant billing a separate E/M service:

- The patient also complains of night sweats, hot flashes and lighter, irregular menses. After a discussion of treatment options, risks and benefits, a prescription for estrogen replacement is given. Because the patient is symptomatic and additional history is taken, along with medical decision making, this could be considered significant. The diagnosis code for menopause would be linked to the E/M code.

- The patient also complains of fatigue, hair loss, feeling cold and lighter menses. On exam, mild hair thinning and areflexia are noted. The physician orders a complete blood count and thyroid stimulating hormone test with the intention of writing a prescription after reviewing the test results. Because symptoms are present and the physician documents extra work in all three E/M key components, this could be considered significant. Diagnosis codes for the symptoms would be linked to the E/M code.

- The patient also complains of bilateral knee pain in the morning. Tenderness and swelling are found on exam. The patient is given a nonsteroidal anti-inflammatory drug prescription. The extra physician work that is documented for all three E/M key components makes this significant. The diagnosis code for knee pain would be linked to the E/M code.

- The patient also states that home monitoring has shown fasting blood sugars of 120 mg/dL to 180 mg/dL and some random sugars over 300 mg/dL. This is a significant problem that needs to be addressed, and extra physician work is performed and documented for all three E/M key components. The diagnosis code for uncontrolled diabetes mellitus would be linked to the E/M code. The status of previously diagnosed stable conditions would be considered part of the preventive medicine service and not separately billable.

**Minor surgical procedure with E/M service**

CPT® code reimbursement for minor surgical procedures includes pre-operative evaluation services such as evaluating the site or problem, explaining the procedure and risks and benefits, and obtaining the patient’s consent. Also, the Centers for Medicare & Medicaid Services (CMS) has clarified that the initial evaluation is included in the reimbursement for a minor surgical procedure and is not separately billable.

For the following scenarios, an E/M service could be billed in addition to the minor surgical procedure:

- At a follow-up visit for the patient’s stable diabetes and osteoarthritis, the patient also complains of a worrisome skin lesion that you remove at that same encounter. These services are separate and significant and not part of the preoperative services for the lesion removal. The code for the lesion removal would be linked to the appropriate lesion diagnosis code, and an E/M service, linked to diabetes and osteoarthritis diagnosis codes, should be submitted as well, with the 25 modifier attached to the E/M code.

- The patient presents with a head laceration, and you also examine the patient for neurological damage before repairing the laceration. It would be appropriate to bill both an E/M service and a laceration repair code because your work was above and beyond what is typically associated with a routine preoperative assessment of the laceration. Separate diagnoses are not necessary.

**Additional thoughts**

Unfortunately, not all insurers will pay you for the separate E/M service even if you code in compliance with CPT® rules. Be sure to have your staff appeal any denied or bundled claims. A review of your documentation by the insurer may result in payment for your provider’s work.

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A round 84 million Americans—about 1 in 3 adults in the country—have what’s known as pre-diabetes, according to the CDC. Prediabetes can then lead to type 2 diabetes.

Identifying patients at risk of developing diabetes is crucial to both improving patient outcomes and reducing costs to the health system. Diabetes costs patients and the health system at large more than $327 billion annually, according to 2017 data from the American Diabetes Association.

Two recent studies looked at prediabetes, and what physicians can do better to identify and treat these patients.

EARLY INTERVENTION HELPS
A study from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), part of the National Institutes of Health, finds that early intervention for patients with prediabetes or newly-diagnosed patients with type 2 diabetes can help to increase insulin production.

The study examined the role of three different treatments and the possibility of slowing the decline of beta cell function, an effect of diabetes. Patients were given either long-acting insulin (glargine) for three months followed by nine months of metformin, liraglutide with metformin for 12 months, metformin alone for 12 months, or a placebo.

All three interventions resulted in higher beta cell function. The biggest improvement was seen in the group receiving both liraglutide and metformin. However, after examining the patients three months following the end of treatment, there was no evidence that the effects were sustained.

“The findings suggest that in individuals with either of these states of dysregulated glucose metabolism, intervening very early can improve insulin production,” says Steven Kahn, MD, the study’s author. “However, as this is not sustained after treatment withdrawal, it indicates that at this time we do not have a treatment approach that can be used intermittently but rather that we have to continue therapy without periods of withdrawal.”

The study also showed that younger patients do not respond as well to treatment—even sustained treatment—as older patients.

When patients aged 10 to 19 were given similar interventions as the adult group (ages 20 to 65), beta cell function declined during treatment and then worsened after treatment ended. The younger patients were given only two treatment regimens: three months of insulin glargine followed by metformin for...
nine months as well as metformin alone for 12 months, because metformin and insulin glargine are the only diabetes 2 treatments approved for youth with type 2 diabetes.

"The findings in both age groups therefore suggest that we should focus on better understanding the disease process in youth as to why it is more aggressive," says Kahn, "and should be trying to identify new targets that can improve and maintain beta-cell function in both youth and adults."

GAPS IN RECOGNIZING PRE-DIABETES

A survey of 1,000 randomly selected primary care physicians by researchers at Johns Hopkins revealed significant gaps in the respondents' overall knowledge of risk factors, diagnostic criteria and recommended prevention practices for prediabetes. The research was published in the Journal of General Internal Medicine earlier this year.

Survey questions evaluated the physicians' knowledge in three areas:

Risk factors that should prompt prediabetes screening, laboratory criteria for diagnosing prediabetes, and recommendations for prediabetes management.

Practice behaviors regarding prediabetes management.

Perceived barriers and potential interventions to improve prediabetes management.

The results revealed substantial gaps in primary care physicians' knowledge in all three categories measured, according to the study's authors.

For example:

On average, respondents selected just 10 out of 15 correct risk factors for prediabetes, most often missing that African Americans and Native Americans are two groups at high risk.

Only 42 percent of respondents chose the correct values of the fasting glucose and Hb1Ac tests that would identify prediabetes.

Only 8 percent knew that a 7 percent weight loss is the minimum recommended by the American Diabetes Association as part of a diabetes prevention lifestyle change program.

According to the study’s authors, 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 diabetes care and management.

"Along with closing the PCP knowledge gaps our survey identified, we believe the problem needs to be addressed at the healthcare system level. This includes concerted efforts to make both healthcare providers and patients more aware of available type 2 diabetes prevention programs."

— NISA MARUTHUR, MD, MHS, ASSOCIATE PROFESSOR OF MEDICINE, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

Based on their findings, the researchers suggest strategies to address the physician knowledge gaps about prediabetes, as well as the system-level obstacles to preventing type 2 diabetes. These include better educating physicians about diabetes prevention, providing easier access for physicians and their patients to national diabetes prevention lifestyle change programs, increasing insurance coverage for such programs, and offering new tools to help primary care physicians improve the procedures and practices by which they diagnose and treat patients with prediabetes.

“We believe that what was learned from our survey can have implications for changing national guidelines and policies regarding type 2 diabetes prevention, including establishing measures of quality for diagnosing and managing prediabetes,” says Eva Tseng, MD, MPH, an assistant professor of general internal medicine at the Johns Hopkins University School of Medicine and lead author of the study. “The public can help by advocating for more insurers to cover prevention programs, along with insisting that public health stakeholders expand access to and availability of these interventions.”
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Getting paid in 2020
Reimbursement for physicians is getting more challenging each year. Between the ever-changing reporting requirements from CMS and contractual differences among commercial payers, just keeping up can be a full-time job. Insurers are asking for more and more data to document patient outcomes and Medicare has its own reporting requirements. New payment models that emphasize primary care are in the works, so decisions doctors make today can affect their future income. Our cover story details the reimbursement trends physicians can expect in 2020.