Beyond COVID

Building Your Practice for a New Future

Practice Management
One year later
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Chronic Conditions
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While it continues to be a global crisis, it’s also clear we’ve reached a tipping point in the COVID-19 pandemic in the United States. More Americans are getting vaccinated, and while things can always change, life is poised to return to normal in the near future.

But should your medical practice return to normal? And what is a normal business model for the post-COVID-19 world?

Our cover story in this, our April issue, focuses on taking a big picture look at how medical practices are changing, and how to apply lessons learned from the pandemic when it comes to a number of complex issues, including payment models and reimbursement, staffing and workflow, virtual, patient access and equity, and much more.

But as we look beyond the pandemic, we also must continue to explore the serious impact this crisis has had on the mental health of both physicians and patients. To that end, we have two features that look at each aspect.

The first is an interview with Michael Myers, M.D., a psychiatrist who has spent his career devoted to the mental health care of physicians. We spoke to him about what the pandemic has done to physician wellness, and what we need to do to care for our caregivers.

The second is our way of tackling the overwhelming need for mental and behavioral health care for patients. We have a shortage of behavioral health care providers, and physicians — especially those in family medicine, internal medicine and pediatrics — are taking on treatment of issues such as depression, anxiety, and more. So how can practices integrate behavioral healthcare into their practice from both a patient care and revenue perspective? Our story explains.

As always, thank you for reading, and send any feedback on our content to medec@mjhlifesciences.com.

Mike Hennessy Sr.
Chairman and Founder
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COVID-19 COVERAGE CENTRAL

Medical Economics® editors are covering what you need to know during the ongoing novel coronavirus (COVID-19) pandemic. Our ongoing coverage of COVID-19 features:

- Breaking news on the latest developments.
- Tips for physicians to extend the life of N95 respirators.
- Mental health tips for doctors and other providers.
- How physicians can protect themselves from COVID-19.
- Strategies for using telehealth.

To read all of our ongoing coverage, go to MedicalEconomics.com

Perfect your telehealth program

Tabassum Salam, M.D., the ACP’s vice president of medical education, discusses what physicians need to know to get started with telehealth right away.

Watch this video and others at: bit.ly/MedEcVideo

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With over a half million dead, millions more hospitalized, the COVID-19 pandemic will be seared into our collective consciousness for generations. In fact, demographers have already determined that Americans born between 2016-2030 will be Generation C for the profound and enduring effects of the COVID-19 experience on their early development and, ultimately, their life outlook.

If the effects are tectonic, so must be the response.

A new path forward
Getting us out of this mess required short term and painful decisions regarding the reduction of spread, namely masks and distancing, alongside one of the most ambitious medical endeavors in human history. The international scientific community — led largely by hefty investments by our federal government — prepaid for vaccines in the hundreds of millions through Operation Warp Speed and other collaborations. The attempt to shorten vaccine development, testing and manufacturing to a 12- to 16-month process relied on the bold assumption that the vaccines would work when they entered clinical trials.

Since the federal government prepurchased the vaccines, it put them in the position of controlling distribution. They chose McKesson as their primary distributor and put the Centers for Disease Control in charge of initial allocations through two programs. The Jurisdictional Program (states, territories and protectorates) and the Federal Pharmacy Program, for which 21 different pharmacy location aggregating entities signed up as network administrators for reallocating vaccine to their pharmacy locations based largely on the number of pharmacies they represented. Long-term care facilities were set up in a separate system specific to their populations and facility staffs.

Mass vaccination favored over community-based administration
The initial allocations for phase 1 groupings were intended to go through the Jurisdictional program and focus on high-risk populations. Jurisdictions largely looked to their Departments of Health, who tended to look towards two main entities for both logistical and political convenience — namely local health departments (LHDs) and large health systems. Both favored off-site, mass vaccination approaches since LHDs provide only a small portion of health care services overall in generally small clinic footprints and hospitals did not want to clog up primary care and other traditional sites where they were desperately trying to bring back revenue on procedures.

Yet polling reveals a stark difference in patient preference compared to the chosen approach.

Underserved and left behind
As of late March 2021, roughly a quarter of the country’s initial vaccination effort, most Americans have received their vaccination not at a health care service location but rather parking lots, airport runways and music or sports venues. For some in public health circles, this brought a nostalgia and a renewed sense of empowerment to a chronically underfunded and underappreciated workforce.

Yet, for many front-line care providers, lack of access to vaccine allocation brought panic and frustration. Many patients expected to get the vaccine from their primary care and pharmacy providers in their communities, where they already receive vaccines and health care services multiple times a year.

We must use the vaccination infrastructure we already have
Our front-line providers at physician practices and pharmacies have been dramatically underallocated COVID-19 vaccinations.

by L. Allen Dobson Jr., M.D., and Troy Trygstad, Pharm.D., Ph.D., MBA
National polling firm Public Policy Polling conducted a survey in February that revealed pharmacies and doctors’ offices as the sites of care for 38% and 32%, respectively, of adult influenza vaccinations in 2019. Yet only 9% and 10% had received their COVID-19 vaccination from those sites of care. This represents a nearly four-fold decrease in access to COVID-19 vaccinations from a patient’s chosen site of care.

When asked what their primary preference for COVID-19 vaccination administration site of care, 36% responded “Doctor’s office” and 24% said “Pharmacy,” indicating largely the same preferences as the influenza vaccination. Mass vaccination sites represented 4% of primary preference, but 17% of actual COVID-19 vaccinations. Hospitals represented 5% of primary preference, but 20% of actual COVID-19 vaccinations.

Meanwhile, patients already receiving care from pharmacists and physicians who have low capacity are at risk being left behind by the mass vaccination approach. For the greater part of January and February, both provider types were left in a lurch for the patients they serve who don’t surf the internet, have a patient advocate or caretaker, have behavioral health limitations, or otherwise don’t trust the government or large institutions. These are patients who make health care decisions based on longstanding relationships.

As former Speaker of the House Tip O’Neal famously quipped, “All politics is local,” so it seems is rationing of health care services. Once vaccines became available, governors and public health officials necessarily and understandably latched onto allocation as a means of demonstrating action and control over the pandemic response. With good intentions in most instances, those officials determined to who, when and where vaccines were delivered, and for the most part successfully channeled vaccine relatively efficiently to most at-risk and socially vulnerable populations. Rates of death and hospitalizations — arguably the two most important metrics — dropped precipitously February and beyond.

Yet, the consequences of leaving out pharmacists and primary care physicians from the initial push for vaccinating at-risk individuals in the community will start to show as spring emerges. As much as one-third of patients over the age of 65 remained unvaccinated as of mid-March.

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This is what government-controlled health care looks like. Frontline providers need to be engaged with public health officials early and often in pandemic response. Pharmacy and primary care need to make the case both now and when preparing for future emergency responses. Front line health care providers, rich in data and relationships and involved in the everyday care of vulnerable populations, are in the best position to serve their patients, pandemic or otherwise. They can be the national guard of the health care system in emergencies.

**A better way**

Mass vaccination clinics are great spectacles, but simple math and the laws of surface area and human behavior suggest a better way. Many polls and some literature suggest a strong link between vaccine hesitancy, or outright resistance to government intervention and health care experimentation. Existing relationships matter, and those strong bonds already exist for hundreds of millions of patients already frequenting our nearly 100,000 pharmacies and primary care practice sites. Pharmacy alone has 50,000 pharmacies enlisted to provide COVID-19 vaccinations, of which only about 10,000 are activated in the Federal program as of mid-March. If each has a reported capacity of 100 doses per day, they alone amount to more vaccine administration capacity than the government will ever supply.

The speed of mass vaccination clinics is no match for our system’s already plentiful vaccination sites of care. Primary care physicians and pharmacists together maintain the capacity vaccinate the entire U.S. population in two months. We already attempt to do that every fall with influenza. Please use the system we already have next time.

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**“PRIMARY CARE PHYSICIANS AND PHARMACISTS TOGETHER MAINTAIN THE CAPACITY VACCINATE THE ENTIRE U.S. POPULATION IN TWO MONTHS. WE ALREADY ATTEMPT TO DO THAT EVERY FALL WITH INFLUENZA. PLEASE USE THE SYSTEM WE ALREADY HAVE NEXT TIME.”**

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Troy Trygstad, Pharm.D., Ph.D., MBA, is the Editor-in-Chief of Pharmacy Times and vice president of Pharmacy and Provider Partnerships for Community Care of North Carolina.
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BEYOND COVID
BUILDING YOUR PRACTICE FOR A NEW FUTURE

by Jeffrey Bendix Senior Editor

The COVID-19 pandemic is the biggest crisis to hit American health care in a century, resulting in more than half a million deaths and millions of people postponing needed care, as well as jeopardizing the future of many medical practices, especially those in primary care.

But like every crisis, this one also brings opportunities for change. For medical practices, it could mean becoming nimbler in their operations, more accessible and affordable and less dependent on fee-for-service payments. The pandemic could also be a chance to reaffirm the physician’s vital role in health care delivery, especially primary care. And it might present an opening to address race- and income-based disparities in health outcomes.

So as COVID-19’s grip on the nation begins to ease, the question becomes: Will lawmakers, health care administrators and individual physicians use the pandemic as an inflection point for changing the direction of primary care? Or put another way, what might primary care after COVID-19 look like?

‘We need to evolve our patient models’
The answer, experts say, will depend almost entirely on two interrelated factors: whether the increased use of telehealth resulting from the
pandemic continues after the pandemic has ended, and the availability of new payment models to support telehealth and other novel forms of care delivery.

“I think the pandemic has created some hopeful opportunities for meaningful change but it’s by no means a sure thing,” says Connie Hwang, M.D., MPH, chief medical officer and director of clinical innovation for the Alliance of Community Health Plans (ACHP). “We’ve seen some really interesting transitions into virtual care models but there are still a lot of questions around whether we can keep those gains and not fall back into business as usual when we reach the end of the pandemic.”

“We know that not all patient needs require a face-to-face doctor visit. There are many things that can easily be done over the phone or as a remote visit,” says Ann Greiner, president and chief executive officer of the Primary Care Collaborative, a nonprofit organization that advocates on behalf of primary care and the patient-centered medical home concept. “But we need to evolve our payment models so as to give patients and primary care clinicians flexibility in how they give and receive care.”

**Payers respond to telehealth surge**

Telehealth use, which had been extremely limited before the pandemic, surged after the Trump administration declared COVID-19 a public health emergency (PHE) in mid-March and in-person patient visits declined drastically. According to the most recent report of the Medicare Payment Advisory Commission, there were 8.4 million telehealth visits paid under the Medicare Physician Fee Schedule in April 2020, compared with 102,000 in February.

Similarly, a study from The Commonwealth Fund found that by early April, 85 percent of primary care providers in the United States were using telehealth services.

When President Trump declared COVID-19 a public health emergency (PHE), Congress and the Centers for Medicare & Medicaid Services responded by making it easier for doctors to use telehealth—telephone, video, and online communications—to treat Medicare patients, and paying them more to do so.

The immediate goal of these changes was to reduce the need for face-to-face visits during the pandemic. But many primary care advocates believe the resulting spike in telehealth use has provided a glimpse into the technology’s potential to expand and transform primary care delivery in the U.S. But for that to happen, they say, the changes put in place at the start of the PHE—or something like them—must become permanent.

While it’s still too early to know if that will happen, MedPAC—the commission that advises Congress on Medicare payment issues—believes the idea is at least worth exploring. In its most recent report, issued in mid-March, MedPAC recommends continuing several of the policies instituted under the PHE for a year or two so as to obtain more evidence regarding telehealth’s impact on care access, quality, and cost.

**Recommendations**

The commission’s specific recommendations for this time period include as follows:

- allowing Medicare to pay for certain telehealth services regardless of the patient’s location at the time of the visit;
- adding some telehealth services to the list of those Medicare covered before the PHE, provided they have potential for clinical benefit; and
- allowing Medicare to cover certain services provided via audio-only (as opposed to audiovisual) E/M visits with established patients if there is potential for clinical benefit.

To reduce the possibility of unnecessary spending and protect against fraud, the report also recommends:

- closely studying the claims of doctors who bill many more telehealth services per patient than similar clinicians;
- requiring clinicians to hold an in-person visit before ordering high-cost durable medical equipment or expensive laboratory tests for a patient; and
- prohibiting “incident to” billing for telehealth services from any clinician who can bill Medicare directly.

The full report is available at [http://www.medpac.gov](http://www.medpac.gov)
May 12.5% of ambulatory care visits were conducted via telehealth. They fell to about 6% in the fall before ticking up again late in the year.

Doctors were able to meet the surge in demand for virtual visits largely because Medicare more than doubled the number of telehealth-delivered services it would pay for, and increased payments for them, for the duration of the PHE. It also allowed clinicians to bill for some telephone-only visits (as opposed to visits that include a video component) and removed most site restrictions for remote visits. The Biden administration has indicated the PHE will continue through the end of 2021.

Absent another health crisis, no one expects telehealth visits to return to the levels seen at the height of the pandemic anytime soon. Still, many physicians and health care executives say the technology’s growth in 2020 use revealed intriguing possibilities for the future of care delivery.

“I think the pandemic gives us an opportunity to reimagine the ways we ensure that the care we’re delivering is high quality and easily accessible,” says Rachel Reid, M.D., a health care policy researcher with the RAND Corp. and practicing internist at Brigham and Women’s Hospital in Boston. “I don’t know that anyone’s nailed exactly what that transition looks like yet, but it’s exciting to think about what could be.”

Expanding access to care

One of telehealth’s biggest potential impacts, experts say, is to make care more widely accessible since it eliminates the need for travel to a doctor’s office. Indeed, with site restrictions on its use suspended, some doctors are already experiencing this.

“We’re able (through telehealth) to see folks who couldn’t come in whether because of transportation issues or because they couldn’t take time off from their jobs,” says Ada Stewart, M.D., president of the American Academy of Family Physicians (AAFP) and a practitioner at a federally qualified health center in Columbia, South Carolina “It’s really been a means to reach out to folks we were previously missing.”

Leon McDougle, M.D., a family physician with The Ohio State University Wexner Medical Center in Columbus and president of the National Medical Association, says that before the COVID-19 outbreak he rarely used telehealth, but now half of his clinic time is virtual. “It has provided opportunities for patients to overcome barriers like lack of transportation, and it gives me more options for virtual follow-ups if I have concerns about changes in a patient’s health status,” he says.

Most of McDougle’s and Stewart’s patients are Black and/or low income, and both view telehealth as a tool for providing more and better health care to people who traditionally have lacked it. But for that to happen, residents of those neighborhoods and communities will need the same access to broadband internet as residents of wealthier communities. Otherwise, Stewart says, “We risk creating more disparities.”

Altered space, staffing requirements

A future where telehealth is a routine form of care delivery could also change how practices use their space and personnel. “There’s no question if you’re doing significantly more telehealth visits it will change your space allocation,” says Jacqueline Fincher, M.D., an internist in Thomson, Georgia and president of the American College of Physicians. “You may find you need fewer rooms for face-to-face visits but more rooms where you can do telehealth visits and show patients ‘You and I are in this room together and it’s a safe space.’”

Fincher adds that reconfiguring office layouts for more telehealth visits could also be an opportunity to create spaces where physicians can work side by side with their support staff, thereby improving communication and care coordination.

Reed Tinsley, CHBC, a practice management consultant in Houston, says practices that continue providing significant numbers of telehealth visits will need to consider how to balance those against the needs of patients seeking face-to-face visits.

With business still down because of the pandemic, he says, many practices have been assigning telehealth care to clinicians whose schedules aren’t full. “What happens when patients start coming back and those people get busy? You’re left without anyone to service the telehealth side,” he says. “So the issue becomes whether a practice has the staffing capacity to handle both. That’s an unknown for most practices because they’re focused on rebuilding from the pandemic.”

Greiner says practices employing telehealth routinely may find they’re using support staff for pre-visit triaging to determine if a patient can be treated remotely or requires an in-person visit. “We’re just beginning to learn how this modality could affect the way primary care gets delivered,” she says.

Greater reliance on remote monitoring

Expanded use of telehealth in a post-pandemic environment could also mean more dependence on remote devices and health apps to monitor common indicators such as blood pressure, pulse, and A1C levels that clinicians routinely obtain.

>> Continues on Page 12
Connecting practices to

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Continued from Page 10 during in-person visits. And while tracking and analyzing that data could require practices to change some aspects of their workflow, Reid sees possible clinical benefits to collecting information this way.

“It’s not necessarily a bad thing to have more measures of physiologic data come from outside the clinic setting and reflect more in real time how patients live their lives,” she says.

Stewart points out, however, that greater dependence on remote monitoring technology could widen care disparities unless the technology is made universally available.

“You can do diabetes control and other things on apps, but many of my patients don’t have access to those,” she says. “So unless we find a way to provide it we’re still going to have inequities.”

Hurdles to meaningful change

Of course, the pandemic’s full potential to transform primary care won’t be realized unless the changes the government put into effect at the start of the pandemic—allowing Medicare to reimburse for remote visits at parity with in-person visits, and reducing or eliminating visit site restrictions—are allowed to continue after the PHE expires.

Doctors organizations and other groups are lobbying to make the PHE telehealth rules permanent. And CMS has launched a study exploring the possibility of doing that for at least some services, according to Shari Erickson, MPH, vice president of governmental affairs and medical practice for the American College of Physicians.

But the odds of those changes continuing after the PHE expires are slim, says Terry Fletcher, CPC, principal of Terry Fletcher Consulting Inc. in Laguna Niguel, California.

“The whole point of expanding telehealth under the PHE was so that people wouldn’t have to leave home in order to receive routine medical care,” she says. “That’s obviously going to change when the PHE is over unless Congress rewrites the law.”

Lawmakers would probably be reluctant to do that, she adds, given the vast increases in Medicare spending and greater opportunity for fraud that would likely result, particularly if telehealth visits occur in addition to rather than as a substitute for in-person visits.

Fletcher points to the actions of commercial payers, many of whom have reinstated the cost-sharing requirements for telehealth visits they suspended at the start of the pandemic. “A lot of them are saying spending (on telehealth) is out of control,” she says.

The need for new payment models

For primary care advocates and many health policy experts, the uncertainty over telehealth’s post-pandemic role is emblematic of the pandemic’s larger takeaway: the need to jettison, or at least significantly modify, fee-for-service payments in favor of models that provide doctors with more financial stability and greater flexibility in medical decision making.

Shawn Martin, MS, executive vice president and CEO of the AAFP, says the academy has been trying to persuade Congress and CMS to develop payment structures that are agnostic to the form of care delivery.

“We want to get to a point where a doctor can use any modality of care for any patient and we’re not incentivizing or disincentivizing them for it,” he says. “We just want them to be able to provide comprehensive, continuous care however they feel is best for their patients.”

“The pandemic has shown the importance of compensation models that offer primary care practices more financial predictability and the freedom to innovate and seize new opportunities,” says Melinda K. Abrams, MS, executive vice president for programs at The Commonwealth Fund.

Abrams points to the example of the Comprehensive Primary Care Plus model, which CMS has been developing since 2017. It combines traditional fee-for-service payments with upfront per-beneficiary per-month fees and performance-based incentive payments. If approved for use throughout the Medicare and Medicaid programs, “I think it has the potential to change the face of primary care payment in the U.S.,” she says.

But even COVID-19’s financial disruption hasn’t been enough to bring about a large-scale transition to value-based payments, Abrams notes. She cites results of a recent NEJM Catalyst poll showing that only 25% of its Insights Council members thought COVID-19 would be a “tipping point” for adopting value-based care.

“The pandemic hasn’t been a massive accelerator to value-based payment but more of a slow, steady march,” she says. “And I think it’s because making that transition requires a certain level of investment in information systems and staffing and changing workflows. And pursuing an innovation agenda in the midst of a pandemic is really hard.

“That said, I still believe the pandemic has demonstrated the importance of value-based payments, and we will continue the forward march.”

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COVID-19 physician practice impact: One year later

by Medical Economics® Staff

More than a year after the COVID-19 virus arrived in the United States, we wanted to ask you, our physician audience, how the pandemic has changed how you approached medicine, the status of your practice, and your own feelings of well-being.

We conducted this survey via Survey Monkey, deployed to our physician email newsletter list, during the month of February 2021. Here’s what physicians told us.

Describe the state of your practice finances now compared with before the COVID-19 pandemic.

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Better than before</td>
<td>6%</td>
</tr>
<tr>
<td>Worse than before</td>
<td>67%</td>
</tr>
<tr>
<td>Same as before</td>
<td>27%</td>
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How has your staffing level changed since before the COVID-19 pandemic?

- I have more staff members today: 6%
- I have fewer staff members today: 48%
- No change: 46%

How does your total in-person patient visit volume now compare to before the COVID-19 pandemic?

- I’m seeing fewer patients today: 80%
- I’m seeing more patients today: 6%
- No change: 14%

Did the pandemic cause your practice to start using telehealth?

- Yes: 81%
- No, we were already using telehealth: 6%
- No: 13%

How does your practice’s telehealth use now compare to your overall use in 2020?

- I’m using telehealth more than last year: 50%
- I’m using telehealth less than last year: 24%
- I’m using it about the same: 14%
- I’ve never used telehealth: 12%
In your own words

What lessons have you learned from the pandemic that you will apply to your practice of medicine going forward?

“Telehealth was not something I used before the pandemic but will continue to use after.”

“Try to find balance with more time off.”

“Masking is going to be the norm for a long while. Vaccine hesitant/refusing patients will be difficult to continue seeing in my practice.”

“Save for a rainy day.”

“We can operate with fewer staff, less internal controls and be more patient focused and profitable.”

“I changed my practice to a direct primary care practice. … I find 2021 to be invigorating, but I basically retired from traditional medical practice and practice more on my own terms in order to make a living now.”

“Stock up on supplies.”

“Don’t overcommit on new projects, especially if requires more staff. Diversify with regard to revenue streams.”

“Pay more attention to those who key in our charges and replace under-performing staff members.”

Do you agree with this statement? “Patients missing routine screenings or treatments has become a major issue.”

Yes: 81%

Is COVID-19 vaccine hesitancy an issue with your patients?

Yes: 56%
No: 28%
Not sure: 16%

How does your level of burnout compare today with before the pandemic?

I’m feeling less burned out today: 63%

No change: 30%

I’m feeling more burned out today: 7%
Michael Myers, M.D., has made physician mental health his life’s work. Myers is a doctor’s doctor and provides mental health services and treatment for physicians. He is a professor of clinical psychiatry at SUNY Downstate Health Sciences University in Brooklyn, New York, and recently published a book titled Becoming a Doctors’ Doctor: A Memoir. He sat down with Medical Economics® to talk about the immediate and long-lasting impact of the COVID-19 pandemic on the emotional health of physicians who are living through it. The following transcript was edited for length and clarity.

Medical Economics® (ME): How did you become a doctor’s doctor?

Myers: One of the pivotal factors was that I lost one of my roommates, a fellow medical student, to suicide. And that was a long time ago, that was in 1962. We often talk about stigma associated with mental illness in students and in physicians. It was unbelievably severe, in terms of its stigma, (and) that’s a little bit better now. But fast-forward, I had no idea at the time that I might end up in psychiatry, or as a specialist in physician health, then it came back to me later as I was becoming more experienced looking after physicians and their family members during my training. And so what I did when I finished my training, which was in 1973 ... for the next 35 years was half-time private practice and half-time academic work. And after years of a general psychiatric practice, I was looking after so many physicians and their family members that they decided to restrict my practice. So ... all I saw were physicians and their family members, right up until the end, and that was a total of 35 years.

ME: Before we talk about the coronavirus 2019 (COVID-19) crisis, I wonder if you could paint a picture of what the state of mental health was like for physicians before COVID-19?
health among physicians is in general?

Myers: What we read and see in the medical media, of course, is the high index of burnout in today’s physicians, and we’ve been seeing that now for I’d say almost 20 years—ballpark figure 50% of practicing physicians suffer from one or more symptoms of burnout. And it varies from one specialty to another. So that’s the short answer.

The longer answer is a little more complicated. I think we’re not hearing from a huge cohort of physicians who actually love what they do. They’re happy being physicians but many of them will say they are under more stress than other hardworking people. We don’t have a monopoly on this, of course, but that’s the way we talk. I also know that because I interview so many applicants to our medical school. If the applications to medical school are sky-high, in fact, they’ve gone up even since COVID-19. There’s this other group of doctors who will become my patients over the years. Doctors are human, too. So we can suffer from anxiety disorders, depression, trouble with alcohol or other drugs, PTSD, things like that, that people in our general society suffer.

ME: Let’s talk a little bit more about the pandemic. What is it like for physicians living through this crisis day to day?

Myers: It’s been really tough. When we did in our department of psychiatry, because we’re not on the immediate front lines, is we offered weekly support groups, for the hospitalist, for the emergency medicine doctors, for the critical care specialists. And then we also offered weekly groups for another group of physicians who were a little bit removed from the front lines. And then we also had groups, of course, for medical students and for residents.

What we were seeing and witnessing in those early days and weeks was shock. Anxiety about contagion, about bringing contagion to one’s own family. Some of our doctors didn’t go home; they would stay at the hospital or in rentals. The isolation was so difficult. As you know, patient families were not allowed to be in the hospital and patients were dying so rapidly. And it was really, really awful for our doctors on the front lines.

I remember so vividly in our groups how so many of them felt useless or that they really weren’t doing anything. I think what that came from was almost like an algorithmic approach to medicine, the things that we’re used to doing. They didn’t have the toolkit. But what my colleagues and I reminded them of is that they were basically doing so much for their dying patients by just being present, by communicating with their families through FaceTime, holding the phone up to (the patient’s) ears. Basically, the humanistic touch of that kind of work.

Because of the unprecedented nature and scale of this event, even physicians such as emergency department physicians were just sort of melting toward the end of the day or toward the end of the week because of the unrelenting pace. That sense that, “I’ve done everything I can and it still didn’t work.”

(Many physicians) have probably heard of the term “moral injury.” That’s the very important work of two individuals, Dr. Wendy Dean and Dr. Simon Talbot. That concept really fits what so many of the physicians were experiencing, especially in situations where perhaps there wasn’t enough PPE (personal protective equipment) or where they were having to reuse their dressing gowns or their masks, things like that. They’re having to make a decision as to who gets a respirator. And then, of course, the separation from their loved ones. This is really about a health care system that needs revamping. It needs to make major changes so that physicians and other health professionals aren’t put into those kinds of conflicts.

ME: During this pandemic we’ve seen our health care providers begging and pleading with the community to wear masks. We’ve seen nurses and doctors in tears on television. And so we’re also seeing a totally different side of our physicians and providers. Is this affecting health care providers, to actually see themselves in this light? Is it affecting their sense of efficacy?

Myers: I think it’s a good thing, quite frankly, that this has gotten play in some respects. It’s our
humaneness, of course, in the face of tragedy, in the face of a pandemic. And yet, in my mind, it doesn’t take away at all from the training, the expertise, integrity and skill of our highly trained front-line health professionals. This is just another piece of them. It’s the human part that is expected at one level to absorb what they are facing.

Now, this has to be watched, though, because individuals still have to have proper rest, they still have to have proper food. They have to make sure that they’re getting breaks. They can’t always be workhorses. In fact, many physicians even before the pandemic felt that they have been sort of used and abused, that they’re just a cog in a wheel. And that’s been some of the contributing factors to that huge cohort of physicians who have felt burned out, and what Dr. Dean and Dr. Talbot would say is an example of moral injury.

Some people recoil at the term “burnout” because they feel that it blames the health professional even though it’s occupationally induced, and they feel sometimes is equated with a lack of resilience. And it’s not that at all; it’s their inability to really practice the craft in the way that they were trained.

Some people wish I was saving more lives. But I feel I am providing value.”

ME: What should physicians be out looking for, for themselves and their colleagues, as the pandemic winds down?

Myers: I have been preaching and writing for years ... across all health professionals, that we must be our brothers’ and sisters’ keepers. Now, I know that firsthand, because being a psychiatrist, I know how elusive some illnesses can be. In other words, somebody can be slipping into a problem with alcohol or drug use. Or they can slip into a depression and not realize it, that it’s actually beginning to affect their well-being, the work that they do, and things like that. So that’s why the next step is for all of us to pay attention to our own self, our own symptoms and signs, and we need to listen to those loved ones of ours who are concerned about us and reach out to us, our parents, our spouses, our kids. And then of course, each other.

It’s can be very simple. “Are you OK?” And if you get a dismissive response, and I think it’s best to follow up with “Are you really OK?” and then to create a safe place where an individual can open up a little bit. I learned a long time ago, too, that when people are feeling quite ill, it’s very hard to make those phone calls, to call somebody and ask for help. So I often recommend that you make that phone call. “Some people recoil at the term ‘burnout’ because they feel that it blames the health professional ... And it’s not that at all; it’s their inability to really practice the craft in the way that they were trained.”
As physicians we are quite familiar with methods in discovering the health of our patients. We use measures such as HDL:LDL ratio, waist-to-height ratio, waist-to-hip ratio and many other measurements to determine the health of our patients. In fact, we’re pretty good at it. We can even use this data to predict what problems the patients will face and even how long they might live.

Did you know there are similar ratios and methods that accountants and business leaders use to determine the financial health of a company? These ratios can tell you the financial health of your practice. I’ve listed the top five financial metrics that every physician should know and use every month.

These are just a few the financial ratios physicians can perform using income statements and balance sheets provided to them by their accountants and office managers. These ratios will help you determine the level of financial stability of your practice and help you make better decisions for your future. Financial health is hard work. Just like we ask our patients to keep track of their diet and exercise activity, we should also closely monitor the financial health of our practices. We must be diligent to actively manage our business.

1 The current ratio
One of the most important ratios to know is a solvency ratio called the current ratio. The current ratio is a simple calculation to perform but a few definitions are needed. When we say “current” in a financial report, we are indicating that we can either convert the asset into cash within a one-year period or the liability is due within one year. Current assets are assets we can convert to cash within one year. Current assets are cash, cash equivalents, accounts receivable (A/R), bad debt allowance and any inventory we have on hand. Current liabilities are bills that must be paid within one year. Current liabilities are all notes and accounts payable due within one year, interest payable, wages payable and income taxes payable.

The current ratio is an indication of the firm’s ability to pay back its short-term liabilities. To obtain this ratio, we take all of the current assets and divide them by the current liabilities. If the current ratio is less than 1, this indicates the company has more debt due within one year than it has assets it can use to pay those debts. This is a critical ratio for any company, particularly in medical practice. If your current ratio is less than 1, you need to seriously consider how your practice will survive should something happen to your cash flow.
Another ratio similar to the current ratio is the quick ratio or acid test. This is the same as a current ratio except that inventories are not included in the numerator. It looks at the most liquid assets and compares them against the current liabilities. If your practice does not hold inventory, then your current ratio is a quick ratio or acid test.

2 Days in accounts receivable
Days in A/R measure a company’s ability to convert receivables into cash. A low days-in-A/R number indicates that the practice can quickly collect on its debts. This ratio varies from industry to industry. The important thing to watch is whether the number increases. If it is increasing, it should spur your staff to investigate why and find ways to bring the number back down. Every practice should know its general days in A/R. It is equally important to know the days in A/R for each payer class. How long does it take for the Centers for Medicare & Medicaid Services (CMS) to pay you? How long does it take for commercial payers to pay you? How long does it take to get paid by patients with health savings accounts? These are all important questions that can help you make better decisions and plan for the future. The calculation is performed by dividing accounts receivable by the revenue and then multiplying by 365.

3 Operating margin
Operating margin is a measure of what proportion of the company’s revenue is left over after paying the variable costs of production of the services or goods. These costs include wages, raw materials, etc. It is important to have a healthy operating margin so that the company has enough cash to pay its fixed costs. This is also known as an operating profit margin for the net profit margin. It is calculated by dividing the operating income by the net revenue.

4 Working capital
Capital measures the practice’s abilities to pay its bills on time. It is another liquidity or solvency ratio. It is calculated by subtracting the current liabilities from the current assets. The larger the number, the larger the working capital and the larger the cushion the firm has should an unexpected downturn in revenue occur.

5 Days in accounts payable
Like days in A/R, days in accounts payable (A/P) measures how long it takes for the practice to pay its bills. This is an important ratio because it can be a lagging indicator of the financial health and solvency of the practice. Also, it can be a good indicator of how well the practice is using its cash. Paying bills too soon might strap the firm for cash in the short term. Paying bills too late puts the practice in jeopardy of financial and legal action. This is also a good ratio to know about those with whom you have service contracts or agreements. If they take a long time to pay their bills, it will give you an indication of what to expect. This calculation is made by the ending accounts payable divided by the cost of sales divided by number of days.

David Norris, M.D., MBA, is an anesthesiologist at Wichita Anesthesiology, Chartered, in Wichita, Kansas and a business consultant with the Center for Professional Business Development.

“These ratios will help you determine the level of financial stability of your practice and help you make better decisions for your future.”

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“ME0421_020-021_Money-Ratios.indd   21"
Review your finances now to keep on track in 2021

It’s always a good time to do a financial review. You’ll make sure your savings and investments are aligned with your goals and reduce income taxes.

**Review IRA, 401(k) and other retirement plan contributions.**
If you didn’t fully fund your retirement plan(s) in 2020, this year you should consider what you can afford to save away. Contributions to 401(k) plans reduce your taxable wages. Many employers will let you make an additional one-time contribution up to the IRS limit.

You may be able to save on 2020 taxes by making deductible contributions to an IRA by April 15, 2021. If your income is too high to get a deduction because you or your spouse are also covered by a retirement plan at work, consider socking away money in a Roth IRA, which has more liberal income limits.

**Review your asset allocation and rebalance if needed.**
Confounding expectations, the stock market has boomed in the past year. As a result, you may find that your asset allocation is unbalanced. Suppose a few years ago you set your allocation as 50% equities (stocks and stock funds) and 50% in fixed-income (bonds, certificates of deposit [CDs], fixed annuities, money markets and similar instruments). Thanks to strong market performance, you’re now 65% in equities and 35% in fixed income.

You’ve done well! Now it’s time to start reallocating to get back to 50-50. Reallocation money in retirement plans as well as annuities and life insurance policies takes less planning because gains here are not taxed until withdrawn.

Some people have enough money in their retirement plans so that they can accomplish their overall rebalancing using only these accounts. Remember, it’s your overall asset allocation that counts, not the allocation in any one account.

If you do need to rebalance your taxable investments, be aware of tax strategy. For instance, if you have unrealized losses, you can sell off losing investments to offset gains from selling your winners. If you’re rebalancing a lot of taxable money, you may want to consult a certified financial planner or certified public accountant for help.

**Consider all your options. You may be able to get a better rate than you expect.**
To boost the economy, the Federal Reserve has slashed short-term interest rates to close to zero. Today, most savings instruments like money market accounts, CDs and bonds pay very low rates, even if you’re willing to tie up your money for a few or several years. If you’ve got CDs or bonds that are about to mature, it pays to consider other options.

If you can afford to tie up your money until age 59½ or are already at that age, there’s another choice that typically pays a higher rate: a fixed-rate annuity. Your age is important because if you withdraw money from your annuity before age 59½, you’ll owe the IRS a 10% penalty on the interest earnings you’ve withdrawn.

Also known as a multiyear guarantee annuity or a CD-type annuity, a fixed-rate annuity behaves a lot like a bank certificate of deposit, with some notable differences.

Like a CD, it pays a guaranteed interest rate for a set period, usually three to 10 years. Unlike a CD, the interest credited to the annuity is tax-deferred until you withdraw it.

While CDs today pay less than 1%, a three-year fixed annuity pays up to 2.4% and a five-year contract up to 3% annually. Annuities are not FDIC-insured but are covered by state guaranty associations, up to certain limits, that vary by state.

A fixed-indexed annuity is another choice if you don’t mind a fluctuating interest rate. It credits interest based on the growth of a market index, such as the S&P 500.

Indexed annuities are suited for people who want to save for the long term while limiting risk without precluding growth.

**Keep beneficiaries updated.**
The listed beneficiaries on annuities, life insurance policies and retirement plans will receive the proceeds upon your death. Check that they’re up to date. Life changes such as marriage, divorce, the birth of children or grandchildren or the death of a loved one may require updating your beneficiaries.

If you’re married, your spouse is normally your primary beneficiary and your child or children are contingent. If you’ve been divorced and remarried, make sure your ex-spouse isn’t still the beneficiary.

**Ken Nuss** is the founder and CEO of AnnuityAdvantage, a leading online provider of fixed-rate, fixed-indexed and immediate income annuities. Send your financial questions to medec@mjh lifesciences.com.
How to navigate physician noncompete clauses

by Heidi Moawad, M.D. Contributing author

Physicians are often faced with noncompete business agreements when signing employment contracts. These may also be required of physicians obtaining hospital privileges. A physician who signs a noncompete agreement, also referred to as a noncompete clause, agrees not to work for a competing practice or hospital within a certain period of time after leaving a job. Breaking the noncompete agreement may incur a hefty fine that is typically spelled out in the physician’s contract.

Often, addressing the fine details of a noncompete clause after the fact adds costly legal fees. There are a few strategies that doctors can adopt before and after signing a contract to avoid problems with noncompete issues.

Negotiating

Some doctors are hesitant about asking for compromises when signing a contract. For example, young doctors may be worried that a contract could be withdrawn after requesting concessions such as removal of a noncompete clause. Jon Appino, principal and founder of Contract Diagnostics, a firm that helps physicians with contract reviews, says dealing with such hesitation is a skill.

“There are careful ways to approach the conversation. Just like good bedside manner, you can learn how to negotiate,” he says.

Appino explains that a physician can be creative with requests.

“They may not be able to change the noncompete, but that doesn’t mean there aren’t many compromises you can make around it,” he says.

Bridging the gap

Of course, sometimes a physician absolutely cannot avoid being penalized for breaking a noncompete agreement. Some of these agreements can impose a fine ranging from $10,000 to $250,000. And geographic limitations may range from within 5 miles to 100 miles of the practice.

For doctors who work in large hospital systems with many satellite offices, the noncompete can encompass all of those locations. These agreements can cover a time period from one to three years after leaving a practice.

When the financial implications of taking a new job are too costly, doctors still need to earn an income before the noncompete restrictions expire. Locum tenens work, often in different states, to provide temporary employment in various geographic regions during this time period.

Telemedicine can be another option. Tisha Rowe, MD, founder of Rowe Network, a multispecialty telemedicine network, has worked with doctors who use telemedicine as a way to bridge the gap before they can start another job in the same town without violating a noncompete agreement.

Benefits of a noncompete clause

There are some positive aspects of noncompete agreements. A practice can lose patients after a physician leaves to set up a practice in the same town, and a noncompete agreement can reduce the chances that this could happen.

Some physicians, particularly those who have worked hard to build their group structure, often see benefits to these arrangements.

“A physician who is happy with their role could see that a noncompete agreement would protect
the group and their colleagues from leaving and causing harm to the group,” Appino says.

**Drawbacks of a noncompete clause**

Newly trained physicians may want some time to decide if they want to stay in a city or town long term. Often, taking an employed position for a few years before starting a practice is the most practical way to do that. And even for those who know they want to start a private practice, most doctors need to work and save up money before they can afford to open their own practice.

With a noncompete agreement, employers have less incentive to be fair to a physician because leaving the practice may require the physician to relocate. And patients may become confused and distraught after their physician leaves without offering to continue to be their doctor.

**Telemedicine**

Telemedicine is emerging as a new way of delivering patient care. However, as this patient care model is emerging, doctors may switch from one telemedicine company to another.

Rowe explains that telemedicine companies generally do not place noncompete agreements in their contracts and that doctors can work for more than one telemedicine firm at a time or sequentially without incurring any noncompete violations.

Rowe explains, however, that she has encountered several doctors who were prevented from taking on telemedicine as a side job due to a noncompete clause imposed by their employers.

Hospitals and medical practices can’t survive without physicians. A physician could certainly take his or her good reputation and loyal patients and leave a practice. A noncompete agreement often presents an obstacle to doing that.

When a physician is considering an employed position or group practice with a noncompete agreement, it is a good idea to discuss the expectations. A doctor needs to openly acknowledge to potential employers or partners that the working relationship needs to be evaluated first before anyone can agree to take a major financial loss for breaking ties. And working out a noncompete agreement that is fair for everyone is one of the ways to ensure that all parties have a reasonable timetable to evaluate the professional partnership and see if it is a good fit.

Noncompete agreements are frequently challenged in legal cases.

“Many states do not allow noncompetes and some states have legislation in the works,” Appino says.

But he still encourages doctors to check all local laws, explaining that even when a doctor hears that a noncompete is unenforceable, the contract may have predetermined damages that are tough to fight against.

“There are careful ways to approach the conversation. Just like good bedside manner, you can learn how to negotiate.”

—Jon Appino, principal and founder, Contract Diagnostics

"Like what you’re reading? Sign up to receive the e-newsletter."
Email archiving is an automated process for preserving and protecting all inbound and outbound email messages (as well as attachments and metadata) so they can be accessed later. In other words, email archiving is storing and making them searchable.

Email archiving providers take this burden off organizations by storing emails on their servers while making them accessible to designated administrators in the organization. This is different than simply creating an email data backup. Data backups do not allow searching, so if a particular email needs to be found, it might take weeks for you to find it.

Is it required by HIPAA?
HIPAA delineates what covered entities need to do to maintain compliance, but it does not provide specific guidelines about how to do it. Email archiving is not explicitly mentioned anywhere in the regulations.

Under the HIPAA Security Rule, healthcare organizations have to retain electronic communications data for a minimum of six years. During this time, access and audit controls must be implemented to protect the confidentiality, integrity, and availability of electronic protected health information (ePHI) to comply with the risk analysis requirements of the Security Rule and prevent improper data modification or deletion. Email archiving is an effective way to accomplish these HIPAA requirements.

How does it work?
Email archiving solutions generally upload emails to the provider’s servers, where the emails are indexed to allow the archive to be searched. The emails are encrypted which reduces the potential for “man-in-the-middle” attacks where data is intercepted.

Since the archived emails cannot be edited or deleted, they are also tamper-proof. Service providers impose tight controls over who can access archived emails to view patient data, fulfill an audit request made by the Department of Health and Human Services (HHS), or provide email content for legal purposes.

What is eDiscovery?
Electronic discovery, better known as eDiscovery, is the process in which electronically stored information (ESI) is requested, searched, located, and produced with the intent of using it in a court case as evidence, for government investigations, or as part of a Freedom of Information Act request.

If your healthcare business must conduct an audit for eDiscovery purposes, the search capabilities of an email archiver make this a vastly easier, faster, and more comprehensive process.

In addition, emails contain metadata (e.g. information about the device used to send a message or the date and time an email was sent) that is a vital part of legal evidence.

Benefits of archiving
There are many benefits to email archiving for your healthcare business. Here are a few of the main ones.

- **Easy storage management.** Covered entities reduce their server load by allowing an email archiving provider to archive and store their emails.
- **Business continuity.** Email archiving preserves the intellectual property contained in business email and its attachments. It also eases the burden on an IT department to find lost emails.
- **Part of disaster recovery plan.** Because the data is stored on a service providers’ servers, email archiving can be part of a healthcare organization’s disaster recovery plan. In the event of a ransomware attack or other catastrophic event that corrupts email data, emails and attachments can be recovered from the archive.
- **Data theft prevention.** Archiving emails also helps to prevent insider data theft or destruction by dishonest or disgruntled employees because you always have a backup.
- **Accelerated audit response.** Retaining searchable emails and attachments from all staff members means that if there is ever litigation, it will be much easier to find and produce the required emails.
- **Disposal of PHI.** In addition to privacy protection, HIPAA also features strict guidelines on how to dispose of PHI. Email archiving offers automated email retention in one centralized place.

Hoala Greevey is the founder and CEO of PauBox, Inc. Send your questions to medec@mjhlifesciences.com.
Integrating behavioral health and primary care

by Lisa A. Eramo, MA Contributing author

When primary care physician Dr. Karen Smith noticed that opioid abuse rates were skyrocketing in her community of Raeford, North Carolina, she decided to do something about it: She partnered with a behavioral health agency to roll out a medication-assisted treatment (MAT) program within the four walls of her practice.

Here’s how it worked: Smith screened patients for opioid abuse during the intake process. When she identified patients who could benefit from MAT, she used a warm handoff to connect them with a psychiatrist who could treat them on-site. This immediate access was a significant benefit for patients in an impoverished community where travel wasn’t easy.

Although Smith could have charged rent for the office space the psychiatrist used, she did not because she was reaping other financial benefits related to her performance in an Accountable Care Organization.

“We were actually seeing improved outcomes and a return on the back end,” she says. “We were controlling the total cost of care for those individuals. The amount we would charge for rent would be nowhere near what we would see in terms of cost control.”

When COVID-19 struck, the MAT program shifted from in-person visits to telehealth. “Patients would have otherwise fallen through the cracks,” Smith says. “With telehealth, we were able to maintain services.”

Nearly one in five U.S. adults lives with a mental illness, and the COVID-19 pandemic has only exacerbated the problem nationwide. More than 85% of primary care physicians report that the mental health of their patients has decreased during the pandemic, according to a recent survey conducted by the Primary Care Collaborative. Thirty-one percent report seeing a rise in patients experiencing addiction.

Integrating behavioral health services into primary care practices is one way to address emerging mental health challenges because it closes the gap between need and access. In October 2019, the American Medical Association (AMA) along with several other leading physician organizations established the Behavioral Health Integration (BHI) Collaborative to help primary care physicians build successful models of integration.

“We’ve been hearing about the challenges of integrating mental health because our primary care colleagues have been talking about this for years,” says Dr. Patrice Harris, practicing psychiatrist and present of the AMA. “That’s where the collaborative comes into focus. We want to continue to provide resources to maximize the potential return on investment. We want to help primary care physicians succeed.”

The collaborative is building an online compendium that includes webinars, remote learning opportunities and other resources (e.g., key steps, best practices and tools) to integrate behavioral health, engage patients and ensure billing and coding compliance.

As Smith’s experience demonstrates, BHI isn’t

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WHAT YOU NEED TO KNOW

CPT CODES FOR BEHAVIORAL HEALTH INTEGRATION

Following are several CPT codes for BHI that can help practices structure their programs and compensation models:
(Note: This is not a comprehensive list.)

<table>
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<th>CPT CODE</th>
<th>DESCRIPTION</th>
<th>NATIONAL AVERAGE MEDICARE PAYMENT FOR NONFACILITY SERVICES*</th>
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<tr>
<td>99406**</td>
<td>Smoking cessation counseling, 3-10 minutes</td>
<td>$15.70</td>
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<tr>
<td>99407**</td>
<td>Smoking cessation counseling, &gt;10 minutes</td>
<td>$28.96</td>
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<td>G0396**</td>
<td>Alcohol/substance abuse counseling, 15-30 minutes</td>
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<tr>
<td>G0397**</td>
<td>Alcohol/substance abuse counseling, &gt;30 minutes</td>
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<td>Annual alcohol screening, 15 minutes</td>
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<td>G0443**</td>
<td>Brief alcohol misuse counseling</td>
<td>$26.87</td>
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<tr>
<td>G0444**</td>
<td>Annual depression screening</td>
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<td>90832**</td>
<td>Psychotherapy, 30 minutes</td>
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<td>Psychotherapy, 60 minutes</td>
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<td>90853**</td>
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<td>96156**</td>
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<td>99484</td>
<td>General BHI care management</td>
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<td>Psychiatric collaborative care management, first month, 70 minutes</td>
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<td>Psychiatric collaborative care management, subsequent months, 60 minutes</td>
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<td>99494</td>
<td>Psychiatric collaborative care management, each additional 30 minutes per calendar month</td>
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<tr>
<td>99452</td>
<td>Professional-to-professional digital consultation billable by primary care provider</td>
<td>$36.64</td>
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<tr>
<td>99483**</td>
<td>Cognitive assessment and care plan</td>
<td>$282.63</td>
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*Medicare payment varies based on your specific Medicare Administrative Contractor locality.
**Medicare-covered telehealth service during the public health emergency.

» FOR MORE INFORMATION

Scan to learn more about BHI in primary care, read the BHI Collaborative's BHI Compendium.

Also refer to CMS' educational guide for two specific BHI models: psychiatric collaborative care services and general BHI care management. It provides operational and billing/coding considerations.
Chronic Conditions / Behavioral Health Integration

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Helpful only during COVID-19. It can also help primary care physicians move the needle on value-based care.

“Studies have shown that untreated depression can complicate the course of diabetes, hypertension, heart disease and post-surgical care,” Harris says. “It’s so important to look at the return on investment in terms of health outcomes.”

BHI: Getting started

As with any new initiative, performing a needs assessment is the first step. Depending on patient needs, there are varying degrees of integration that might be appropriate for a primary care practice.

Sean Weiss, partner and vice president of compliance at DoctorsManagement, says primary care physicians should run a utilization report for the past 30 days, then ask these critical questions:

- How many unique patients had a mental health diagnosis, and what were those diagnoses? This requires asking patients to fill out Patient Health Questionnaires such as the PHQ-9, GAD-Z, PHQ-2 or EPDS.
- What was the average duration of those encounters?
- How often did those patients receive a referral to an external behavioral health provider?
- How often did those patients receive a prescription and for which medications?

“Data is king,” Weiss says. “It’s about establishing clinical need.”

This analysis can also help physicians determine the right credentialed provider, he adds. For example, if they frequently write prescriptions, it might make sense to partner with a psychiatrist. If the majority of patients have anxiety or struggle with alcohol abuse, maybe a psychologist or social worker is the best fit.

Choosing a BHI model

The good news is that depending on the model chosen, physicians don’t need to completely re-engineer their practices, Harris says.

For example, some primary care physicians may choose to simply consult with an external psychiatrist on a case-by-case basis. This model might work well in practices with a low volume of patients with mental health diagnoses. In other models, a behavioral health specialist works on-site collaborating through varying degrees of co-created care plans and shared systems. The specialist may or may not be employed directly by the practice.

Physicians also need to think about billing implications, says Jackie Coult, CHBC, senior healthcare consultant at Eide Bailly LLP, who recently worked with a primary care practice struggling to cover an employed social worker’s wage because commercial insurance payments for the psychotherapy services she performs are relatively low.

Experts say physicians should consider these questions:

- What current procedural terminology (CPT) codes will the behavioral health specialist actually bill? See the sidebar for more information. Keep in mind that state licensure requirements, payer policies and individual areas of expertise will dictate what type of provider can bill for each type of service, Coult says.

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What do payers pay for the CPT codes that the specialist will most likely bill? Be sure to differentiate between Medicare, Medicaid and commercial payers (including each individual plan).

What is the anticipated service volume?

These questions can help primary care physicians determine not only whether a direct full- or part-time employment model makes financial sense, but also specifically what type of compensation structure to offer, Weiss says. Some practices use a salary while others use a lower base amount plus volume-driven bonus payments, he adds.

**Telehealth considerations**

During the public health emergency, the Centers for Medicare & Medicaid Services (CMS) expanded its list of telehealth-covered CPT codes to include various BHI-related services. The good news is that telehealth can help practices lower overhead costs for BHI.

“Telehealth is going to play more and more of a role in the integrated care of patients,” Weiss says. Investing in a compliant telehealth platform can help primary care physicians achieve a return on investment, he adds.

Telehealth-based BHI is something Smith hopes payers will continue to cover even after the end of the public health emergency.

“It enables access and quality care, it’s efficient, and it’s cost-effective. It meets the quadruple aim,” says Smith. “Once you address mental health problems, you’ll see an improvement in the overall health of patients.”

When it comes to BHI, she says independent primary care physicians can lead the charge. “One of the reasons I’ve been so successful is because I’m a solo physician,” Smith says. “I had the freedom to actually pursue this area of interest. When physicians are confined, that interferes with physician well-being and their desire to do what’s best for the patient.”

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**3 ways physicians can foster behavioral health relationships and increase reimbursement**

by Charlie Hutchinson Contributing Author

1 **Develop a mini pilot list of patients**

   Before diving straight into discovering and fostering relationships with behavioral health professionals, it’s important for PCPs to be curious about the needs of their patients.
   
   Are there any patients that have been diagnosed with a physical health condition in addition to a mental health concern like depression?

   If so, these patients may benefit the most from integrated care between physical and behavioral health providers. Developing a list of 10 or so patients who meet these criteria to start will allow a practice to create a mini-pilot group and craft a program based on the needs of those patients.

   Without understanding the patients who would benefit from a potential collaborative care program the most, finding the right behavioral health professionals becomes a more difficult task.

2 **Ask colleagues**

   Where does one even start in finding behavioral professionals who are both knowledgeable and willing to collaborate with PCP practices?

   Chances are other PCPs in the surrounding area have collaborated with behavioral health professionals in the past or are in the middle of a similar process.

   This method also acts as a great preliminary vetting process, assuming the PCP’s opinion is respected among colleagues. Gathering several opinions from various PCPs will hopefully contain a diverse group of professionals and provide a great first step in gathering initial candidates.

3 **Pick up the phone**

   Collaborating with behavioral health professionals doesn’t have to be a complicated process or large financial investment. Sometimes, it’s as simple as picking up the phone and contacting them.

   This kind of collegial setting will hopefully provide an opportunity for both sides to get to know one another and determine if there’s a fit for collaboration in the future. It’s also a great opportunity to hear how they would diagnose and treat a current patient’s behavioral health issues and better understand their diagnostic process.

   Behavioral health integration may sound complicated, but it doesn’t have to be and a simple act of asking someone to lunch may be all that’s needed to get things started.”
CODING INSIGHTS / CHRONIC CONDITIONS

Coding case studies

Depression

by Renee Dowling, CPC Contributing author

Getting paid requires accurate documentation and correct code selection. In our coding case studies, we explore the correct coding for a specific condition based on a hypothetical clinical scenario. This particular scenario involves a patient presenting with symptoms of depression. See if you can choose the correct codes.

Clinical scenario

Chief complaint
follow up for depression

History
Patient, 56, presented with continued chronic fatigue and concentration issues. Reports regular physical activity, such as swimming at the YMCA up to one hour at a time, up to four times per week. Patient has had an 8-pound weight gain since last office visit. She notes daily activities such as walking in the park and going to the YMCA. She has modified diet and has consulted with nutrition services for evaluation. Reports adherence with healthy diet provided by dietetic services. Patient is in remission from colon cancer, not currently on medication administration of chemotherapy. She states that weight gain and continued fatigue may be the result of chemotherapy. Patient denies fever, chills, headaches, weakness and light-headedness.

Review of Systems


HENT: Negative

Eyes: Negative
Respiratory: Negative
Cardiovascular: Negative
Gastrointestinal: Negative
Endocrine: Negative
Genitourinary: Negative
Musculoskeletal: Negative
Skin: Negative

Allergic/Immunologic: Negative
Neurological: Negative
Hematological: Negative

Psychiatric/behavioral: Has had decreased concentration but no dysphoric mood, self-injury, sleep disturbance or suicidal ideas.

Physical Exam

Blood pressure: 110/70
Temperature: 97.8 °F
Height: 5’7”
Weight: 307 pounds
Last menstrual period: 10/08/2012
BMI: 48.08 kg/m2

Constitutional: She is oriented to person, place and time. She appears well-developed and well-nourished. She is active. No distress.

HENT:

Head: Normocephalic
Right ear: Hearing, tympanic membrane, external ear and ear canal normal.
Left ear: Hearing, tympanic membrane, external ear and ear canal normal.

Mouth/throat: Uvula is midline, oropharynx is clear and moist and mucous membranes are normal.

Eyes: Conjunctivae, extraocular muscle and lids are normal. Pupils are equal, round and reactive to light.

Neck: Normal range of motion

Cardiovascular: Normal rate, regular rhythm, S1 normal, S2 normal and normal heart sounds. Exam reveals no gallop. No murmur heard.

Pulmonary/chest: Effort normal and breath sounds normal. No respiratory distress. She has no decreased breath sounds. She has no wheezes. She has no rhonchi. She has no rales.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is no hepatosplenomegaly. There is no tenderness. There is no rigidity, no rebound and no guarding.

Musculoskeletal: Normal range of motion.

Neurological: She is alert and oriented to person, place, and time. Speech is normal.

Psychiatric: She has a normal mood and affect. Her speech is normal and behavior is normal.
**Assessment and plan**
- Other fatigue.
  - CBC and differential TSH
- Depression, unspecified depression type.
  - Refill trazodone HCL (trazodone oral)
- Morbid obesity due to excess calories.
  - Continue regular exercise and healthy diet

**Documentation coding requirements**
When documenting depression, include the following:
- Major depressive disorder
  - Single (in partial or full remission) or recurrent episode
  - Mild, moderate or severe episode
  - With or without psychotic features
- Bipolar disorder with current episode depressed (mild or moderate severity)
- Mood disorder with or without major depressive-like episode
- Adjustment disorder with depressed mood
- Postpartum depression

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**DIAGNOSIS CODE**

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</table>

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Indianapolis. Send your diagnosis coding questions to medec@mjlifesciences.com
The health care industry has for years been trying to figure out how to get people to buy in to telehealth services. Were users concerned about security? Was it too hard to use? Will older patients be comfortable seeing their doctor online? It turns out that a pandemic was the catalyst no one saw coming.

Telehealth care in the pandemic and beyond
The Centers for Disease Control and Prevention reports that telehealth usage increased 50% in the first quarter of 2020 compared with the first quarter of 2019, with a 154% increase noted by the start of the second quarter of 2020 from the prior year. Changes in the way telehealth visits were reimbursed helped make this change happen and encouraged vendors and health care providers to offer increased support for virtual health platforms.

The problem then became how providers could quickly pivot to provide the services their patients needed without seeing them in person. According to a Kaiser Family Foundation (KFF) report, many providers didn’t have the capacity to offer telehealth at the level the pandemic required at the beginning of 2020. Regulatory changes brought a new influx of cash to health care systems to create or upgrade telehealth systems. The KFF revealed that while 50 of America’s largest health systems already had telemedicine programs in place, only about 15% of physicians in those systems actually used the platform.

The explosion of demand for telehealth services and new financial support for this channel meant that many health care systems had to consider revising or replacing their platforms and offering support and education to providers and patients. Health care systems that didn’t have systems already in place found out quickly that there is a lot more to telehealth than a virtual connection.

More than just video
When it comes to telehealth platforms, there is no such thing as a one-size-fits-all approach. Each patient and provider has unique needs and there is a wide range of services offered in every health system. Organizations need a flexible vendor partner that can satisfy different preferences among both physicians and patients, says Dan Olson, senior vice president of provider and payer solutions at Amwell, a Boston-based telemedicine company.

“We find that our customers have a wide range of needs and many want an integrative solution,” Olson says. “But they also have providers that really want fast, easy, and simple.”

Early in the pandemic, some health care providers resorted to private systems like Zoom or FaceTime to see patients if their systems weren’t
ready to meet their virtual patient care needs. But these platforms bring up privacy concerns and there is no consistency through the health care system. The focus shouldn’t be just seeing a patient over a video stream but also providing them with a safe and secure space that will allow providers to integrate care with their electronic medical record (EMR). It’s not enough just to put a screen between patients and providers.

“Everyone ran out with COVID and tried to do video visits. The market is kind of paused now as vendors look at enabling virtual health throughout the entire care continuum,” says Patrick Rainville, director of business development at Iron Bow Healthcare Solutions, a telehealth firm headquartered in Virginia.

**Systems should be agile and integrated**

Health care systems should be looking for enterprise platforms that don’t need to be developed from scratch. Software platforms that can be configured for individual workflows at the use level—not coded—are in high demand, Rainville explains.

“A vendor should offer something that can scale from home use and wellness to ambulatory, skilled, acute care and more,” he says.

Telehealth systems have to be agile and easy to use for both providers and patients while also offering a consistent experience. Blending flexibility and consistency can be difficult. A lot of practices launched telehealth solutions quickly to meet the demand presented by the coronavirus 2019 (COVID-19). One problem of hasty solutions was that many lacked integration to a health system’s electronic health record (EHR), he says.

“Usually companies that struggle don’t have an EHR integration,” says Chad Anguilin, vice president of in-practice technology services at the Michigan-based health care consulting firm Medical Advantage.

There also must be an understanding of clinical care and workflow, he says.

“It’s not enough to just offer a telephone number or link. It’s about training and support for everyone involved. Everything from triage to ‘webside manner’ is completely different in telehealth, and you have to be trained properly from the front office to the clinical team,” Anguilin adds.

**Look for a proven record, adaptability**

A vendor must be able to evolve with your needs and scale across an enterprise, too. There are a lot of technology solutions that can connect people, but delivering care is a different animal. A vendor partner should have a record of success — and be able to prove it.

“You need a partner that has done its due diligence and vetting,” Olson recommends. Experience matters when it comes to telehealth platforms, he adds.

A good vendor will be able to demonstrate success elsewhere and be willing to create workarounds and flexible solutions where you need them. They should share where their gaps are and what they are planning to be able to move forward. Telehealth isn’t a static platform.

“Ask for two or three references in a similar specialty,” Anguilin says. “If it’s taking a long time to find those references, that should be a red flag.”

Health care systems will also want to make sure their vendor partner is prepared to stay around and help long after a contract is signed.

“Choosing a partner that has done this before or who has a customer base where they have demonstrated success is important,” Olson says. “A lot of people claim they can do things, but they don’t. The relationship is critical. So I would ask [the vendor], ‘What is your model for support and what do I get with what I’m buying?’”

—Joseph Brennan, Moonshot Health Consulting

"The relationship is critical. So I would ask [the vendor], ‘What is your model for support and what do I get with what I’m buying?’"

—Joseph Brennan, Moonshot Health Consulting
Roland Therriault, president and executive vice president of sales at InSync Healthcare Solutions, says it's important for a forward-thinking telehealth vendor to offer the following:

**EHR Integration:** Telehealth software should provide a seamless experience between patients and providers. The best solutions allow easy appointment scheduling and documentation of care during a patient visit to ease administrative burden. Otherwise, providers are forced to switch between platforms entering and reviewing information instead of concentrating on patient care.

**Collaborative Care:** Solutions that allow information exchange between stakeholders improve care delivery. When care team members can send and receive notes and videos, patients ultimately receive more coordinated, effective care.

**Telehealth Medical Billing:** There are many EHR platforms capable of providing or integrating with telehealth providers. However, the important question to ask is: How is telehealth billing handled? The best solutions automate the claims creation process when a visit begins and allow for denial management and batch rebilling.

**Flexibility:** Cookie-cutter telehealth solutions that don’t allow for customizations to address specific practice nuances should be marked off any list. Health care is complex, and no two practices are alike. A large provider organization will have access to resources that a small, specialty practice will not. Plus, the needs of a mental health provider are much different from those of a pediatrics practice. Telehealth solutions should be able to address these nuances.

Therriault suggests practices and health systems ask the following questions when choosing a vendor partner:

- Can you provide a proven track record of successful implementations?
- What implementation and support options do you provide?
- How much of your budget is dedicated to ongoing research and development?
- What is your pricing structure?
- Can your solution integrate with my EHR and billing systems?
- Does your solution allow providers to document during a session?
- Can we customize the solution to fit our practice’s needs?
- Is the telehealth solution HIPAA-compliant, and can it protect against emerging security threats?
Continued from Page 33

might not be health care specific. It’s important to have that experience in health care because workflows and all the different systems you work with are very different than turning on a web meeting. You need account management and support teams that will walk you through it and build trust.”

The biggest question, says telehealth expert Joseph Brennan of Moonshot Health Consulting, in Grand Rapids, Michigan, is how the system and patients will be supported after the health system signs on.

“When implementing a technology that is in health care, whoever is supporting you — the relationship is critical,” Brennan says. “So I would ask [the vendor], ‘What is your model for support and what do I get with what I’m buying?’”

It’s helpful to have a dedicated project manager or support team from start to finish, Anguilm adds. Sustainability is also key. If waivers and reimbursement change once the pandemic subsides, you shouldn’t need to find a new platform. A good partner will have a full implementation plan laid out, detail how you will reach out to and educate patients, provide reimbursement information and more. Avoid long-term contracts, he adds, because there isn’t much information yet on what reimbursement for telehealth will look like a year from now.

“Simply put, a good vendor partner program should feel like an extension of ongoing operations. Health care organizations looking for a strong partner for telehealth should expect a level of support that maximizes opportunity and minimizes headaches and interruptions to current workflows,” adds Roland Therriault, president and executive vice president of sales at InSync Healthcare Solutions, a Florida-based health care technology company. “Vendor partners should take on the heavy lifting of implementations, technology adoption and optimal use of a telehealth solution. In addition, the best relationships ensure ongoing success by keeping providers apprised of evolving regulatory movements, ensuring infrastructures align with the most advanced security functionality and ongoing support and oversight of end-user education. This way, providers are able to focus on patient care and other mission-critical activities.”

**Red flags and warning signs**

When it comes to telehealth, the big challenge seems to be on the technology end. But solutions that focus on technology alone aren’t enough. Telehealth platforms have to have a deep understanding of health care and the needs of both patients and providers. When searching for a telehealth platform, there are a number of things to watch for, including vendors that overpromise, Olson warns.

“That should raise a red flag, in my opinion,” Olson says. “A vendor saying that it can do anything a customer wants is not practical in the real world.”

Ask vendors for references from providers that use their system already. They should be willing to share success stories, Olson says.

Anguilm adds that it’s also important to look for glitches and delays during demonstrations of the program. If it happens in a demo, it will happen live, he warns. Make sure the company can support the technology it promises. Brennan suggests that part of the vendor partner selection process should include a discussion of failure and connection rates. Do users who sign on stay on for their appointments? Where are people dropping off and what can the vendor do to help address this?

There should be ongoing support and service, too, with teams dedicated to address patient problems and support providers.

“When you’re looking for a partner, look for someone who has been around and has a full-service offering,” says Kevin Greene, director of health care sales at Iron Bow. It’s not enough for a vendor to supply a product. There needs to be operational and clinical support with an understanding of the outcomes you are trying to reach, he adds.

The best vendors offer helpdesk services and ongoing support for both clinical and technical support.

“One thing is if you are looking for a vendor, you get commodity offerings. When you look for a partner, you get someone who will invest with you,” Greene says. “You need partners that want to have a shared-risk environment that will put skin in the game, like a per-click share to make sure the program is successful.”

Overall, Brennan says, understand that not every solution works for every system, and that there is a big difference between technology and health care. The key is finding someone who understands your goals and knows what it will take to get you there.

“It’s all the same thing. It’s videoconferencing bolted onto your EMR,” he says. “But if the person you’re talking to doesn’t have any health care references, that’s a big red flag. They’re either brand new and you’re going to be their first customer, or it’s not going that great. Many tech people don’t understand how intricate every aspect of health care is. ‘This isn’t a retail shopping experience; this is health care.’”
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