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MedicalEconomics.com
**POWER TO PREVENT EXACERBATIONS WITH**

When added to standard of care, **FASENRA** is proven to reduce annual exacerbation rate and improve lung function in patients with severe eosinophilic asthma.†1-4

*Statistical significance for FEV1 improvement was established at end of treatment. Week 4 results were descriptive only. FASENRA demonstrated greater improvements in change from baseline in pre-bronchodilator FEV1 compared with placebo at Week 4 (first measured time point after administration of treatment dose) that were maintained through end of treatment.*4

†Data from the US CHRONICLE Study, an observational study of subspecialist-treated adults with severe asthma that evaluated 1168 eligible and 659 enrolled patients between February 27, 2018 and December 1, 2018. For this analysis, eosinophilic asthma was defined as treatment with anti-IL5/IL5R therapy (estimated 28% of eligible patients) or blood eosinophil counts >150 cells/μL in patients not receiving anti-IL5/IL5R therapy (estimated 41% of eligible patients). Estimates for patients not receiving anti-IL5/IL5R therapy were derived from enrolled patients with available blood eosinophil counts (n=213) and projected to the full eligible population.

‡Data are not intended to suggest comparison of safety or efficacy to any other IL-5 or IL-5Rα treatment.6

Power to Prevent Exacerbations with FASENRA

In a US study of adults with severe asthma, more than 2 OUT OF 3 PATIENTS HAD Eosinophilic Asthma†5

FASENRA is the #1 respiratory biologic selected by specialists for new patients with severe eosinophilic asthma16

**IMPORTANT SAFETY INFORMATION**

**CONTRAINICATIONS**

Known hypersensitivity to benralizumab or excipients.

**WARNINGS AND PRECAUTIONS**

Hypersensitivity Reactions

Hypersensitivity reactions (eg, anaphylaxis, angioedema, urticaria, rash) have occurred after administration of FASENRA. These reactions generally occur within hours of administration, but in some instances have a delayed onset (ie, days). Discontinue in the event of a hypersensitivity reaction.

Acute Asthma Symptoms or Deteriorating Disease

FASENRA should not be used to treat acute asthma symptoms, acute exacerbations, or acute bronchospasm.

Reduction of Corticosteroid Dosage

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with FASENRA. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

Please see additional Important Safety Information throughout and accompanying Brief Summary of full Prescribing Information.
**FASENRA** is not indicated for treatment of other eosinophilic conditions or for the relief of acute bronchospasm or status asthmaticus.

**BETTER BREATHING AFTER THE FIRST DOSE**

**Prevented exacerbations**

51% reduction in AER* (0.74) compared to placebo + SOC (1.52) in Trial 1 (48 weeks)\(^1\)

\(P < 0.0001\)  

**Reduced or eliminated OCS use**

75% reduction in median OCS dose compared to 25% reduction with placebo + SOC in Trial 3 (28 weeks)\(^1\)

\(P < 0.001\)  

FASENRA (n=73), placebo (n=75)

52% of patients who were controlled on doses ≤12.5 mg **eliminated OCS use** compared to placebo + SOC (19%) in Trial 3 (28 weeks)\(^1\)

FASENRA (n=42), placebo (n=42)

The analysis of this endpoint was not multiplicity protected. Result is descriptive only.

In Trials 1 and 2, FASENRA and placebo were administered with high-dose ICS/LABA (inhaled corticosteroids/long-acting β\(_2\)-agonist) with or without other controllers, including systemic steroids.\(^2,3\) In Trial 3, FASENRA and placebo were administered in addition to daily OCS (7.5 to 40 mg) plus SOC, which is defined as high-dose ICS/LABA with or without other controllers.\(^4\)

The most common adverse reactions (≥3%) from Trials 1 and 2 in patients who received FASENRA Q8W (n=822) or placebo (n=847) included headache (8% vs 6%); pyrexia (3% vs 2%); pharyngitis* (5% vs 3%); and hypersensitivity reactions* (3% vs 3%).\(^1\)

Adverse reactions from Trial 3 with 28 weeks of treatment with FASENRA (n=73) or placebo (n=75) in which the incidence was more common in FASENRA than placebo include headache (8.2% compared to 5.3%, respectively) and pyrexia (2.7% compared to 1.3%, respectively). The frequencies for the remaining adverse reactions with FASENRA were similar to placebo.\(^1\)

**IMPORTANT SAFETY INFORMATION (cont’d)**

**Parasitic (Helminth) Infection**

It is unknown if FASENRA will influence a patient’s response against helminth infections. Treat patients with pre-existing helminth infections before initiating therapy with FASENRA. If patients become infected while receiving FASENRA and do not respond to anti-helminth treatment, discontinue FASENRA until infection resolves.

**ADVERSE REACTIONS**

The most common adverse reactions (incidence ≥ 5%) include headache and pharyngitis.

Injection site reactions (eg, pain, erythema, pruritus, papule) occurred at a rate of 2.2% in patients treated with FASENRA compared to 1.9% in patients treated with placebo.

Please see additional Important Safety Information throughout and accompanying Brief Summary of full Prescribing Information.
STUDY DESIGNS

Trials 1 and 2
Trial 1 (48-week) and Trial 2 (56-week) were 2 randomized, double-blind, parallel-group, placebo-controlled, multicenter studies comparing FASENRA 30 mg SC Q4W for the first 3 doses, then Q8W thereafter; benralizumab 30 mg SC Q4W, and placebo SC. A total of 1204 (Trial 1) and 1306 (Trial 2) patients aged 12-75 years old with severe asthma uncontrolled on high-dose ICS (Trial 1) and medium- to high-dose ICS (Trial 2) plus LABA with or without additional controllers were included. Patients had a history of ≥2 exacerbations requiring systemic corticosteroids or temporary increase in usual dosing in the previous year. Patients were stratified by geography, age, and blood eosinophil counts (≥300 cells/μL and <300 cells/μL). The primary endpoint was annual exacerbation rate ratio vs placebo in patients with blood eosinophil counts of ≥300 cells/μL on high-dose ICS and LABA. Exacerbations were defined as a worsening of asthma that led to use of systemic corticosteroids for ≥3 days, temporary increase in a stable OCS background dose for ≥3 days, emergency/urgent care visit because of asthma that needed systemic corticosteroids, or inpatient hospital stay of ≥24 hours because of asthma. Key secondary endpoints were pre-bronchodilator FEV1, and total asthma symptom score at Week 48 (Trial 1) and Week 56 (Trial 2) in the same population.1,2

Trial 3
A 28-week, randomized, double-blind, parallel-group, placebo-controlled, multicenter OCS reduction study comparing the efficacy and safety of FASENRA (30 mg SC) Q4W for the first 3 doses, then Q8W thereafter; benralizumab (30 mg SC) Q4W, and placebo (SC) Q4W. A total of 220 adult (18-75 years old) patients with severe asthma on high-dose ICS plus LABA and daily OCS (7.5 to 40 mg/day), blood eosinophil counts of ≥150 cells/μL, and a history of ≥1 exacerbation in the previous year were included. The primary endpoint was the median percent reduction from baseline in the final daily OCS dose while maintaining asthma control.3,4

REFERENCES


IMPORTANT SAFETY INFORMATION (cont’d)

USE IN SPECIFIC POPULATIONS
The data on pregnancy exposure from the clinical trials are insufficient to inform on drug-associated risk. Monoclonal antibodies such as benralizumab are transported across the placenta during the third trimester of pregnancy; therefore, potential effects on a fetus are likely to be greater during the third trimester of pregnancy.

INDICATION
FASENRA is indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

INDICATION (cont’d)
• FASENRA is not indicated for treatment of other eosinophilic conditions
• FASENRA is not indicated for the relief of acute bronchospasm or status asthmaticus

Please see additional Important Safety Information throughout and accompanying Brief Summary of full Prescribing Information.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.FDA.gov/medwatch or call 1-800-FDA-1088.
FASENRA® (benralizumab) injection, for subcutaneous use

Initial U.S. Approval: 2017

Brief Summary of Prescribing Information. For complete prescribing information consult official package insert.

INDICATIONS AND USAGE

FASENRA is indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype [see Clinical Studies (14) in the full Prescribing Information].

Limitations of use:

• FASENRA is not indicated for treatment of other eosinophilic conditions.
• FASENRA is not indicated for the relief of acute bronchospasm or status asthmaticus.

DOSE AND ADMINISTRATION

Recommended Dose

FASENRA is for subcutaneous use only.

The recommended dose of FASENRA is 30 mg administered once every 4 weeks for the first 3 doses, and then once every 8 weeks thereafter by subcutaneous injection into the upper arm, thigh, or abdomen.

General Administration Instructions

FASENRA is intended for use under the guidance of a healthcare provider. In line with clinical practice, monitoring of patients after administration of biologic agents is recommended [see Warnings and Precautions (5.1) in the full Prescribing Information].

Administer FASENRA into the thigh or abdomen. The upper arm can also be used if a healthcare provider or caregiver administers the injection. Prior to administration, warm FASENRA by leaving cartridge at room temperature for about 30 minutes. Visually inspect FASENRA for particulate matter and discoloration prior to administration. FASENRA is clear to opalescent, colorless to slightly yellow, and may contain a few translucent or white to off-white particles. Do not use FASENRA if the liquid is cloudy, discolored, or if it contains large particles or foreign particulate matter.

Prefilled Syringe

The prefilled syringe is for administration by a healthcare provider.

Autoinjector (FASENRA PEN™)

FASENRA PEN is intended for administration by patients/caregivers. Patients/caregivers may inject after proper training in subcutaneous injection technique, and after the healthcare provider determines it is appropriate.

Instructions for Administration of FASENRA Prefilled Syringe (Healthcare Providers)

Refer to Figure 1 to identify the prefilled syringe components for use in the administration steps.

Figure 1

1. Grasp the syringe body, not the plunger, to remove prefilled syringe from the tray. Check the expiration date on the syringe. The syringe may contain small air bubbles; this is normal. Do not expel the air bubbles prior to administration.

2. Do not remove needle cover until ready to inject. Hold the syringe body and remove the needle cover by pulling straight off. Do not hold the plunger or plunger head while removing the needle cover or the plunger may move. If the prefilled syringe is damaged or contaminated (for example, dropped without needle cover in place), discard and use a new prefilled syringe.

3. Gently pinch the skin and insert the needle at the recommended injection site (i.e., upper arm, thigh, or abdomen).

4. Inject all of the medication by pushing in the plunger all the way until the plunger head is completely between the needle guard activation clips. This is necessary to activate the needle guard.

5. After injection, maintain pressure on the plunger head and remove the needle from the skin. Release pressure on the plunger head to allow the needle guard to cover the needle. Do not re-cap the prefilled syringe.

6. Discard the used syringe into a sharps container.

Instructions for Administration of FASENRA PEN

Refer to the FASENRA PEN ‘Instructions for Use’ for more detailed instructions on the preparation and administration of FASENRA PEN [See Instructions for Use in the full Prescribing Information]. A patient may self-inject or the patient caregiver may administer FASENRA PEN subcutaneously after the healthcare provider determines it is appropriate.

CONTRAINDICATIONS

FASENRA is contraindicated in patients who have known hypersensitivity to benralizumab or any of its excipients [see Warnings and Precautions (5.1) in the full Prescribing Information].

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Hypersensitivity reactions (e.g., anaphylaxis, angioedema, urticaria, rash) have occurred following administration of FASENRA. These reactions generally occur within hours of administration, but in some instances have a delayed onset (i.e., days). In the event of a hypersensitivity reaction, FASENRA should be discontinued [see Contraindications (4) in the full Prescribing Information].

Acute Asthma Symptoms or Deteriorating Disease

FASENRA should not be used to treat acute asthma symptoms or acute exacerbations. Do not use FASENRA to treat acute bronchospasm or status asthmaticus. Patients should seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with FASENRA.

Reduction of Corticosteroid Dosage

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with FASENRA. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

Parasitic (Helmithin) Infection

Eosinophils may be involved in the immunological response to some helmith infections. Patients with known helmith infections were excluded from participation in clinical trials. It is unknown if FASENRA will influence a patient’s response against helmith infections.

Treat patients with pre-existing helmith infections before initiating therapy with FASENRA. If patients become infected while receiving treatment with FASENRA and do not respond to anti-helmithin treatment, discontinue treatment with FASENRA until infection resolves.

ADVERSE REACTIONS

The following adverse reactions are described in greater detail in other sections:

• Hypersensitivity Reactions [see Warnings and Precautions (5.1) in the full Prescribing Information]

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Across Trials 1, 2, and 3, 1,808 patients received at least 1 dose of FASENRA [see Clinical Studies (14) in the full Prescribing Information]. The data described below reflect exposure to FASENRA in 1,863 patients, including 1,556 exposed for at least 24 weeks and 1,387 exposed for at least 48 weeks. The safety exposure for FASENRA is derived from two Phase 3 placebo-controlled studies (Trials 1 and 2) from 48 weeks duration [FASENRA every 4 weeks (N=841), FASENRA every 4 weeks for 3 doses, then every 8 weeks (N=822), and placebo (N=847)]. While a dosing regimen of FASENRA every 4 weeks was included in clinical trials, FASENRA administered every 4 weeks for 3 doses, then every 8 weeks thereafter is the recommended dose [see Dosage and Administration (2.1) in the full Prescribing Information]. The population studied was 12 to 75 years of age, of which 64% were female and 79% were white.

Adverse reactions that occurred at greater than or equal to 3% incidence are shown in Table 1.

Table 1. Adverse Reactions with FASENRA with Greater than or Equal to 3% Incidence in Patients with Asthma (Trials 1 and 2)

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>FASENRA (N=822)</th>
<th>Placebo (N=847)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Pharyngitis*</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hypersensitivity reactions†</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

1Pharyngitis was defined by the following terms: ‘Pharyngitis’, ‘Pharyngitis bacterial’, ‘Viral pharyngitis’, ‘Pharyngitis streptococcal’.

†Hypersensitivity reactions were defined by the following terms: ‘Urticaria’, ‘Urticaria popularis’, and ‘Rash’ [see Warnings and Precautions (5.1) in the full Prescribing Information].
As with all therapeutic proteins, there is potential for immunogenicity. The detection of immunogenicity with placebo.

In Trials 1 and 2, injection site reactions (e.g., pain, erythema, pruritus, palpable) occurred at a rate of 2.2% in patients treated with FASENRA compared with 1.9% in patients treated with placebo.

Immunogenicity

As with all therapeutic proteins, there is potential for immunogenicity. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to benralizumab in the studies described below with the incidence of antibodies in other studies or to other products may be misleading.

Overall, treatment-emergent anti-drug antibody response developed in 13% of patients treated with FASENRA at the recommended dosing regimen during the 48 to 56 week treatment period. A total of 12% of patients treated with FASENRA developed neutralizing antibodies. Anti-benralizumab antibodies were associated with increased clearance of benralizumab and increased blood eosinophil levels in patients with high anti-drug antibody titers compared to antibody negative patients. No evidence of an association of anti-drug antibodies with efficacy or safety was observed.

The data reflect the percentage of patients whose test results were positive for antibodies to benralizumab in specific assays.

Postmarketing Experience

In addition to adverse reactions reported from clinical trials, the following adverse reactions have been identified during post approval use of FASENRA. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These events have been chosen for inclusion due to either their seriousness, frequency of reporting, or causal connection to FASENRA or a combination of these factors.

Drug Interactions

No formal drug interaction studies have been conducted.

Use in Specific Populations

Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to FASENRA during pregnancy. Healthcare providers can enroll patients or encourage pregnant women and treatment adjusted as necessary to maintain optimal control.

Animal Data

Data

In a prenatal and postnatal development study conducted in cynomolgus monkeys, there was no evidence of fetal harm with IV administration of benralizumab throughout pregnancy at doses that produced exposures up to approximately 310 times the exposure at the maximum recommended human dose (MRHD) of 30 mg SC [see Data].

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Disease-associated maternal and/or embryo/fetal risk:

In women with moderately controlled asthma, evidence demonstrates that there is an increased risk of pre eclampsia in the mother and prematurity, low birth weight, and small for gestational age in the neonate. The level of asthma control should be closely monitored in pregnant women and treatment adjusted as necessary to maintain optimal control.

Data

Animal Data

In a prenatal and postnatal development study pregnant cynomolgus monkeys received benralizumab from beginning on GD20 to GD22 (dependent on pregnancy determination), on GD55, once every 14 days thereafter throughout the gestation period and 1-month postpartum (maximum 14 doses) at doses that produced exposures up to approximately 310 times that achieved with the MRHD (on an AUC basis with maternal IV doses up to 30 mg/kg once every 2 weeks). Benralizumab did not elicit adverse effects on fetal or neonatal growth (including immune function) up to 6.5 months after birth. There was no evidence of treatment-related external, visceral, or skeletal malformations. Benralizumab was not teratogenic in cynomolgus monkeys. Benralizumab crossed the placenta in cynomolgus monkey. Benralizumab concentrations were approximately equal in mothers and infants on postpartum day 7, but were lower in infants at later time points. Eosinophil counts were suppressed in infant monkeys with gradual recovery by 6 months postpartum; however, recovery of eosinophil counts was not observed for one infant monkey during this period.

Location

Risk Summary

There is no information regarding the presence of benralizumab in human or animal milk, and the effects of benralizumab on the breast fed infant and on milk production are not known. However, benralizumab is a humanized monoclonal antibody (IgG1κ-class), and immunoglobulin G6 (Ig6) is present in human milk in small amounts. If benralizumab is transferred into human milk, the effects of local exposure in the gastrointestinal tract and potential limited systemic exposure in the infant to benralizumab are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for benralizumab and any potential adverse effects on the breast-fed child from benralizumab or from the underlying maternal condition.

Pediatric Use

There were 108 adolescents aged 12 to 17 with asthma enrolled in the Phase 3 exacerbation trials (Trial 1: n=53, Trial 2: n=55). Of these, 46 received placebo. 40 received FASENRA every 4 weeks for 3 doses, followed by every 8 weeks thereafter, and 22 received FASENRA every 4 weeks. Patients were required to have a history of 2 or more asthma exacerbations requiring oral or systemic corticosteroid treatment in the past 12 months and reduced lung function at baseline (pre-bronchodilator FEV1<70%) despite regular treatment with medium or high dose ICS and LABA with or without OCS or other controller therapy. The pharmacokinetics of benralizumab in adolescents 12 to 17 years of age were consistent with adults based on population pharmacokinetic analysis and the reduction in blood eosinophil counts was similar to that observed in adults following the same FASENRA treatment. The adverse event profile in adolescents was generally similar to the overall population in the Phase 3 studies [see Adverse Reactions (6.1) in the full Prescribing Information]. The safety and efficacy in patients younger than 12 years of age has not been established.

Geriatric Use

Of the total number of patients in clinical trials of benralizumab, 13% (n=320) were 65 and over, while 0.4% (n=9) were 75 and over. No overall differences in safety or effectiveness were observed between these patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

OVERDOSAGE

Doses up to 200 mg were administered subcutaneously in clinical trials to patients with eosinophilic disease without evidence of dose-related toxicities. There is no specific treatment for an overdose with benralizumab. If overdose occurs, the patient should be treated supportive with appropriate monitoring as necessary.

Patient Counseling Information

Advise the patients and/or caregivers to read the FDA-approved patient labeling (Patient Information and Instructions for Use for FASENRA PEN) before the patient starts using FASENRA and each time the prescription is renewed as there may be new information they need to know.

Provide proper training to patients and/or caregivers on proper subcutaneous injection technique using the FASENRA PEN, including aseptic technique, and the preparation and administration of FASENRA PEN prior to use. Advise patients to follow sharps disposal recommendations [see Instructions for Use in the full Prescribing Information].

Hypersensitivity Reactions

Inform patients that hypersensitivity reactions (e.g., anaphylaxis, angioedema, urticaria, rash) have occurred after administration of FASENRA. These reactions generally occurred within hours of FASENRA administration, but in some instances had a delayed onset (i.e., days). Instruct patients to contact their healthcare provider if they experience symptoms of an allergic reaction [see Warnings and Precautions (5.1) in the full Prescribing Information]. Not for Acute Symptoms or Deteriorating Disease

Inform patients that FASENRA does not treat acute asthma symptoms or acute exacerbations. Inform patients to seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with FASENRA [see Warnings and Precautions (5.2) in the full Prescribing Information].

Reduction of Corticosteroid Dosage

Inform patients to not discontinue systemic or inhaled corticosteroids except under the direct supervision of a physician. Inform patients that reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy [see Warnings and Precautions (5.3) in the full Prescribing Information].

Pregnancy Exposure Registry

Inform women there is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to FASENRA during pregnancy and that they can enroll in the Pregnancy Exposure Registry by calling 1-877-311-8972 or by visiting mothertobaby.org/Fasenra [see Use in Specific Populations (8.1) in the full Prescribing Information].

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Rev. 10/19 US-30659 10/19

FASENRA® (benralizumab) injection, for subcutaneous use
CHAIRMAN’S LETTER

Fight for your dream job

Is this your dream job? Think about it. Look at where you are in your career. Think back to what you wanted when you left medical school. Are you doing what you envisioned back then? Are you satisfied with where your path has taken you?

If not, what do you need to do to get there?

The fact is, physician careers are changing (and maybe changing more than we even know now, as the health care system grapples with the COVID-19 pandemic). Hospitals and health systems have grown and consolidated, and one of the results of that is more physicians working as employees rather than owning their own practices. While this grants many physicians more stable working hours and other benefits, there is also a loss of freedom that comes with being an employee rather than a business owner. And sometimes that loss of freedom can lead to resentment, burnout and other negative emotions — especially if a physician feels like they have lost control of their career because of unsatisfactory contract terms.

In our cover story, we speak to physicians and other experts about how physicians should approach the negotiation process for a new position, and how to ensure they fight for what they need for career fulfillment. I think there is much our physician audience can learn, and hopefully our coverage will inspire you to introspection and help you continue the fight for your dreams.

We also have tons of COVID-19-related coverage in this issue, including an exclusive survey of physicians asking them how the pandemic is affecting them, their patients and their businesses. The results are not pretty, and they show that much more needs to be done to protect physicians and their practices from financial harm.

And here is a quick run through of some of the other content we have on tap this month:

- What can be done to improve the prior authorization process? We talk to a physician expert about how to reduce this seemingly intractable hassle.
- Can virtual scribes increase your efficiency and help you concentrate on your patients during an appointment? We analyze whether using these scribes is right for you.
- Patient stories can be powerful. Can they be so powerful that they help inspire others to change their habits and improve their adherence to treatment programs? Check out a unique feature on physicians exploring this idea.

We’d love to hear from you! Please write to us and let us know your story ideas and how Medical Economics® can best serve physicians during these challenging times. Contact our editors at medec@mjlifesciences.com. Stay healthy!

Mike Hennessy Sr.
Chairman and Founder of MJH Life Sciences
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A LONG-TIME PHYSICIAN LEADER DISCUSSES THE RESPONSE AND WHAT COMES NEXT.

10 TIPS TO REDUCE EXPENSES

ONE PHYSICIAN CHANGED HIS PRACTICE MODEL IN MARCH — AND IT SAVED HIM.

How to recruit young providers

After COVID-19

How to cope and care for yourself

The pandemic is decimating practices, our survey results show

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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 includes:

- 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/coronavirus

How physicians can get started now

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

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MEDICAL ECONOMICS  JUNE 2020
COVID-19 Survey

The COVID-19 pandemic has upended all aspects of life in the United States, including the way physicians treat their patients. This is an unprecedented time, and the challenges physicians and their practices are facing are ones they have not experienced before.

In an effort to learn how the pandemic is affecting frontline physicians, we sent a survey via e-mail to our physician readers on May 6 and closed the survey on May 12. More than 550 physicians responded. This is what they told us.

Q: Have you treated, or are you now treating, anyone infected with COVID-19?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>52%</td>
</tr>
<tr>
<td>No</td>
<td>48%</td>
</tr>
</tbody>
</table>

Q: Where have you treated COVID-19 patients?

- 18% In office
- 16% At hospital
- 19% Via telehealth
- 47% I have not treated COVID-19 patients
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you increased the amount of telehealth you are using to treat patients?</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Do you have adequate access to COVID-19 test kits?</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Do you feel you have adequate personal protection equipment when treating COVID-19 patients?</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>Have any patients you've treated for COVID-19 died from the disease?</td>
<td>17%</td>
<td>41%</td>
</tr>
<tr>
<td>I have not treated COVID-19 patients</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>Are you concerned that you or a family member will contract COVID-19?</td>
<td>79%</td>
<td>21%</td>
</tr>
</tbody>
</table>
In your own words: physicians tell us how COVID-19 is affecting their practices

“Emotionally exhausting, financially challenging, next to impossible to run a primary care office with all of the restraints placed on us.”

“I am definitely burned out and concerned about getting my family and friends sick.”

“We are trying to keep afloat. I realize there are patients who suffer economic hardship and may not be scheduling appointments.”

“I am concerned that health disparities will worsen and many high risk minority patients will not be offered clinical trial opportunities.”

“We may not be in business by the time this is over.”

“The medical profession is not appropriately taking care of non-COVID-19 patients.”

“My practice is down 75% since COVID-19.”

“Increased telemedicine, but overall down about 80% total volume. Afraid that telemedicine will be the new norm with lower quality and lower reimbursements.”

“Overall, the practice is steady with virtual visits.”

Q: Have you taken any steps to reduce the chances that you will infect family members, such as living somewhere else?

Yes 46%
No 54%

Q: Are you experiencing feelings, or added feelings, of stress/burnout/sadness as a result of the COVID-19 pandemic?

Yes 68%
No 32%

Q: Are you aware of any of your patients who have experienced a health crisis or deterioration of a chronic condition that could have been prevented by routine follow-up care or contact with health care services?

Yes 50%
No 50%

Q: Are you concerned that some of your patients may be foregoing routine or acute medical care because they are afraid of exposure to COVID-19 in an office or other clinical setting?

Yes 94%
No 6%

Q: How are your patient volumes now, compared with before the pandemic?

3% I’m seeing more patients
90% I’m seeing fewer patients
7% I’m seeing about the same number of patients
Strategies for coping with physician depression during COVID-19

Physicians, just like the patients we serve, are facing an unprecedented emotional burden from the COVID-19 pandemic. First-line responders are at especially high risk of experiencing psychological hardship from the burden of disease, death and anxiety, while physicians not on the front lines are feeling the strain of worried patients, financial hardship and uncertainty about the future.

Increased emotional stress during this difficult time may also increase the risk of physician depression. An estimated 300 to 400 physicians take their own lives each year.

EMOTIONAL CONTAGION

Emotions, just like viruses, are contagious. Psychologist and author Steven Cohen, Psy.D., notes that doctors, just like all others, are at risk of internalizing the negative feelings of the people around them. Physicians who work in a daily atmosphere of severe emotional distress and fear must take special precautions to avoid being overwhelmed by negative emotions.

According to Cohen, the first step to managing emotional distress is to simply acknowledge and examine our emotional reactions. Physicians often experience guilt, anxiety or shame when we experience powerful emotions like sadness or anger. This discomfort prompts us to try to repress these feelings. Cohen says that it’s essential to acknowledge and reflect on these feelings. The simple act of labeling our emotions can be a powerful tool in coping with these feelings.

This is especially important when we experience the emotional impact of patient death. Physicians who lose patients report feelings of self-doubt, failure, guilt and powerlessness. Physicians also report sadness after a patient’s death, including experiencing insomnia and crying. Traditionally, grief in medical training has been considered weak or unprofessional, and doctors have been encouraged to keep their feelings inside. Rather than openly expressing grief, physicians instead use compartmentalization, isolation and distraction to avoid our negative emotions.

The problem with these techniques is that they are emotional barriers that prevent us from addressing our feelings. Instead, we must practice healthy coping mechanisms such as acknowledging our feelings and accepting support from others.

SHARE YOUR FEELINGS

Physicians are often reluctant to share our negative emotions with others. Sometimes we choose not to share the negatives in our life because we don’t want to burden our friends or partners. This noble intention can cause a relationship rift because it does not allow others in our life to offer support. Ultimately, that leads to our own isolation. It is critically important to open up about our feelings with those closest to us — a family member or trusted friend or colleague.

In some cases, we may need to reach out to a professional to help us cope with powerful emotions. Asking for help is not a sign of weakness. It takes more courage to ask for help than it does to suffer in silence. And getting help makes us stronger so we can help others.

We must remember that we are not alone. Physicians are incredibly resilient — you do not get through medical school, internship and residency without incredible fortitude. We will get through this as well. We just need a little help from our friends, family, each other and, perhaps, a good psychologist.


MedicalEconomics.com
In 2019, after 20 years in practice, Laurie Montague, M.D., was growing restless. The Manchester, New Hampshire, family doctor found she was spending more time on paperwork and administrative responsibilities and less on what she truly enjoyed: caring for patients. She also wanted to be closer to her daughter, who was expecting her first child, in Cincinnati.

But those were just the beginning of the changes Montague wanted to make. Conversations with a physician recruiter, along with the self-knowledge gained from two decades of work experience, enabled Montague to assemble a more extensive wish list of things that she knew would make her happy in a job and that she lacked at the position she then held with the Department of Veterans Affairs.

With that list in hand, the recruiter found a position for Montague with Primary Health Solutions, a federally qualified health center based in the Cincinnati suburb of Hamilton, Ohio, near her daughter. The center has a staff to handle administrative issues, leaving Montague and other clinicians free to focus entirely on patient care. And the contract the recruiter negotiated on her behalf includes many of the other items on her list, such as a role teaching residents, a four-day workweek and six weeks of vacation, providing Montague ample time to spend with her daughter and new granddaughter.
Six months into the job, Montague rates it a 9 on a scale of 10. “Nothing’s ever perfect, but it has become something where I look forward to going into work in the morning,” she says.

THE MUST-HAVES AND DEAL BREAKERS

Until recently, finding a position as satisfying as Montague’s wasn’t a significant problem for most doctors. That’s because the majority were self-employed, either as solo practitioners or partners in a small group, and thus had the freedom to shape their job as they wished.

But the number of physician practice owners has dwindled in recent years, and by 2018, employed doctors outnumbered those with an ownership stake in their practice, according to AMA data. That means before starting a job search, whether they’re first out of training or making a midcareer switch, doctors need to envision what would make them happy in a job. Then they need to develop specific criteria for making that vision a reality — the must-haves and the deal breakers — and be prepared to negotiate them as part of their employment contract.

“Standard institutional employment contracts are framed in a way that benefits the employer’s interest, not the individual doctor’s,” says Richard Roberts, M.D., J.D., emeritus professor of family medicine at the University of Wisconsin-Madison School of Medicine and Public Health. “And unless you’ve thought ahead of time about what’s important to have or not have in your contract, you may not get what you want.”

GET IT IN WRITING

Having the must-haves and the deal breakers in writing becomes especially important when a work situation changes in ways the doctor doesn’t like. “If everything goes great from the day you’re hired, the contract just sits in a file cabinet,” Richard Roberts says. “It’s when things start to fall apart that the contract gets pulled out. So when negotiating a contract, you need to picture yourself at your most vulnerable because those are the situations when the contract becomes your one source of power.”

“I don’t think that money buys happiness. It can buy candidates, but it doesn’t necessarily keep them.” — Lucien Roberts, M.H.A., FACMPE, Practice Administrator, Gastrointestinal Specialists Inc., a Gastroenterology Practice, Richmond, Virginia

Because of his legal background, Richard Roberts has provided informal employment counseling to many physicians he taught when they were medical students. A mistake he frequently sees is waiting too long to begin the process of introspection that job and career decisions often require.

“It’s not that I want young doctors spending all their residency years talking to headhunters, but I do want them to

Trends in starting salaries for primary care

Primary care doctors have seen substantial gains in their starting salaries in recent years, the result of continued demand for their services and fewer young doctors entering the field.

<table>
<thead>
<tr>
<th>Year</th>
<th>Salary Increase</th>
<th>2014</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$190,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>$216,000</td>
<td>13.7%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$180,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>$210,000</td>
<td>16.7%</td>
<td></td>
</tr>
</tbody>
</table>

The dollar amounts are for salaries only and don’t include signing or productivity bonuses or the value of fringe benefits. Data from the Medical Group Management Association.
be thinking about their priorities,” Richard Roberts explains. And while doctors may think informally about these things during the early years of training, as they begin considering employment offers, they need to do it in a more systematic fashion, he says. That might be through some form of decision matrix or discussions with a spouse or a significant other or close family members. “Once they (doctors) do that, it becomes much easier to shape a contract that’s more to their liking,” he says.

Going through this process is also helpful to employers, Richard Roberts adds. “In my experience, most employers aren’t seeking to shortchange the doctor, because it’s not in their interest to treat this highly compensated person badly. But the employer doesn’t necessarily know what the doctor really wants unless the doctor makes it clear,” he notes.

**EVALUATE THE COMPENSATION PACKAGE**

Not surprisingly, financial compensation is a major consideration when mulling a job offer, especially for young doctors eager to enjoy the fruits of their years of training and to start paying off student loans. In that regard, there is good news for primary care doctors, who are seeing a steady increase in the size of their compensation packages.

Most hospital systems and large multispecialty practices today pay their employed doctors a base salary plus a productivity bonus, which kicks in once the doctor exceeds a predetermined financial decision.

From that standpoint, the best opportunities lie with practices that own property or equipment capable of generating ancillary revenue, such as a catheterization lab or an endoscopy facility, says Mike Belkin, J.D., FACHE, CMPE, a divisional vice president with the physician recruitment firm Merritt Hawkins in Dallas. “Those are the kind of buy-ins that make a lot of sense because you’ll have dependable revenue coming in from those ancillaries that aren’t tied to your personal production,” he says.

After physicians decide they want to join a practice, Belkin adds, the timeline and the price of partnership are the next important considerations.

“Some groups are less motivated to put a partnership track in writing; they prefer to keep it loose,” he says. “But you definitely want something in your agreement that references how many years it will be before there’s a partnership discussion.”

Two years is the norm for partnership consideration, he adds, “but some practices will offer after one year, especially for a physician who will be a business-minded owner from day one.”

While the specific dollar amount of a buy-in depends on the type of practice and its location, Belkin says, in most cases it will be based largely on the value of the practice’s hard assets, such as equipment and accounts receivables. That represents a significant change from the recent past, when intangibles such as goodwill were included in the calculation, substantially raising buy-in prices.

continues on page 16
As a physician-led insurer, ISMIE understands the immense challenges healthcare professionals face every day – especially in recent weeks. Our Wellness Center includes a wealth of resources to help you navigate personal and professional challenges, including private consultations. Visit it at ismie.com/wellness.

For other COVID-19 resources, visit ismie.com/covid-19.
“Standard institutional employment contracts are framed in a way that benefits the employer’s interest, not the individual doctor’s. And unless you’ve thought ahead of time about what’s important to have or not have in your contract, you may not get what you want.”

— RICHARD ROBERTS, M.D., J.D., EMERITUS PROFESSOR OF FAMILY MEDICINE, UNIVERSITY OF WISCONSIN-MADISON SCHOOL OF MEDICINE AND PUBLIC HEALTH

Continued from page 14

threshold of relative value units (RVUs) in a certain time frame, usually quarterly, explains Mike Belkin, J.D., FACHE, CMPE, a divisional vice president with the physician recruitment firm Merritt Hawkins in Dallas. All those elements — base salary, the RVU threshold for earning a bonus and the dollar amount per RVU beyond the threshold — may be negotiable, he adds.

“It will depend on how challenging it is for that facility to get you to move to that location,” Belkin says. “That gets into the supply-and-demand equation. If the hospital is in a desirable area, it isn’t as motivated to pay you a higher salary, lower your bonus RVU threshold or pay you more per work RVU.”

Richard Roberts notes that employers often will include additional financial incentives that doctors need to consider when comparing the overall size of compensation packages. For example, $250,000 would seem like a significantly better starting salary than $220,000. “But what if the $220,000 employer has better benefits, offers a signing bonus and has a student loan repayment incentive? That might really change the picture,” he says.

MONEY ISN’T EVERYTHING
For all the focus on compensation, doctors have to balance it against factors such as location, workplace culture and relationships with colleagues when deciding whether to take a job. Jon Appino, founder and principal of Contract Diagnostics, a consulting firm based in Kansas City, Missouri, that specializes in reviewing physician contracts, echoes that view. He distinguishes between what he terms “lifestyle practices” and practices for which the emphasis is on maximizing earnings.

“I think a physician needs to decide in advance which of those they’re looking for,” Appino says. “If they want eight weeks of vacation to start and minimal call, it might require sacrifices to their income.”

“I don’t think that money buys happiness. It can buy candidates, but it doesn’t necessarily keep them,” says Lucien Roberts III, M.H.A., FACMPE, practice administrator for Gastrointestinal Specialists Inc., a gastroenterology practice in Richmond, Virginia.

Lucien Roberts, who conducts initial screening of candidates for the practice, says it recognizes the importance of ensuring its physicians can earn a comfortable living. But in the end, he adds, “what we’re really looking for is someone who wants to buy what we’re selling, which is a team approach to patient care. So I’m focused on that, and the money part is secondary.”

Lucien Roberts says an important part of his screening process is taking candidates to the practice’s three offices. “I like to see how they talk to my staff,” he says. “If they don’t look down on them and treat them as some kind of lesser species, then I know that’s someone we want (as) part of us.”

The on-site visit is equally important from the doctor’s perspective, says Lucien Roberts, because it’s an opportunity to observe the organization; talk to physicians, administrators, lower-level employees and patients; and thereby get a feel for the organization’s values and culture. “When I was advising residents in their job searches, they might say about a particular place, ‘There’s such a good vibe about the place, they share my commitment to helping the underserved and seemed to share all my values.’ And that has a lot do with whether you’re going to be happy somewhere,” he concludes.
CODING INSIGHTS

Telehealth is the future — and the future has arrived

For several years, we’ve seen Medicare and the American Medical Association’s Current Procedural Terminology (CPT) manual slowly approach the age of telehealth. Despite a lot of discussion and many headlines during each of the past few years, the codes and coverage embracing the modern age of medicine have lagged far behind the technology.

This isn’t limited to telehealth, or even to coding and payments. The degree of penetration and utilization of the electronic health record in the last decade has left many of the regulations intended to deal with the business of medicine in the dust. Rules written to govern the paper chart don’t really jibe with reality anymore. The old consult language of “communicated by written report” hasn’t changed since those notes were typed on a typewriter and envelopes addressed by hand.

The federal documentation guidelines, a standard for the past 25 years and a physician’s daily confinement of compliance, are the latest to show up in the rear-view mirror.

Fast-forward to the future in a matter of weeks, at least temporarily. Since the public health emergency that is COVID-19 came to America in January, the Centers for Medicare & Medicaid Services (CMS) has unleashed a series of changes intended to allow the codes and coverage to catch up with the newly imposed reality of telehealth.

Although specific e-service and telehealth-type codes were in their infancy, both the CPT and CMS systems are equipped to allow for telehealth services and claims to be clearly identified, coded and billed.

CPT had introduced the star symbol next to certain codes that were eligible for telehealth. Modifier 95 has been around for some time and identifies services performed via synchronous telemedicine with real-time audio and video communication.

The place of service (POS) codes, as CMS now uses them since March 31, allow the agency to determine whether or not the service rendered was a traditional remote originating site (POS 2) or the new temporary version using office, hospital or other POS codes (11, 22, etc.).

Until March, the single largest obstacle to widespread adoption of telehealth for office services was the geographic limitation imposed by Medicare’s originating site requirement — that the originating site be outside of a major metropolitan area. That was the elephant in the road, effectively blocking the use of the codes for any urban and many suburban areas, regardless of the practicality.

COVID-19 moved the elephant, at least for now. Welcome to the future.

Since late March, CMS has taken extraordinary steps to allow providers to do what needs to be done, and to pay them for it. Among those steps:

- As of March 6, Medicare will pay for office, hospital and other visits furnished via telehealth, including those in a patient’s place of residence, across the country. A range of providers, such as doctors, nurse practitioners, clinical psychologists and licensed clinical social workers, are able to offer telehealth services to their patients. Additionally, the Department of Health and Human Services Office of Inspector General is providing flexibility for health care providers to reduce or
Telehealth codes to know

There are numerous options when it comes to reporting visits that are not the traditional face-to-face office visit. This varies somewhat by payer, of course.

Medicare has temporarily relaxed some of the geographic and security/privacy restrictions on Telehealth visits — including the office visit codes. This will allow patients to call your office, and as long as there is some type of combined audio/video communication between the provider and the patient — these visits can be billed with the 99201-99215 series codes, adding the 95 modifier. For Medicare there are numerous options:

**Office Codes (99201-99215)**

The new visit codes to the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Any new visit codes 99201-99205 would likely need to be coded based on time given the limitations of the exam. The established patient codes 99211-99215 could be billed by counseling time or by documenting the level of history and medical decision-making associated with a given code level.

**Virtual Check-Ins (G2012)**

A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications devise to decide whether an office visit or other service is needed. This is provided to an established patient, not originating from a related E/M service provided within the previous 7 days.

**E-Visits (G2061-G2063)**

Online digital E/M service, for an established patient, for up to seven days, cumulative time during the 7 days. For Medicare these are:

- **G2061**: for up to seven days, cumulative time during the seven days; five-10 mins.
- **G2062**: for up to seven days, cumulative time during the seven days; 11-20 mins.
- **G2063**: for up to seven days, cumulative time during the seven days; 21 or more minutes.

**Private payers**

For private payers and some Medicare Replacement plans, you can use:

- **99421**: five-10 minutes
- **99422**: 11-20 minutes
- **99423**: 21 or more minutes

Those are the mainstream codes to consider here. Reimbursement varies with the office visit codes typically paying the most. Go the websites for United Healthcare, BCBS, Aetna, CIGNA, Humana and others for specific policy changes.

To document your visit, be sure to note in your EHR the date, time and duration of the encounter. Also record the relevant history, and exam, decision-making and other management elements as you would any other visit.

It’s truly a back-to-the-future moment as this is the documentation standard that the CMS and CPT manuals are moving to on January 1, 2021. The items above are just some of the larger moves. There are many more, including new ones such as payment for certain phone calls. The CMS website has the latest updates, which have been posting every few days.

So, although all of this activity is unfortunately in response to COVID-19, it is heartening to see CMS respond so appropriately and relatively quickly. Who knew an elephant could move so quickly? But once we are through this health care crisis, CMS will face another challenge, perhaps a more difficult one: How to get the telehealth genie back in the bottle.

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**Bill Dacey, M.H.A., M.B.A., CPC-I,** is principal at The Dacey Group Inc., a consulting firm dedicated to coding, documentation and compliance concerns for physicians. Send your billing and coding questions to Medec@mjhlifesciences.com.
Telehealth codes to know

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**Money**

**Coding Insights**

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Bill Dacey, M.H.A., M.B.A., CPC-I is principal at The Dacey Group Inc., a consulting firm dedicated to coding, documentation and compliance concerns for physicians. Send your billing and coding questions to Medec@mylifesciences.com.
It’s likely you’re spending less time at your practice because patients are leery about coming in for an office visit as a result of the COVID-19 pandemic. The impact it’s having on practice revenue is daunting, especially for independent physicians. Obviously, revenue generation is necessary to sustain your practice. But what about the other side of the cash flow coin — reducing operating expenses? When was the last time you took a hard look at your expenditures to help increase profitability?

Now is the perfect time to evaluate your expenses, cut out any fat and seek better terms with your vendors or find new ones. Here are some common areas where you may be able to reduce costs.

✅ Computer support
If you’ve been using the same tech support person forever, it’s probably time to shop around. The number of tech support people has grown exponentially over the past decade.

✅ Medical supplies
It’s difficult for solo or small group practices to negotiate lower pricing with large medical suppliers. Discounts are based primarily on volume. Local or regional suppliers may be more willing to win, or keep, your business at better prices than you are paying now.

✅ Equipment rental
Are you still paying for outdated or unused equipment? Are your lease terms reflective of the current economy and interest rates? Eliminate unnecessary rentals where you can, and negotiate new terms for your leases.

✅ Office supplies
Take inventory of what you have, and determine what your short-term needs are. Use the internet to shop around for the best price, and order in smaller quantities.

✅ Miscellaneous
Do you even know what’s lumped into this category? If not, it’s time to find out.

✅ Telephone
There are plenty of options. Compare the national and regional phone carriers as well as Voice over Internet Protocol (VoIP) carriers.

✅ Staff
No one wants to lay off staff, especially when the economy is reeling and the unemployment rate is escalating. Talk to your staff and find out what their needs are. Do you have anyone who can change from full time to part time? Is anyone willing to be furloughed until things improve?

Trimming operating expenses can save your practice thousands of dollars a year. It’s something we recommend to every practice when we transition them to concierge medicine. With reduced expenses, and the annual membership fee, the practices we work with have seen little economic impact from the pandemic.

Remember, the downturn in the economy is affecting most companies, and no one is going to want to lose your business.

Neil R. Hoyt Sr. is a health care executive who has been transitioning practices to concierge medicine for the past 16 years. Send your financial questions to medec@mjlifesciences.com.
You’ve controlled their A1c and blood pressure. But your patients with chronic kidney disease (CKD) and type 2 diabetes (T2D) are still at risk.1-3

**INFLAMMATION AND FIBROSIS ARE DESTROYING YOUR PATIENTS’ KIDNEYS**

CKD PROGRESSION IN T2D IS INFLUENCED BY 3 MAJOR DRIVERS1-4:

- **METABOLIC DRIVERS**
  - Elevated blood glucose (A1c) levels

- **HEMODYNAMIC DRIVERS**
  - Rise in blood pressure
  - High intraglomerular pressure

- **INFLAMMATORY AND FIBROTIC DRIVERS**
  - Proinflammatory cytokines
  - Fibrotic proteins

Today, the treatment of CKD in T2D does not adequately address inflammation and fibrosis, a major driver of CKD progression.

IT’S TIME TO EXPLORE AN UNADDRESSED DRIVER OF CKD IN T2D AT [CKD-T2D.COM](http://CKD-T2D.COM)


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Why changing to concierge medicine during COVID-19 was the best decision I ever made

by ZEV COHEN, M.D.

For most of us, our personal timelines will forever be demarcated as before and after COVID-19. My professional journey will likewise be defined as before and after my change to a concierge medicine practice. In what can be viewed as a seemingly insurmountable challenge wrapped in an extraordinary opportunity, both of these events occurred simultaneously for me last March. Three months later, I can say with no reservations whatsoever, that it was the best decision possible.

Far from being risky or ill-timed, my transition to concierge medicine has benefitted both me and my patients in ways that continue to beautifully unfold.

I encourage physicians who are reeling from the pandemic’s destructive effects to consider the concierge model as a way to thrive sustainably and practice some of the best medicine of your career.

Ten months ago ...

My journey to personalized care began last summer, when a concierge executive spurred me to consider how long I could continue to practice at the frantic pace required to remain independent. Because I accommodated walk-ins as well as scheduled appointments, it was not unusual for me to see up to 40 patients each day. Lunchtime consisted of renewing medications, reviewing labs and X-ray results and answering patient calls, a process that was repeated nightly after I closed the office at 7 p.m. The next day, the cycle repeated itself. Anyone in private practice has felt the same frustration I did at having no time for anything but the most cursory contact with patients.

Well before COVID-19, the current system had irretrievably broken down, and I was determined to find another, better way.

Personalized touch

On March 9, my new concierge practice launched. One week later, a state of emergency was declared with strict social distancing guidelines put in place.

The impact of changing to a concierge model was enormous. With the much smaller number of patients in my care, I am able to be available at any time. For patients who are alone, or coping with chronic conditions it is tremendously comforting to know they can connect easily and frequently with me. The outreach goes both ways, as I check in often with my most vulnerable patients to see how they are faring. When they share their anxiety about a critically ill relative, I now have the time to help them navigate difficult decisions and in some cases, even recommend lifesaving care.

I can also extend my use of telemedicine with longer virtual visits to manage patients with chronic illnesses. Because my income is now sustained through membership payments, there is no need for concern about potentially lower reimbursement rates for telemedicine or a sharp decline in office visits. Instead, I can focus on spending time on every aspect of my patients’ care.

Going forward

I believe the benefits of my smaller, personalized practice will take on even greater meaning in a post-COVID-19 world. I can nurture the close relationship my patients seek with their doctors.

My advice to other doctors considering making the change is: Don’t do it yourself. There were times that I worried about how the unprecedented crisis of COVID-19 might affect the launch and ongoing growth of my new practice. For me, the Specialdocs Consultants, LLC, team has proven to be ideal partners, guiding and advising me throughout the evolving situation, with a strong and clear commitment to my long-term success.

No one can predict the twists and turns ahead as we slowly return to a new normal, so make sure the company you choose shares your values, respects your philosophy of care and will keep working hard for you long after your initial transition.

Zev Cohen, M.D., is a primary care physician specializing in internal medicine. He has been caring for patients in the New York area for more than 3 decades.
Reforming the prior authorization process

by TODD SHRYOCK Managing editor

When it comes to top physician frustrations, prior authorizations rank near the top of the list, right next to poorly designed EHRs. Jack Resneck, M.D., a dermatologist and immediate past chair of the American Medical Association board of trustees, has watched prior authorizations steadily expand in scope, become more time consuming for doctors and negatively affect patient care. Resneck is now leading a call for reform of the prior authorization process that would return it to its original purpose and free physicians from excessive interference in the doctor-patient relationship. He recently published data and outlined the changes needed for prior authorizations in JAMA.

Medical Economics® spoke with Resneck about what has gone wrong with prior authorizations and the challenges of fixing them. The interview has been edited for clarity and brevity.

Q: Medical Economics®: How did prior authorizations get so out of hand?

Resneck: When prior authorization came into being, it was really focused on brand new drugs with very high price tags where the evidence was still accumulating, and maybe where there was variation in care. It has gotten to the point where I, as a dermatologist, am literally doing prior authorizations every day on generic topicals like cortisone products that were invented in the 1960s. So the expansion — and we’ve seen this in the data — has been dramatic. It’s no longer focused on high-cost drugs that are unique or on new drugs. It’s no longer focused on outlier physicians in any way. It really just seems to have taken on a life of its own.

Q: ME: Can health plans possibly be saving money? They still have to administer all the prior authorization requests, staff the phones and facilitate the review process.
Resneck: It’s a good question. I wonder the same thing, although my experience is that the people on the other end who are adjudicating my prior auths are typically not of the same specialty. I don’t always know the level of training of the person at the other end. But yes, there are certainly people taking all of these appeals and processing all these things. I have heard from some pharmaceutical company executives, when we sat down with them, that even for things that get approved 95% of the time, they still have the feeling that they’re saving a lot of money on the other 5%. It just seems ridiculous and at the end of the day, you don’t want to be doing cost savings on appropriate treatments that patients actually need. This happens to the extent that my patients’ care is getting delayed because they’re waiting days and days while this process goes on, until they just give up and don’t go back to the pharmacy.

Q: ME: Your report mentioned that the percentage of people who abandon their prescriptions and never pick them up is relatively high, correct?

Resneck: I think about 37% of prescriptions that are initially rejected for one reason or another when a patient goes to the pharmacy are never picked up. That’s really disappointing. There are also some studies that I quoted in the paper, particularly in the mental health arena, where we actually see increased costs for some of these patients because their underlying disease flares and gets out of control. So, ultimately, they have more expensive care, more hospitalizations, more impacts on their life and health. Maybe the insurance company saved a few dollars up front, but it’s costing them and patients in the long run.

I had a patient who had severe lifetime eczema, whose life had really been changed by a biologic. I’m fairly conservative about prescribing biologics, but for this patient, it was completely appropriate. They actually got theirs approved initially, but a year later it came time for renewal. I dutifully filled out the pages of paperwork demonstrating that this patient had had amazing improvement. They were able to sleep again, they were able to work again and therefore, this was a good medication for this patient and they deserved to get it reauthorized. What I got back was a rejection, saying the patient no longer met the severity criteria. Someone is just looking at a screen and saying, “well, the disease isn’t extreme enough.” The irony is, it’s because the drug is working. They were suggesting that I take the patient off therapy for a couple of months, let them have a bad flare up, and then they would qualify again. It’s absurd, and for that one instance, it led to over 20 phone calls and several hours on my part arguing on the phone. It has gotten ridiculous; the health plans will tell you this is focused on outliers but it’s really not.

“The expansion (of prior authorizations) … has been dramatic. It’s no longer focused on high-cost drugs that are unique or on new drugs. It’s no longer focused on outlier physicians in any way. It really just seems to have taken on a life of its own.”

Q: ME: Do patients understand that this is a health plan issue or do they sometimes blame the physician?

Resneck: Well, I think both pharmacists and physicians are the ones who are face-to-face with the patient, so we are a lot easier to access than their health plan. We’re the first to really hear about these frustrations and I think the opacity of the entire drug pricing and prior auth pipeline has gotten to a point where it is difficult for patients to know about. And frankly, we have times as physicians where the transparency is not ideal in terms of what we can see as well. So, you’ll have some plans where these decisions are made by the pharmacy benefit manager and sometimes it’s a plan issue. Sometimes those two blame each other, and you end up calling back and forth. I think for all of us the opacity is a problem.
One of the things that I asked for in this report, which you would think in this era of computers and digital health would not be a big ask, is better information at the point of care. When I am sitting down in an exam room with a patient and we’re talking about treatment options, and there may be four or five things that would work well, it would help if I could type the first choice into my e-prescribing system in my electronic health record. And then it would pop up immediately and tell me whether that option was or wasn’t on formulary for that patient, whether it required prior auth or not, how much the co-pay would be for that patient, and I could quickly do the same for any alternatives.

But while there’s some technology that occasionally allows for that, the majority of the time that information is not made available to us by the health plan or the pharmacy benefit manager. Often, we don’t end up finding out these things until the patient gets to the pharmacy. The formularies and the prior auth requirements change week to week, so it’s not even predictable. We’re asking for that transparency. It’s point of care and frankly, it would help us at times when there are two things that would both work well and are safe, and one costs way more than the other; we would be happy on behalf of our patients and the health system to be good stewards of resources and choose the highly effective thing that happened to be cheaper. But we don’t see that information in front of us, and that really surprises our patients.

Q: ME: What else needs to happen to fix this issue?

Resneck: Well, one of the main things is just getting the volume of prior auths back into a reasonable space. As physicians, we’re realistic and we don’t expect that to magically vanish tomorrow. We are really asking to rightsize this. If there are medications or procedures for which prior authorizations are ultimately approved an overwhelming majority of the time, those things shouldn’t be on the prior auth list. Medications that have no cheaper, safe alternative shouldn’t be on the prior auth list. And similarly, for individual physicians who are prescribing, the health plans have the data on whom the outliers are.

The vast majority of us are practicing evidence-based medicine, fighting these bad prior auth battles on behalf of our patients, explaining why the treatments we’re prescribing are appropriate and ultimately getting the overwhelming majority of our prescriptions approved after a whole lot of extra administrative burden and cost. They ought to take those of us who ultimately get most of our things approved and “gold card” us, which is when for some period of time the level of scrutiny on you goes down.

Sure, they can watch the data, and if something dramatic changes, they can come back and change somebody’s status. We got some early agreement from health plans’ leadership, who signed a consensus statement and said that they would work with us on this, but we just haven’t seen movement.

The average physician tells us they’re doing 31 prior auths every week and, as of a year ago, are spending about 15 hours of their time and their staff’s time doing them.

It’s incredibly frustrating, because most of the time the person at the other end of
the phone that you’re having this conversation with is typically not a physician. And they are almost always not the same type of specialty physician. Oftentimes, they’ve not heard of the disease you’re treating, so they’re just typing it into a computer and seeing what comes up on their screen.

You’re spending time that you could be spending with other patients. Instead, you are trying to educate them about why this is actually the standard treatment for this disease and isn’t even an unusual request.

Q: ME: So all this time that’s going to prior authorizations could be time spent with patients, or even with your own family to reduce the growing burnout problem.

Resneck: That’s right. When we study burnout, the data show that the things that cause burnout are the things that get in the way of why you went into medicine in the first place, such as being able to provide the kind of care you want to provide to your patients. Prior auths have really risen for many people to the top of that list. When I used to travel around the country talking to physicians, poorly designed EHRs were at the top of that list, but prior auths have really exceeded that in terms of what I now hear. It is incredibly frustrating not to be able to get your patients on the therapies that they need to get better.

The other thing is: it’s not just a burnout issue. We have tremendous administrative costs in our health care system in this country. When you think about the amount of time that every practice is having to spend doing this and the amount of time that health plans are spending on the other end processing our requests and our appeals, it seems to me there’s a tremendous amount of waste here.

Q: ME: Is there anything an individual doctor can do to change the prior authorization process?

Resneck: We have a number of efforts in legislatures and with regulatory bodies in Washington and around the country to put some guardrails around this system again, not to get rid of it, but to make it function more closely aligned with its original purpose.

So, for example, in Congress right now, we have HR3107, which asks for some transparency, among other things, around prior authorization requirements. We’ve been working with the administration on trying to reduce the burden around Medicare Advantage and Medicare Part D plans, over which they have authority, and change some of the rules about how health plans do prior auths. And then a number of state legislatures around the country are taking this up; Kentucky passed a very good bill last year, for example. So I think it’s important that frontline physicians reach out to their members of Congress, to their state legislators and talk to their state medical society about what bills are coming up in their own states to help make sure that lawmakers and policy makers understand. That was part of the purpose of my piece, continuing this conversation, so that people understand just how frustrating this is, especially for our patients.

“If there are medications or procedures for which prior authorizations are ultimately approved an overwhelming majority of the time, those things shouldn’t be on the prior auth list.”

Q: ME: You mentioned Kentucky passed a good bill, so do you see more positive change on the horizon?

Resneck: We’ve got a long way to go. But I am feeling more optimistic because as I talk to lawmakers and policy makers about this, they are increasingly understanding that this has gotten out of control. When I’m talking to them, almost every one of them has personally experienced or had a family member experience the ridiculousness of being stuck in this maze. So I am optimistic. It’s going to be a journey and take us a while to get this change done, but we are going to keep working incredibly aggressively. This is too important to let it go on as it is.
Managing millennial physicians

by KEITH A. REYNOLDS Associate Editor

As the physician shortage gets worse, experts say the health care system needs millennial physicians to shore up the workforce. At the same time, as millennials are seeking changes to the day-to-day operations of the system, they’re driving a much larger conversation about what health care should look like.

Ted Epperly, M.D., president and CEO of Family Medicine Residency of Idaho in Boise, sees the millennial generation of physicians as a way to refill the ranks but warns that all physicians aren’t equal. It will take more than one millennial to fill the hole left by a retiring baby boomer doctor, he says.

“The data on this is that for every retiring boomer physician, it’ll take about 1.7 millennial replacements,” Epperly says. “And the reason isn’t that they’re not as capable. It’s that they’re not willing to put in the 80-hour workweeks.”

Andrew Hajde, CMPE, assistant director of association content at Medical Group Management Association in Englewood, Colorado, says the health care system is reaching a point where millennial physicians are becoming the only ones left to pick up the slack of retiring boomers and Generation Xers before Generation Z comes of age. “I think you have to learn to work and integrate (millenials) into your system,” he says.

Millennial physicians are simply different from the generations of doctors who have preceded them, and that can pose challenges for physicians seeking to fold them into their practices as doctors. These challenges include different attitudes toward work-life balance, technology and mentoring.

Work-life balance and purpose

While some pundits may decry millennials’ love of avocado toast and their shunning of certain industries, Epperly says he believes they are bright and creative physicians who aren’t afraid to put in the labor, though their philosophy is diametrically opposed to his own generation’s views on work. “They want to do (the work) quickly, efficiently and effectively, but then they want to hand it over to the next capable and accountable person so they can then get to” the rest of their lives, he said.

A survey of final-year medical students performed by national physician search and recruitment firm Merritt Hawkins found that new doctors are taking their desire for more free time into account when evaluating employment opportunities.

Natasha Bhuyan, M.D., is a family physician and regional medical director with One Medical in Phoenix and is a millennial. In her role with One Medical, she speaks to many millennial physicians, and what sticks out to her about the cohort is their desire to be fulfilled by practicing medicine.

Unlike previous generations, though, millennials don’t base success on hours spent in the office or number of patients seen, Bhuyan says. “They’re measuring success based on fulfillment of purpose, based on developing meaningful relationships with patients and having time to connect with patients, improve their behaviors and see health results and outcomes change,” she says.

The millennial physician is less interested in starting their own practice and prefers employment with a physician organization aligned with their values, according to Bhuyan.

Hajde spent years managing group practices. He says this move from starting a practice may be due to the increased emphasis on avoiding burnout. “They see some people, not just physicians, but those with different jobs and careers across the board, struggling with burnout and other things when they try to take on too much at one time,” he says.

Millennial physicians are less interested in being the prototypical “cowboy” doctor, seeking to take care of all a patient’s needs, and more interested in being members of a team in which each member has their role, with the combined goal of offering the patient high-quality care, Bhuyan says.
What young physicians want from a first job

Final-year residents are the future of medical practice in the United States. But what kind of work are they looking for when starting their careers? Merritt Hawkins, a national physicians search and consulting firm, surveyed final-year medical residents to learn about the recruiting process, what young physicians want out of their first employers and what preferences they use to decide on where and how they want to practice. Here are eight things to know about young physicians entering the job market.

1 **Young physicians are in high demand**
Sixty-five percent of residents surveyed said they had received more than 50 recruiting offers, and 45% had received more than 100 offers.

2 **Young physicians focus on location, pay and work-life balance**
Respondents said the most important criteria when evaluating job opportunities were the following:
- Geographic location
- Good financial package
- Adequate personal time

3 **Hospitals are their preferred practice setting**
Young physicians ranked their preferred practice setting in the following order:
- Hospital employee
- Single-specialty group employee
- Multispecialty group employee
- Partner with another physician
Only 2% said they wanted to go into solo practice.

4 **They want to practice in big cities**
One in 5 residents said they would rather work in a city with more than 1 million people.
Another 45% wanted to work in cities with at least 250,000 residents.

5 **Residents are concerned by student loan repayment**
Residents who have loans are very concerned about repayment. Forty-two percent have more than $200,000 worth of loans.

6 **Residents feel less prepared to handle the business side of medicine**
When it comes to topics such as employment contracts and compensation arrangements, residents said they felt:
- Very prepared (8%)
- Somewhat prepared (54%)
- Unprepared (38%)
Fifty-three percent said they had received no formal training on these topics in medical school.

7 **Physicians have different concerns compared with other generations**
The top five concerns were:
- A good income
- Educational debt
- Availability of free time
- Insufficient practice management knowledge
- Dealing with payers

8 **Some young physicians have career buyer's remorse**
Nineteen percent of final-year residents said they would not choose medicine as a career if they had the chance for a do-over.
“I like to think of mentorship more like coaching: How do we coach physicians to reach the top of their potential and beyond? How do we push people beyond what they think is their best?”

—NATASHA BHUYAN, M.D., FAMILY PHYSICIAN AND REGIONAL MEDICAL DIRECTOR, ONE MEDICAL, PHOENIX

Technology
Experts say millennial physicians are more comfortable with technology than other generations.

Cristy Good, M.P.H., MBA, CPC, CMPE, a senior industry adviser with Medical Group Management Association, says that technology is a key marker in the generational divide in practices. Whereas some older physicians may be reluctant to use newer technology or have resisted technology in general, the millennial is looking for tools that increase communication. She says where older physicians may have stuck with paper charts and were used to discussing things in staff meetings, the millennial physician was using an EHR in medical school and

believes communication among colleagues can be handled in quick emails and text messages.

With many millennials not having experienced a world without the widespread integration of the internet, Epperly says the younger physician is extremely tech savvy and isn’t even going to look at working at a practice where the technology isn’t current.

Bhuyan says that while millennial physicians are indeed looking for better technology integration, they aren’t seeking technology just for the sake of it; they’re looking for technology that allows them to practice at the top of their license without getting burned out. “We want technology that enables us to have a career that’s professionally rewarding and takes out all those inefficiencies and administrative burdens in the system that tend to drive that burnout,” she says.

Hajde says that millennial physicians must be cautious, as too much communication technology can turn patients off because of the lack of personal contact with their physician. “I think that as newer physicians come into the field using technology, we have to be really careful to kind of maintain that relationship with the patient,” he says. “They need to look at them when they’re seeing the patient and not stare at the computer screen.”

Feedback and mentoring
Epperly says the key things millennial physicians are in need of are feedback and mentoring, which are different from the needs of Gen Xers. “They see the value of picking a senior person’s brain to help them be more efficient and more effective.”

Bhuyan says that millennials have also changed the forms that feedback and mentoring can take. The model is no longer just a senior physician transferring everything they know to the junior physician. “I like to think of mentorship more like coaching: How do we coach physicians to reach the top of their potential and beyond? How do we push people beyond what they think is their best?” she says.

Bhuyan adds that millennial physicians should have a hand in guiding their own development and mentoring, and practice managers should be willing to place them into higher roles within the practice.
The long-term impact of the COVID-19 pandemic

by JEFFREY BENDIX Senior Editor

Public health officials and physicians are focusing their energies now on stopping the spread of COVID-19 and treating patients who are ill with the disease.

But what will be the long term impacts of this pandemic on our health care system? And what does it tell us about the state of public health in the us today and going forward?

Medical Economics recently sat down via Zoom with Richard Roberts, M.D., J.D., Professor Emeritus of public health, Family Health at the University of Wisconsin School of Medicine. Roberts has long made a study and been interested in the intersections between public health primary care and health care policy.

The following transcript has been edited for length and clarity.

Q: Medical Economics: How do you think our health care system is going to look different after COVID-19? What will the impact of the pandemic be?

Roberts: My hope is that we’ll have learned some of the lessons of history, and be in a position to better plan for the next disaster. And the World Health Organization, by the way, estimates that there are about 500 incidents a year around the world that qualify as disaster. So this is not going to go away, this phenomenon of something catastrophic. But that will learn from these lessons and these months or years, and begin to undergo some fundamental restructuring of how our system’s organized, funded and where we put our priorities.

Q: ME: What kind of changes you think we need to make?

Roberts: Well, if you compare the United States system to many others around the world, there’s much about the U.S. system that I’m very proud of. We have great advances in technology and taking care of very extreme problems. But the reality for us, compared to most of the rest of the world, is that we don’t do as good a job around prevention, early detection and keeping small problems small.

And that really is the role, ultimately, of public health and primary care.

I hope — I don’t know that I expect it — but I hope that we’ll learn that that’s important. In fact, if I may, if you look back at just recent examples: Hurricane Katrina, and the health fallout for that is still going on. Up to one in six of the people that went through evacuation from Hurricane Katrina still have Post Traumatic Stress Disorder. If you look at the folks in New York City near the World Trade Center, they have a higher incidence of both physical and mental health problems than one would have expected.

And so let’s take a very short term view of this pandemic. How many ventilators do we need today? That’s important when you’ve got people needing ventilators today, but then when things have quieted down, will we say: ‘We’re all done with that one’ and not learn from it. I think that would be a terrible mistake.

Q: ME: How do you expect the delivery of health care, particularly primary care, to change?

Roberts: I think some of it will be good, and I think some of it will not be so good. I’ve watched and talked with many colleagues around the country and around the world about other post-disaster situations. And one of the things that a crisis like this does is it forces you to think more creatively.

I’ve been very impressed with many of the creative solutions that people, both in primary care and in secondary or tertiary care, have been coming up with. You know, if I got one ventilator and four people that need it, is there a way I can attach all four at once to the ventilator? Those are creative solutions, not necessarily desirable solutions, but that may be the best you’ve got. And I think
The COVID-19 impact on practices has been devastating

by KEITH A. REYNOLDS Associate Editor

The COVID-19 pandemic has caused patient volumes to decrease for 89% of practices, while 82% say they’re limiting well care and chronic care visits, according to the most recent survey from the Primary Care Collaborative.

The survey, conducted in April, paints a grim picture of the financial health of practices across all 50 states. More than 57% of respondents say less than half of their work is reimbursable.

The pandemic has also created challenges with staffing, with 41% of practices reporting outages due to illness and quarantine for clinicians, 42% have seen outages due to similar situations with nurses, and 30% for front desk staff. A total of 82% of respondents say the COVID-19-related stress on their practice has been severe or close to severe, the survey says.

One bright side of the pandemic has been the widespread adoption of telehealth services to help shore up business, but that has come with its own challenges as 65% of respondents say they have patients who can’t use the services due to a lack of computers or internet. The expansion of the services have been limited with 40% of respondents relying mostly on video, 13% relying on e-visits, and 16 percent relying on patient portals. For comparison, 44% are conducting the majority of their telehealth visits by telephone, according to the survey.

The pandemic also seems to be hitting the most vulnerable in the community the hardest with 20% of respondents reporting a “shockingly high” increase in COVID-19 impact on those patients who have lost their jobs and 36% reported an increase of burden on this group.

People who are still going to work seem to be hit the hardest of all, though, as 27% of respondents saw meaningful increases among essential workers and 22% reported an increase among those who can’t work from home, the survey says.

and what our systems have done here is they say, ‘OK, we’re going to stream people that have COVID-19 type symptoms to just one urgent care center.’ And then people that do not have those kind of symptoms we will send to a different urgent care center so there’s not exposure, and then condense down several primary care clinics into one so that even for the more usual problems — diabetes, high blood pressure, that sort of thing — people are able to have access. So that to me is a creative response, trying to figure out what you can do to minimize exposures.

Unfortunately, as care gets ever more fragmented, it gets harder to do this. But being able to connect with the intensivist taking care of your patient, at least by phone or video chat, to really let this person know in short order. Your sense of who this patient is that they’re taking care of, and how they’ve responded to the crisis and how their families have responded to crisis. When you’re the doctor on the firing line, trying to decide whether you innovate or not, it can be terribly helpful to have a patient’s primary care physician communicate with you.

The things that I see that are not so good, potentially, is that while one of our creative responses has been to use telemedicine much more than we did — and I think a lot of that can be quite good — my worry is that people will swing the pendulum too far the other way and forget the patients actually need to be listened to.

Most telemedicine consults are pretty brief. Nobody likes to sit on the phone or computer terribly long. So the telemedicine consults tend to be more brief. You can’t touch their arm to reassure them that everything’s going to be okay. There’s so many things that we do that are really non-verbal, that I don’t want that to be lost.

So, even though we may be using telemedicine to move information back and forth more readily than we used to, which is good, we still have to be mindful that this is about taking care of human beings and not checklists of symptoms that we are dealing with virtually.

Q: ME: Some policy experts have said that the response to the COVID-19 pandemic has revealed some very basic flaws in our public health system. Do you agree?

Roberts: I would agree with it. The flaws really relate to an inadequate infrastructure. It’s not just infrastructure on health care services, it’s actually...
some of the inadequacies in terms of our society in general. Poor people do worse, they’re more likely to get the disease. People that are living paycheck to paycheck, the person that’s having to show up at a grocery store. It becomes obvious that poor people always suffer at the hands of disasters like this. They’re not able to shelter themselves as readily and things like that.

If you look at the major epidemics from plague to smallpox, they always create change in society. And one of the things that happens, unfortunately, is we tend to blame and stigmatize.

So it’s this group of people that’s causing this problem. We need to begin thinking more seriously and comprehensively that health outcomes have a lot to do with what we now call the social determinants of health: your poverty level, your educational level, where you live, the zip code you’re in. These are all things that are key determinants of how healthy or not you are. And for the people that are a little more money oriented, what you have to help them understand is that unhealthy folks don’t show up for work. People need to have access to essential health care.

So it drives a lot of policy discussions around universal coverage. It drives a lot of discussions around basic economic justice principles, which is what much of the presidential debate among the Democratic candidates certainly centered around. My hope is that we’ll have learned some of the lessons from the past and move in a better direction so that we don’t take these things for granted, that people be able to make their own way and somehow they’ll all muddle through, when in reality you’ve got hundreds of thousands or more dying. You got to have a system that people can rely on.

If you think that investing more significantly in primary care and preventive public health care is expensive, try not investing. That’s way more expensive. And not just economically, you’re also ignoring the suffering that goes on as well.

So I have no doubt that COVID-19 is going to change the political landscape. I’m not smart enough to know exactly what that’s going to be, and how it will look. But my prediction will be some additional illumination of the income gaps that we have in this country. And I hope that we can take that on as a challenge.

**Q:** What are some changes you’d like to see the country make going forward when it comes to public health and care delivery?

**Roberts:** Let me start at the ground level, because that’s often where all of the action really happens. One of the things that I’ve really been proud of, is everybody in the health care sector — doctors, nurses, custodial staff — have been stepping up, even though they know that they may be on that ventilator later. They’re stepping up in ways that I think are just really powerful.

Now, I hope that in the future, we in primary care will be thinking about our roles more expansively than simply: my workload begins and ends at the door to my office. No, it doesn’t. It reaches out into the community. And we need to begin to communicate that better. There are things that the public health people do that can inform us. And there are things that we can do in the reverse direction.

For example, one of the things that in my practice we did for 30 some years was use a strategy called community oriented primary care, where we actually engage the community and trying to sell health priorities based on what was felt to be a key problem by the community in terms of health issues. And then we would work with the local public health agencies to collect data that they were already collecting.

For the primary care doctor to sit back and say, ‘Well, I kind of know all of this stuff. I know what’s going on out there because I’ve talked to a few of my patients.’ Well, no, you don’t. Because that doesn’t mean that you’ve talked to the rest of your patients, or even more importantly, the people in community that have no health care right now. So much greater bridge building needs to go on between public health and primary care.
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Physicians can take steps to protect their families from COVID-19

It is the greatest fear physicians and all others working in health care currently face: What if they unknowingly infect their families and loved ones with novel coronavirus (COVID-19)? Some are going as far as living apart from their families for the duration of the crisis, according to news reports and an article posted on the American Medical Association’s website. “Obviously it is heavy on the mind of all providers who are working with patients who are infected and those who we don’t know that are infected with COVID-19,” Mark Rupp, M.D., a professor and chief of the infectious diseases division at University of Nebraska Medical Center (UNMC) in Omaha, said in the article. “All of us are having those questions and concerns as we head home to our family and loved ones.”

Although Rupp says he believes it is important that physicians take steps to protect themselves and their families at work and home, he doesn’t believe physicians must completely stay away from their families. “That’s just not something that’s necessary, nor do I think it is healthy for people’s mental health,” he said.

Family support is key to helping a physician maintain optimal mental health while facing the uncertainty of COVID-19 at hospitals, health systems and practices, he noted. “Some of these emotional supports that people need and require are very important, and if we get into a situation where we’re expecting health care providers to come to work and then go home and be isolated, that is not going to be a healthy situation for anybody.”

Rupp’s top six tips for protecting yourself and your family during the pandemic are as follows:

1. Immediately screen anyone who enters the health care organization for fever or respiratory illness; if either are present, that person should be “immediately taken into the appropriate setting where they can be evaluated and cared for as safely as possible,” Rupp said. “The first and probably most important step is not so much what you do when you get home, but it’s what you’re doing at work that really is going to count. … You need to be using the appropriate precautions when you encounter patients.”

2. Use appropriate respiratory protection, gowns, gloves, droplet protection and N95 or higher respiratory protection when dealing with infected patients.

3. Reduce contact and the number of health care professionals interacting with a potentially infected patient via telehealth or other electronic means. “Institutions need to concentrate on providing as safe a work environment as possible with careful attention to administrative and engineering controls to reduce risk,” Rupp said.

4. Practice proper hand-washing. “(This is) by far the most important thing to do to protect your family,” Rupp said. Also crucial: Avoid touching your face.

5. Change out of work clothes after arriving home if it provides “a little piece of mind,” Rupp said. There is no need to change in the garage or another area outside the home. “There really isn’t any information that if you’re using appropriate gowns and gloves at work that you need to worry about bringing the coronavirus home on your clothing,” Rupp said. “If you put your clothes through just normal laundry, that should take care of things just fine.”

6. Don’t share plates, cups, utensils, toothbrushes and similar items. “Practice common-sense precautions with your family,” Rupp said.

Christine Blank is a contributing author. Send your practice management questions to Medec@mjhlifesciences.com.
The threat of a malpractice lawsuit is something every physician worries about. And for good reason. Studies have found that about half of all physicians will face a malpractice suit at some point in their career. But, despite these statistics, doctors should not think a lawsuit is inevitable. In fact, malpractice experts say there are practical steps that physicians can take to prevent lawsuits. It boils down to having open, honest communication with your patients — and documenting those encounters clearly and comprehensively.

Medical Economics® (ME) recently sat down with malpractice attorney Fred Cummings, J.D., of Dickinson Wright in Phoenix, Arizona, to discuss ways physicians can proactively defend themselves against the threat of a lawsuit. The interview below was edited for length and clarity.

Q: Medical Economics®: How likely is a physician to face a lawsuit during their career?

Fred Cummings, J.D.: Statistics really vary. I’ve seen statistics showing that as many as a third to more than half of physicians can reasonably anticipate facing a lawsuit at some point in their medical career. And of those who’ve been sued, about half of them will get sued again.

Q: ME: Can you talk about some of the main reasons physicians are sued?

Cummings: Generally, the main reason why physicians are sued is because of either a failure to diagnose a condition or an unexpected complication from surgery. Or even just any type of poor outcome may lead to a physician being sued. In general, for a primary care physician, a lot of times, failing to refer a patient to an appropriate specialist is going to get them in trouble. I often lecture to physicians and say the primary reason physicians get sued is poor documentation. If the outcome is the reason that motivates a patient to sue, it’s documentation that motivates an attorney to bring that lawsuit.
Q: ME: Many physicians are concerned about lawsuits resulting from errors with the EHR system. Can you talk a little bit about some of these problems and the potential risks?

Cummings: EHRs themselves do not cause a lawsuit. But the poor application of that tool can cause a lawsuit. Training is a big issue — not knowing exactly how they work and what they’re supposed to do. And sometimes they’re not set up like you might find in a traditional chart. For example, there isn’t a section that indicates the test that came in was reviewed.

Another aspect is the repopulation of charts from prior visits, which is the copy-and-paste method. That’s a huge problem in a primary care office as well as a hospital. I’ve seen electronic health records take the hospital chart from 100 pages to 400 pages because of repopulation. The problem is that sometimes, hospital-day one is transferred as if it were in existence on hospital day five. We got an improvement without any additional therapies. Just the last sentence is what the doctor did on post-op day five. That’s a problem because we’re going to assume that the records on that day reflect what the patient’s care was.

The other aspect of electronic health records that get physicians in trouble is that physicians tend to rely too much on the drop-down box method that you find a lot in EHRs. In a lawsuit scenario, if something isn’t marked, sometimes that’s interpreted as you didn’t check. And I know that every physician has heard, “If it’s not documented, it didn’t happen.” Right? That includes recording the negatives. And that’s a big thing for electronic medical records.

Another aspect, of course, are things that you would find in any chart: information that’s not correctly taken down in complete medication lists, not having your electronic medical record set up so you receive warnings if you prescribe one medication and then prescribe another medication that may be contrary. A hospital, of course, has that system in place, but now I think we’re finding the trend is that physicians are also supposed to have a similar system in their bailiwick of their electronic medical records. It’s all about patient safety.

Q: ME: In your experience, what are patients really looking for when they sue for malpractice?

Cummings: You know, physicians are surprised sometimes to find out that patients aren’t solely motivated by money. I think there is somewhat of a misconception that it’s a jackpot mentality — that patients sue because they can get a lot of money. But the fact is, especially in the medical negligence field, there are so many barriers to bringing a successful lawsuit that money really is not the primary driving force. A lot of times patients just want to know what happened.

And that’s partly because the physician has not communicated what happened and why it happened or given a reasonable explanation — so patients feel they have to seek answers. Another reason can be solely so that whatever happened to them doesn’t happen to others. And then there are some surprises. Rising motivations including revenge, getting back at the physician — “If they did this to me, I want to make sure they don’t practice again.” Those type of reasons. Those type of patients are quickly disillusioned by the system because we generally do not take such actions in a civil lawsuit. But a lot of times, patients just simply want to find out what happened.

Q: ME: What are some communication techniques that physicians can use to help prevent a malpractice lawsuit?

Cummings: Communication is essential. And that is really the root of all relationships, isn’t it? And no more so than a physician-patient relationship. And sometimes, of course, the pressure to document and listen to the patient is overwhelming.

“If the outcome is the reason that motivates a patient to sue, it’s documentation that motivates an attorney to bring that lawsuit.”
A lot of times, patients complain about the fact that, “The doctor never looked at me. He was spending the whole time on his computer. He was saying that he was trying to input what I was saying, but he never looked at me. And then he didn’t really explain what he was doing. I didn’t feel like he listened to me.”

I can tell you, especially in the primary care field, if a patient feels like they’ve been listened to — that you heard their complaints and then explained why they were feeling what they were feeling and what you were going to do about it — you create a bond. That’s how you do it. Through communication. Making them feel that they’re part of their health care.

Q: ME: You spoke earlier about the importance of documentation. What are some common mistakes that physicians make when it comes to documentation?

Cummings: First of all, it’s to document in and of itself. Do not abandon your tried-and-true principles of the SOAP format — subjective findings objective findings, assessment and plan. Do not abandon that because your EHR doesn’t seem to fit it quite as well. Even in the comments section, you want to make sure all those things are there. Why? Because somebody down the line, a lawyer or another physician, needs to know what your thought process was. And sometimes, just putting down the bare bones will create a false impression in the record.

Also, physicians often don’t pay attention to what they’re actually putting down. They don’t check their dictation, so they don’t notice that words are missing. Sometimes they’re critical words, or they rely too much on their memory. And this is very true for electronic medical records, boilerplate things that they have already pre-populated in the chart because this is a routine thing they do all the time. Or it’s a condition they treat all the time, and they already have a boilerplate. This is what we do. It’s cookie cutter. But the problem is, as we know, patients aren’t cookie cutter. The round peg doesn’t fit into that square hole, right? And so that’s where, a lot of times, physicians get into trouble — for not individualizing the patient’s chart.

And then every other aspect of charting that you’ve heard about before still exists today, which is that charts are incomplete. Medications are not all written down in the correct amounts or what the patient presently is taking. Patient medical histories aren’t recorded. Essentially, the patient chart is your documentation of your interaction with this patient and your understanding of the patient’s health care. And if something’s missing, then that’s going to get exploited later.

Q: ME: So if you’re facing a lawsuit, what are some things you should do right away to try to mitigate your risk? And what are some things that you should not do?

Cummings: Certainly, you do not want to ignore it. I have had physicians who, on day 23 — three days after they’re supposed to answer the complaint — call me and say, “I got this complaint, but I don’t know what to do with it.” And so what happens is not necessarily good for the physician. The first thing you want to do is not ignore the fact that you’ve been sued. The second thing you want to do, if you have medical negligence insurance, is contact your insurance carrier, which is a requirement of every medical policy, insurance policy out there.

“[Defensive medicine] may later come back to bite you. We can all see that scenario happening: You’ve ordered a test that you think might not be necessary, but you need to make sure your butt is covered. And then something happens as a result of the test. And so let me tell you where that goes — the doctor is putting profits over patient care. And that is a deadly argument in a jury trial.”
Next, you want to marshal your records and all the records that relate to the patient — not just the ones that you think relate to the care that might be an issue, but all your care for that patient. Because everyone is going to want to see all your care for that patient. Something to keep in mind: it is not just any particular visit they may be focused on, it may be your continuity of care, and whether that was present or not. So that’s another thing. Here’s what you don’t want to do. You don’t want to change the record, you don’t want to modify the record and you don’t want to add to the record. You want to keep the record as it is.

The second thing you don’t want to do is talk to everyone about the lawsuit — how you feel wronged by it, how the patient is wrong and you’re right, what’s wrong with the legal system today. Just talk to your insurance carrier, your lawyer and your spouse. That’s it. You don’t want to talk, and the reason is because anything you say — sort of like we hear on crime shows — can and will be used against you. That could cause someone to go out and interview people you’ve talked to and find out what your present state of mind is. Did you make any admissions? That’s what you want to avoid.

Q: ME: One of the things we often hear about is that physicians practice defensive medicine to try to prevent lawsuits. Does defensive medicine actually work? Does it actually help prevent a lawsuit?

Cummings: Well, if by defensive medicine, do you mean ordering that test or recommending medical treatment solely to reduce the threat of a lawsuit? That may not necessarily be the best option. Is it an option that serves the physician hoping that they don’t get later sued for malpractice? I would say studies are mixed on this.

Believe it or not, some evidence suggests that defensive medicine works. However, there are downsides to that. And let’s just talk about things that aren’t legal, the medical ethics of it. Because if you know you’re doing a test that might not be necessarily indicated, but you just want to make sure you’re protected, that is not medically ethical. Second, you might not be solving the problem because by ordering the test or medical procedure, you’re now subjecting the patient to additional risk of harm. That may later come back to bite you. We can all see that scenario happening: You’ve ordered a test that you think might not be necessary, but you need to make sure your butt is covered. And then something happens as a result of the test. Now the motivation and reason for the test are going to be issues as well. And so let me tell you where that goes — the doctor is putting profits over patient care. And that is a deadly argument in a jury trial.

“Do not abandon your tried-and-true principles of the SOAP format. . . . Why? Because somebody down the line, a lawyer or another physician, needs to know what your thought process was.”

So I certainly understand why defensive medicine is practiced. And yes, sometimes it’s successful, but you’re really increasing your risk of having a malpractice suit brought against you. And one that may not be defensible.
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LEGALLY SPEAKING

Common malpractice insurance coverage during the COVID-19 pandemic

Telemedicine: What do I need to know?
This is our most common question. Most major liability insurance companies are changing their internal underwriting guidelines to allow practices to be more telemedicine-based until the COVID-19 pandemic ends. This is generally for COVID-19-related reasons, but what this entails has been loosely defined:

- Do you need to protect your patients from the virus, is one of your staff sick?
- Do your patients fall into a higher-risk pool and thus telemedicine is a safer medium?
- Are there mandated state orders?

Physicians must document the relationship to the COVID-19 Pandemic as the telemedicine portion of their practice expands.

The utilization of telemedicine normally requires physicians to be licensed in the state where the patient is physically located. However, some states have waived the licensure requirement due to the pandemic. Physicians need to check with each state to verify that they comply with all state licensing regulations. Here is a current list of state licensing waivers and adjustments. If you are adding a new state to your practice for telemedicine, you should contact your agent or broker.

Can I reduce my policy from full-time to part-time status?
Adding this endorsement to your current coverage will reduce your overall premium costs. Most physicians choose this path because their practice has been reduced significantly due to the pandemic. Many are experiencing a significant drop in patient visits; certain procedures could be deemed elective and patients may choose to reschedule their appointments.

Can I temporarily suspend my coverage?
There have been a wide range of responses from malpractice insurance companies pertaining to suspension during the COVID-19 Pandemic; from no cost during the suspension to having the premium reduced by a certain percentage. Adding a suspension endorsement to your current coverage states that you are not seeing any patients during this time, and no coverage is provided during the suspension period. There are also specific rules covering the minimum and maximum length of time for a suspension endorsement to be approved. These vary greatly among all insurance companies. Contact your agent if you have any specific questions or concerns.

Can I expand my scope of practice?
This is for doctors who are working outside their specialty to assist with the COVID-19 crisis. Some insurance companies are covering this if it’s related to the pandemic, while others are not. Please contact your agent if you plan to work outside your specialty.

I’m a retired physician

Can I delay my payment?
Most malpractice insurance companies are extending due dates and suspending policy cancellations due to non-payment. Your premium will be due eventually, but many companies are providing additional time to make payments in this difficult time. Contact your agent or broker if you plan on missing any payments or need additional time to make yours.

Who wants to help. What do I need to do?
If you are a retired physician with a tail endorsement, some companies have issued statements that Tails will not be jeopardized for physicians who temporarily provide patient care specifically related to the COVID-19 Pandemic. If you will be working during the pandemic, it’s recommended you contact your agent or broker to ensure you’re fully covered.

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Erik Leander is the chief technology officer and chief information officer of Cunningham Group, a medical malpractice insurance agency. Send your legal questions to Medec@mjlifesciences.com.
Jennifer Bacani McKenney, M.D., knew her already busy schedule would become almost unmanageable when she found out another physician at her Fredonia, Kansas-based family practice had passed away unexpectedly. As she incorporated a deluge of patients into her schedule, McKenney says her workload quickly spiraled out of control. "It was unsustainable," she recalls.

All of that changed eight years ago when she hired a virtual scribe — someone who works off-site or in a different area of the practice (i.e., not in the exam room) — to document important aspects of the encounter so she could focus on providing patient care and working more efficiently.

McKenney’s scribe works in a separate room in the same office without ever having patient contact. The scribe also remotely controls the EHR and navigates to various sections that McKenney needs to see, so she rarely needs to touch the keyboard. For example, if she wants to review the patient’s most recent mammogram, the scribe pulls up the results. If she wants to order amoxicillin for an ear infection, the scribe sends the script to the pharmacy electronically.

The practice has since hired three additional scribes (one for each of the other two physicians and one for the nurse practitioner). The practice has also joined an accountable care organization and consistently meets all of its quality benchmarks — an accomplishment that McKenney attributes directly to its virtual scribes.

In particular, McKenney’s scribe performs a pre-visit review of the patient’s chart and lets her know as she walks from one exam room to another what was discussed during the last visit as well as what should be addressed currently. The scribe also identifies any preventive tests (e.g., mammograms and colonoscopies) for which the patient may be due. "It’s a much more efficient way of moving through the day," she says.

Another bonus: Her documentation is more comprehensive, often translating to higher reimbursement. That’s because the scribe reminds her to address additional complications, enabling her to bill a higher-level evaluation and management (E/M) code.

With the help of a scribe, she says she can also provide better patient care. "We get such good one-on-one time with our patients looking them in the eyes, chatting and doing what we do as doctors.”

Perhaps most importantly, her quality of
life has improved. “I don’t know that I would still be practicing if I didn’t have a virtual scribe,” she says, adding that she ends her workday at 5 p.m., cooks dinner every night and spends more time with her family.

THE VIRTUAL SCRIBING SOLUTION
Many experts have heralded medical scribes as a potential antidote to the administrative burden facing physicians, says Dale Kivi, MBA, senior director of communications at Aquity Solutions, an outsource transcription services vendor in Glen Allen, Virginia. “Physician burnout is becoming a significant crisis in the U.S. health care marketplace,” he says. “Suicide rates for physicians are twice that of the general population.”

In some cases, physicians can either see additional patients or they can use that time to pursue personal interests, says Kivi.

Scribing itself isn’t new, but the virtual aspect is—something that’s only possible given the proliferation of EHRs (and digital data) that people can access simultaneously from multiple locations, says Jay Vance, founder of GoScription, LLC in San Antonio, Texas.

Physicians often use an Alexa-type device managed over a secure connection with secure mobile phone apps as a backup in case of connectivity issues, says Kivi. Smaller recording devices, such as those that can be attached to a laptop, are used when the encounter recording is provided to off-line scribes without two-way audio communication between the physician and scribe.

The good news is that going virtual means physicians aren’t limited to individuals in their local areas, says Vance. They can work with other qualified

Twelve questions to consider before hiring a virtual scribe
Due diligence when vetting potential virtual scribe companies can make or break a physician’s success. Following are 12 questions for physicians to ponder before investing time and resources into one.

- Does the virtual scribe listen live, or do they access a recording of the visit?
- Can the virtual scribe ask questions for clarification in real time? For example, can the scribe ask a question aloud (e.g., “Can you repeat the blood pressure results?”), or must they send an instant message?
- If listening to a recording, how are questions handled, and how long does the company retain the recording?
- Can physicians test the quality of the audio during a trial run before hiring the company?
- Is the company willing to sign a business associate agreement, thereby making it subject to Health Insurance Portability and Accountability Act privacy rules?
- What does the company do if the virtual scribe platform fails, Wi-Fi goes down or the electronic health record is temporarily unavailable?
- What key performance indicators (e.g., revenue, patient volume or average relative value unit) does the vendor use to determine return on investment?
- With what specialties do the scribes have experience, and in which electronic health record systems are they proficient?
- How does the company handle turnover and unanticipated absences?
- What is the average time it takes for a scribe to work at full capacity with minimal physician input?
- Does the company strive to ensure a good personal and professional match between the physician and virtual scribe? If so, how?
- Does the company perform internal audits to ensure high-quality documentation? How does the company handle scribes who produce subpar documentation?
Virtual scribes

candidates (e.g., medical transcriptionists, certified nursing assistants, medical coders, or billers or medical assistants) nationwide, he adds.

Another advantage: The scribe isn’t in the room, says Vance, adding that the physical presence of scribes in an otherwise confidential exam room can make some patients feel uncomfortable.

However, even though patients don’t see the scribe (and vice versa), physicians still need to obtain verbal consent for the scribe to listen, says Vance. Many physicians even introduce the scribe by name at the beginning of the visit. They also need to be ready and willing to forgo the scribe if a patient doesn’t agree to the arrangement, although he says this doesn’t happen often based on his experience, he adds.

ADAPTING TO CHANGE

Still, using a virtual scribe does require proactive planning. For example, physicians may need to reduce their patient volumes by as much as 85% for a couple of weeks while they provide the scribes with feedback on their work, says Kivi.

“The more time you put in up front with your scribe giving them routine, regular feedback, the more they will morph the notes to your specific style,” says Christina Taylor, M.D., an internist in West Des Moines, Iowa, who has been using a virtual scribe for the last two years. For the first couple of weeks, Taylor had a 60-minute daily call with her scribe. Now, it’s a 30-minute call every couple of months. Her scribe relays important information to a team of individuals who can fill in as needed, so she doesn’t need to document using previous methods when her scribe is sick or on vacation.

At Taylor’s clinic, visits are recorded, encrypted, and sent to India where virtual scribes complete documentation in the EHR. Because India is approximately 12 hours ahead of Iowa, Taylor’s notes are usually ready for her review when she comes in the next morning. Once she reviews and signs the note, the recording is deleted.

Taylor, who previously saw 18 or 19 patients a day now sees 24 or 25 patients a day with the help of a virtual scribe. The quality of her documentation has improved, enabling her to better capture patient severity and acuity for capitated and value-based payments as well as transitions of care.

In addition to providing feedback to the scribe, physicians may need to be more mindful of how they verbalize details of the visit, says Bonnie Monico, CHDS, president-elect of the Association for Healthcare Documentation Integrity in Modesto, California.

“Physicians have the final ownership of the medical record,” says Zach Taft, senior director of scribing solutions at 3M/M*Modal in Pittsburgh, Pennsylvania. “All information entered by a scribe is ultimately the responsibility of the physician.”

Does a virtual scribe pay off?

Whether it’s improving patient access, generating additional revenue or simply attaining a better work-life balance, experts agree there’s a definitely return on investment for virtual scribes.

One recent study found that using scribes increases work relative value units per hour by 10.5%, increases patients seen per hour by 8.8% and increases patient face time by 57%. A similar study also found decreased off-hour EHR documentation work, greater patient interaction during visits and greater job satisfaction.

Consider this scenario: A physician spends one hour charting each night, or five hours per week. If the physician spends those same five hours seeing patients, they could theoretically see four patients with acute problems (or two patients with complex problems) per hour. This translates to approximately $44,000 to $71,000 annually, depending on the E/M level reported. With a median salary of a medical scribe at $34,000, the payoff can be significant.

“You’re working and getting paid for it rather than just working to document—and not getting paid,” says Jennifer Bacani McKenney, M.D., an internist in Fredonia, Kansas.

Here’s another way to think of it: In order to cover the cost of a scribe, a physician likely needs to see only two additional patients per day (level 3 E/M), so the scribe doesn’t cut into the physician’s take-home pay, says Taylor. “Some people are happy to see the extra two patients and get their life back,” she adds.

Physicians can either hire scribes directly or work with an outside company that recruits the scribe and takes care of all of the technology requirements for the virtual exchange as well as employee benefits. Another perk is that a third-party company can ensure backup assistance when scribes are absent for any reason, says Taft.
EHR implementations and numerous other interoperability initiatives have dominated health care industry technology agendas for nearly two decades. Although the resulting “connected landscape” has driven a treasure trove of operational efficiencies and patient care improvements, it also serves as host to the most lucrative attack surface across industry.

Put bluntly, for an increasingly sophisticated, global community of cybercriminals, health care pays — both figuratively and literally.

The cyberattack by the WannaCry ransomware cryptoworm in 2017 demonstrated this point. Clinical networking vulnerabilities and the consequences of a successful breach were exposed in dramatic fashion.

The reality is many health care systems have little visibility into which medical devices are connecting to their networks.”

Whether history will record WannaCry as the industry’s wake-up call already seems irrelevant, as health care networks continue to be compromised in an increasing number of ways and at an unprecedented pace.

Cyberattacks against health care organizations jumped 60% in 2019, while crippling Trojan ransomware programs like Emotet and TrickBot climbed by 82% between the second and third quarters, according a 2019 Cybercrime Tactics and Techniques report by Malwarebytes, an anti-malware provider. Whether the subject of an external attack or caused by internal human error, the problem is that most health care delivery organizations don’t have the technology or expertise to detect and react to either in a reasonable timeframe.

In fact, the 2019 Cost of Data Breach Study conducted by the Ponemon Institute confirmed that the average time for a health care organization to identify a breach is 236 days — almost two months longer than the average across other industries — and then an additional 93 days to contain it. Even more alarming, the average total cost of a data breach in the health care industry is $6.45 million. The total damage — whether to patients, devices, care delivery systems or record keeping infrastructure — is hard to imagine. And keep in mind, these are self-reported numbers.

Examining the problem
Sometimes referred to as “bringing down silos,” the interoperability trends of the past several years are essentially a push for new front-, middle- and back-office connections. Specific to cybersecurity, the adoption of “smart devices,” also known as the Internet of Things (IoT), has exploded. It seems that every device in use anymore, whether to facilitate patient care directly (e.g. patient monitors, infusion pumps, radiology, etc.) or to improve the way systems are managed — from cameras to elevators to HVAC — are “talking” to one another. As expected, the data being generated are proving to be immensely valuable and strategic, as the resulting operational efficiencies has made dramatic strides in short order. And, since there’s no such thing as “plug and play” cybersecurity, the market’s leaders are quickly differentiating, both in terms of innate capabilities and the ability to bring them to life in successful implementations.

Mitigating health care’s cybersecurity risks in the era of hyperconnectivity

by JONATHAN LANGER Contributing author

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The solution is visibility
For these reasons, connected asset visibility must be comprehensive and include highly granular device-profiling detail. This is definitely a case where the more data, the better, and enriched, contextualized data are best. So, it’s not just about discovering what’s connected inside your network. Instead, what’s required are detailed device-specific profiles, including an understanding of the device’s needs and workflow, knowledge of how the device interoperates, how it is being used and its security posture.

Due to the proprietary nature of both clinical and medical devices and the unique, often undocumented communication protocols that they use, visibility remains a major challenge. And given how these assets are maintained, updated, patched, etc., a continuous view into their status is essential, whether for good, safe operations or security purposes.

When that kind of continuous, real-time visibility is available, most things are possible. For example, instead of health care technology management workers scrambling to determine if a newly published threat is relevant, any/all existing and newly published threats can be instantly correlated. Armed with knowledge, anomalous behaviors at the network level can also be detected and safely terminated. The list goes on. The operational benefits can actually change the organizational profile of those enlisted to execute the improvements.

In short, you must establish an accurate baseline and build security programs from the ground up. You must know your endpoints at the individual level and build from there. In doing so, you can not only create and enforce appropriate security policies, but also overhaul preventative maintenance programs and rationalize replenishment programs.

The hyperconnected future
Telehealth and the bring-your-own-device trend are driving an even more connected landscape. And because COVID-19 will result in permanent changes that continue to drive both, management and security challenges will clearly increase. Looking ahead, it’s not difficult to envision a future where a majority of care is delivered through mobile, remote-capable monitoring solutions, so leaders must take notice.

Recognizing that budgets and cybersecurity experiences vary, a logical first preparatory step is to take inventory of the type of information are they transmitting and what, if any, security policies exist? What is the difference between device counts under mobile device management pre-COVID-19 versus the number of devices in use post-COVID-19? The good news is that the market’s leading solution providers are genuinely on top of the problem space. The bad news is that separating the marketing hype from reality can be difficult.

Choosing vendors that are focused on the acute care subvertical makes sense, since cross-industry solutions rarely work in health care. If the right vendor is selected, financial offices can justify their investments against a business case that is based on operational improvements that can be monetized — and ultimately benefit patients.

Jonathan Langer is the CEO of Medigate. Send your technology questions to medec@mjhlifesciences.com.

Increase in cyberattacks against health care organizations in 2019, compared to 2018
60%
When Boston-based internist Annie Brewster was diagnosed with multiple sclerosis (MS) in 2001, she was in denial. “Coming to terms with a diagnosis takes a long time,” she says. “For me, it took five years.” Initially, she wasn’t ready to attend a support group, but she did want to read about other patients with MS. “I didn’t want to hear media sound bites,” she says. “I wanted true stories with the full arc — stories of how people are moving forward despite the hardships that are put in front of them.”

These stories, she says, are what helped her process her diagnosis so she could move forward. It wasn’t until nearly a decade later, though, that she decided to formally pursue her passion for patient stories. In 2010, she began collecting, editing and, ultimately, sharing stories in collaboration with a Boston-based public radio station to help patients and their families cope with illness.

“Initially, I was thinking it would be great to create a library of stories so patients who might have a similar diagnosis could listen and feel less alone and more connected,” says Brewster.

Eventually, this project developed into what is now the Health Story Collaborative, an organization dedicated to harnessing the healing power of stories. It includes dozens of stories from patients with terminal cancer, addiction, depression, infertility and more — all shared with the help of a Health Story Collaborative team member who works with each storyteller to depict an authentic account of their experience.

**USE PATIENT STORIES TO IMPROVE CARE**

Referring patients to Health Story Collaborative or other resources (e.g., blogs, discussion forums, YouTube videos and movies) is helpful on many levels, says Brewster. Patient stories are therapeutic not only for the patient who tells the story, but also for the listener or reader who is inspired by it. They’re also helpful for physicians, who can use the stories to augment the clinical care they provide, Brewster adds.
"Experiencing others’ stories help patients feel less isolated and more connected," says Brewster. "We know there are benefits of social connectedness and harms of social isolation."

Staying connected is especially relevant during COVID-19, says Kate Burke, an emergency physician at Milford Regional Medical Center in Massachusetts and a senior medical adviser at PatientsLikeMe, a health and social network where patients share information about medication side effects, treatments, daily health challenges and victories, and everyday life. The site includes more than 750,000 people living with nearly 3,000 different conditions.

"COVID-19 has brought out significant anxiety and loneliness for a lot of folks," says Burke, adding that a lot of stigma exists around those who test positive. "People feel guilty, and they’re scared that they’re going to get their loved ones sick. We have noticed a lot of conversations in our forums where patients are supporting each other."

PatientsLikeMe provides a forum specifically for COVID-19 that includes more than 75,000 people sharing information about symptoms and treatments, as well as activities to do while social distancing, recipes, artwork and more.

Serious illness can be equally as isolating, says Rita Charon, physician, literary scholar, and founder and executive director of the program in narrative medicine at Columbia University in New York City. Patients want to read the stories of others to remind them that they’re not the only person going through a painful experience, she adds.

Experiencing others’ stories has additional benefits, says Pamela Rutledge, a media psychologist and director of the non-profit Media Psychology Research Center in Newport Beach, California. The center examines how people consume, produce and distribute information across all media technologies to better understand and predict behavior and impact.

"There is benefit to patients being able to connect to others, share stories and offer encouragement," Rutledge says. "This is a social component of most behavior change. It has been shown to facilitate compliance with dieting, exercise or health management." Some physicians may even want to consider collecting and posting patient stories (with permission) on restricted areas of their own websites that only patients can access, she adds.

To do this, though, they should ideally partner with someone who can capture the story in a respectful way that motivates others, advises Brewster, whose work is grounded in the field of narrative psychology, focused on helping individuals tell stories in psychologically productive ways.

Teaming up with a professional writer who is skilled at profiling others can also be helpful, says Charon, since the goal is to tell a story that resonates with others and inspires.

"In essence, all of us are storytellers, and what we bring to the doctor’s office is much more than a list of symptoms — it’s a story. A lot of times, if you just let someone tell their story, some of the things you might have had to dig for are just handed to you on a silver platter."

— JEFFREY MILLSTEIN, M.D., AN INTERNIST AND ASSOCIATE MEDICAL DIRECTOR FOR PATIENT EXPERIENCE, PENN MEDICINE, PHILADELPHIA

Physicians should encourage patients to experience other patients’ stories and to come prepared to appointments with questions, as well as insights into what they have learned on their own about their symptoms, says Jeffrey Millstein, M.D., an internist and associate medical director for patient experience at Penn Medicine in Philadelphia. Millstein is one of 18 administrative and clinical leaders who helped create the Penn Medicine Listening Lab, a storytelling initiative that embraces listening as a form of care. "I would much rather hear about what patients are learning," says Millstein. "Let’s get it out on the table so we can talk about it."

Burke agrees. "It’s OK if a patient has a lot of information and is making some determinations based on what they’re learning because patients are really smart," she says. "I often say, ‘I may have studied this in..."
medical school, but you live with this every day. You can give me insights.”

**VET POTENTIAL RESOURCES**
When it comes to suggesting specific resources for your patients, experts provide the following advice:

✔ Is it a corporate or non-profit-sponsored resource? Although information on a corporate-sponsored website, for example, may be helpful for patients, it may also be biased in favor of a particular medication or treatment. This is important for patients to understand as they review the information.

✔ What have patients found helpful? Sometimes the best resources come from patients themselves. Ask for recommendations for blogs, podcasts, discussion forums and more. Also ask patients why these resources are particularly helpful. What is it that resonates with them, and how can the resources be helpful to others?

**HELP PATIENTS FEEL HEARD**
In addition to arming patients with external resources that can help validate their experiences, physicians can do their part to make patients feel heard. “Even if you only have 15 minutes, there’s a lot that you can do to make patients feel as though you see them and are listening to them more fully,” says Brewster, who intentionally makes eye contact and avoids looking at the EHR for too long.

“In essence, all of us are storytellers, and what we bring to the doctor’s office is much more than a list of symptoms — it’s a story,” says Millstein, who starts each visit with this open-ended question: Can you tell me the story of what brought you in today? “A lot of times, if you just let someone tell their story, some of the things you might have had to dig for are just handed to you on a silver platter,” says Millstein, adding that this strategy can actually help physicians save time, not add additional burden.

Using active listening skills and providing patients with resources to support their emotional needs can greatly improve the patient experience, says Brewster. “When doctors deliver a diagnosis, we often think of it as the end of the story,” she says. “We come in as detectives with a problem to solve. We solve it, and then we think the story is over. But for the patient, that’s just the beginning.”

“There is benefit to patients being able to connect to others, share stories and offer encouragement. This is a social component of most behavior change. It has been shown to facilitate compliance with dieting, exercise or health management.”

— PAMELA RUTLEDGE, MEDIA PSYCHOLOGIST AND DIRECTOR, MEDIA PSYCHOLOGY RESEARCH CENTER, NEWPORT BEACH, CALIFORNIA
Dealing with the rising cost of insulin

The health care community weighs in on how to make insulin affordable.

by KEITH LORIA Contributing author

More than 7 million Americans depend on insulin, a medication that has no substitute and for which prices continue to rise. The steep cost of insulin makes it difficult for the growing number of Americans with diabetes to afford this lifesaving medication.

“It’s a big problem,” says Diana Isaacs, Pharm.D., BCPS, BCACP, a spokesperson for the Association of Diabetes Care & Education Specialists (ADCES). “People with Type 1 diabetes require insulin to live. People with Type 2 diabetes often need it to avoid severe complications. The high cost forces people to make tough choices about their health.”

The American Diabetes Association (ADA) believes that no individual in need of insulin should go without it due to prohibitive costs, yet just over a quarter of people who get the drug have reported that cost affects their use. When people with diabetes cut back or skimp on their insulin doses, they’re at risk of serious, sometimes deadly consequences.

Many people look to their primary care doctor for help. “Primary care providers should let all their patients taking insulin know that Novolin N, Novolin R and Novolin 70/30 are insulins that can be bought over the counter,” Isaacs says. “They are $28 per vial or $42 for a box of pens. (Although) these insulins are not exactly comparable to newer insulins, they are much lower cost and can be a good option if someone is in a bind.”

The American Diabetes Association recommends that health care providers discuss the cost of insulin preparations with patients to help clarify the advantages, disadvantages and financial implications of options. “Providers should prescribe the lowest-priced insulin required to effectively and safely achieve treatment goals,” says LaShawn McIver, MD, the ADA’s senior vice president of government affairs and advocacy. “This may include using human insulin in appropriately selected patients.”

Providers also should be aware of the rising cost of insulin preparations and how this negatively affects adherence, as well as be trained to appropriately prescribe all forms of insulin based on evidence-based medicine. Aaron Toleos, a spokesperson for Right Care Alliance, says primary care doctors can’t change the cost of their patients’ medications, which limits what they can do.

“With an investment of time and determination, they can sometimes figure out which insulin products are both appropriate and affordable under a patient’s plan. But it’s common for individual drug coverage to change, and it’s hard to keep up,” he says. “Some physicians tell patients about insulin tourism or suggest mail order from Canada, where it can usually be purchased for around 10% of the U.S. cost.”

Sarah Sato, N.P., a certified diabetes educator with the Alpine Center for Diabetes, Endocrinology and Metabolism in Superior, Colorado, says that although primary care providers may not have time to answer every question, they should tell patients about the over-the-counter insulin option and about manufacturer coupons and discount cards for people who are commercially insured. She emphasizes that although there is no shame in asking for cheaper options, people often feel embarrassed or hesitate to take the time of their provider or pharmacist to discuss the issue.

“I think this problem has been catastrophic for a lot of families, and it’s finally being addressed. Colorado has passed, for example, a maximum price per month for insulin in order to bypass the massive out-of-pocket costs people can see,” Sato says. “There are other insulins that are much cheaper and can be purchased without a prescription, but they don’t work the same as the ones we usually prescribe and can be risky to use if...
the person isn’t familiar with the differences.”

Cost-cutting resources
It can be challenging to navigate the wealth of information available to doctors and patients, according to the experts. To help, each insulin manufacturer has its own website and resource center, and patient assistance programs can assist with determining discount eligibility.

Isaacs recommends the Insulin Cost Savings Resource Guide from ADCES, available at diabeteseducator.org/affordability. It summarizes the available programs and gives guidance depending on type of insurance coverage (Medicaid, Medicare, commercial, none).

Moving toward change
Because of advocacy efforts, states are starting to cap insulin costs. The ADA has been working at the state and federal levels to bring about public policy changes to ensure that no one goes without insulin because of cost. According to McIver, health care providers who want to take the next step on this urgent issue can make their voice heard regarding bills that aim to lower insulin costs in the short term at diabetes.org/advocacy/platform. Health care providers should direct patients struggling to pay for insulin to the ADA website InsulinHelp.org, she adds.

“For anyone with commercial insurance, you should always check to see if there is a co-pay card available before picking it up from the pharmacy,” Isaacs says. “For those without insurance, patient assistance programs can often help, and the salary caps are much higher than people realize — for example, as high as 400% above poverty level, which is $103,000 for a family of four.”

Insulin does not need to be expensive; it needs to be accessible. Sato says that overall, the system is designed to make money for the corporations at the expense of the patient, with billions of dollars in play for insurance companies and drug manufacturers.

“But it seems like the people have made their anger more known now, and so places like Colorado passing price cap laws has made a difference for those residents and may become a watershed for other states to follow suit,” she says. “I believe that the industry needs to feel the anger of the patients in their wallets before real change may manifest, and steps like the state law change may be the best way to help that happen.”

With an investment of time and determination, they can sometimes figure out which insulin products are both appropriate and affordable under a patient’s plan. But it’s common for individual drug coverage to change, and it’s hard to keep up.”

— AARON TOLEOS, RIGHT CARE ALLIANCE
Coping case studies: Migraine and headaches

by RENEE DOWLING, CPC Contributing author

Getting paid requires accurate documentation and selecting the correct codes. In our Coding case studies, we will explore the correct coding for a specific condition based on a hypothetical clinical scenario. Check out the following scenario involving a patient presenting with a headache and see if you can choose the correct codes.

Clinical Scenario:
Patient presents with a headache, including since pressure.

HISTORY OF PRESENT ILLNESS
Headache with sinus pressure.
- Imitrex has been helping
- Patient thinks she needs increased dose
- Has had sinus pressure with headache this week
- has been taking Flonase, which helps, tried Allegra and Zyrtec
- uses albuterol, having to take inhaler daily right now
- Headache hurts with cough

REVIEW OF SYSTEMS
Constitutional: Negative for fever.
HENT: Positive for congestion and sinus pressure. Negative for rhinorrhea and sore throat.
Eyes: Negative for itching.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Skin: Negative for rash.
Neurological: Positive for headaches.

PHYSICAL EXAM
Vitals
BP: 132/74
Pulse: 87
Resp: 18
Temp: 97.9 °F (36.6 °C)

Constitutional: She appears well-developed and well-nourished.
Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal and breath sounds normal. She has no wheezes.
Abdominal: Soft. Bowel sounds are normal. There is no tenderness.
Neurological: She is alert and oriented to person, place, and time.

ASSESSMENT / PLAN
Migraine without status migrainosus, not intractable, unspecified migraine type.
- Improving
- Increase Imitrex to 50mg every two hours as needed for migraines=
- Return in one month for follow-up

How should this be coded? Here is some background information on documentation requirements and the available ICD-10 codes.

Documentation Coding Requirements

When documenting a migraine, include the following:

- Type:
  - Hemiplegic
  - Persistent migraine aura
  - Chronic
  - Ophthalmoplegic
  - Periodic headache syndrome
  - Abdominal
  - Menstrual
  - Other

- With or without:
  - Aura
  - Cerebral infarction
  - Status migrainosus
  - Cyclic vomiting

- Intractable or not intractable
  - G43 Category Additional Coding Guidance:
    Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth digit character 5)
### Chronic Conditions

#### Coding case study

<table>
<thead>
<tr>
<th>MIGRAINE ICD-10 CODES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>G43.001</td>
<td>Migraine without aura, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.009</td>
<td>without status migrainosus</td>
</tr>
<tr>
<td>G43.011</td>
<td>Migraine without aura, intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.019</td>
<td>without status migrainosus ●</td>
</tr>
<tr>
<td>G43.101</td>
<td>Migraine with aura, not intractable, with status migrainosus ●</td>
</tr>
<tr>
<td>G43.109</td>
<td>without status migrainosus ●</td>
</tr>
<tr>
<td>G43.111</td>
<td>Migraine with aura, intractable, with status migrainosus ●</td>
</tr>
<tr>
<td>G43.119</td>
<td>without status migrainosus ●</td>
</tr>
<tr>
<td>G43.401</td>
<td>Hemiplegic migraine, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.409</td>
<td>without status migrainosus</td>
</tr>
<tr>
<td>G43.411</td>
<td>Hemiplegic migraine, intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.419</td>
<td>without status migrainosus</td>
</tr>
<tr>
<td>G43.501</td>
<td>Persistent migraine aura without cerebral infarction, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.509</td>
<td>without status migrainosus</td>
</tr>
<tr>
<td>G43.511</td>
<td>Persistent migraine aura without cerebral infarction, intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.519</td>
<td>without status migrainosus</td>
</tr>
<tr>
<td>G43.601</td>
<td>Persistent migraine aura with cerebral infarction, not intractable, with status migrainosus ●</td>
</tr>
<tr>
<td>G43.609</td>
<td>without status migrainosus ●</td>
</tr>
<tr>
<td>G43.611</td>
<td>Persistent migraine aura with cerebral infarction, intractable, with status migrainosus ●</td>
</tr>
<tr>
<td>G43.619</td>
<td>without status migrainosus ●</td>
</tr>
<tr>
<td>G43.701</td>
<td>Chronic migraine without aura, not intractable, with status migrainosus</td>
</tr>
<tr>
<td>G43.709</td>
<td>without status migrainosus</td>
</tr>
</tbody>
</table>

● Code also any associated seizure (G40.-, R56.9)
● Code also the type of cerebral infarction (I63.)
● For cyclical vomiting not related to migraine, use: K31.89 along with a code from category R11
● Code also associated premenstrual tension syndrome (N94.3)
# Documentation Coding Requirements

When documenting a **headache**, include the following:

- **Type:**
  - Hemicrania continua
  - New daily persistent
  - Hypnic
  - Primary cough
  - Primary exertional
  - Primary stabbing
  - Cluster
  - Persistent migraine aura
  - Chronic or episodic
  - Intractable or not intractable
  - Post-traumatic or acute post-traumatic

## Headache ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G44.009</td>
<td>Cluster headache syndrome, unspecified, not intractable</td>
<td>G44.309</td>
<td>Post-traumatic headache, unspecified, not intractable</td>
</tr>
<tr>
<td>G44.011</td>
<td>Episodic cluster headache, intractable</td>
<td>G44.319</td>
<td>Acute post-traumatic headache, not intractable</td>
</tr>
<tr>
<td>G44.019</td>
<td>Episodic cluster headache, not intractable</td>
<td>G44.51</td>
<td>Hemicrania continua</td>
</tr>
<tr>
<td>G44.021</td>
<td>Chronic cluster headache, intractable</td>
<td>G44.52</td>
<td>New daily persistent headache (NDPH)</td>
</tr>
<tr>
<td>G44.029</td>
<td>Chronic cluster headache, not intractable</td>
<td>G44.81</td>
<td>Hypnic headache</td>
</tr>
<tr>
<td>G44.029</td>
<td>Chronic cluster headache, not intractable</td>
<td>G44.82</td>
<td>Headache associated with sexual activity</td>
</tr>
<tr>
<td>G44.201</td>
<td>Tension-type headache, unspecified, intractable</td>
<td>G44.83</td>
<td>Primary cough headache</td>
</tr>
<tr>
<td>G44.209</td>
<td>Tension-type headache, unspecified, not intractable</td>
<td>G44.84</td>
<td>Primary exertional headache</td>
</tr>
<tr>
<td>G44.211</td>
<td>Episodic tension-type headache, intractable</td>
<td>G44.85</td>
<td>Primary stabbing headache</td>
</tr>
<tr>
<td>G44.219</td>
<td>Episodic tension-type headache, not intractable</td>
<td>G44.89</td>
<td>Other headache syndrome</td>
</tr>
<tr>
<td>G44.229</td>
<td>Chronic tension-type headache, not intractable</td>
<td>R51</td>
<td>Headache</td>
</tr>
</tbody>
</table>

### Diagnosis Code

**G43.909** Migraine, unspecified, not intractable, without status migrainosus.

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your diagnosis coding questions to medec@mjlifesciences.com.
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To learn more about this topic and explore it in greater detail go to:
gotoper.com/online-cme-activities/cpc/cpc-mbcc20bia-alcl

4 Things You Should Know About BIA-ALCL

Learning Objectives
Upon successful completion of this activity, you should be better prepared to:
• Describe presenting symptoms of BIA-ALCL and how to distinguish this cancer from other breast implant problems.
• Identify best practices in BIA-ALCL treatment and discuss evidence available for treatment options.
• Detail a treatment strategy that incorporates a multidisciplinary team to optimize outcomes for patients with BIA-ALCL.

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Instructions for Participation/How to Receive Credit
1. Read this activity in its entirety.
2. Go to gotoper.com/go/mbcc20bia-alcl to access the online version of the activity and complete the posttest.
3. Answer the evaluation questions.
4. Request credit using the drop-down menu.

You may immediately download your certificate.
Breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) is a recently defined malignancy that affects women who have undergone breast implant surgery for reconstructive or cosmetic purposes. The risk of BIA-ALCL for patients with textured breast implants has been estimated between 1:2832 and 1:30,000 across global studies; however, a prospective analysis from a single surgeon indicates the incidence may be as high as 1:355 in patients with textured implants. Early recognition of BIA-ALCL is critical for prompt diagnosis and treatment with curative intent. Here are four important things you need to know about BIA-ALCL.

1. **BIA-ALCL is rare and associated with the use of textured breast implants.**

BIA-ALCL is a rare type of T-cell lymphoma first described in 1997, recognized as a potential malignancy associated with breast implants by the FDA in 2011, and as a distinct disease entity by the WHO in 2016. Typically, this indolent malignancy presents in the capsule surrounding a breast implant that has been used for cosmetic or reconstructive purposes, and behaves more similar to solid tumors than to other non-Hodgkin lymphomas.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>First described</td>
</tr>
<tr>
<td>2011</td>
<td>Potential malignancy</td>
</tr>
<tr>
<td></td>
<td>associated with breast</td>
</tr>
<tr>
<td></td>
<td>implants-FDA</td>
</tr>
<tr>
<td>2016</td>
<td>Distinct disease</td>
</tr>
<tr>
<td></td>
<td>entity-WHO</td>
</tr>
</tbody>
</table>

Early strategies to improve on aesthetic features of breast implants included the use of polyurethane coated silicone, which was associated with a chronic inflammatory reaction to help prevent capsular contracture. The adhesive quality of polyurethane allowed shaped implant design, but its use was discontinued due to concerns about potentially toxic degradation products. Following the withdrawal of these coated implants, manufacturers came up with proprietary texturing processes for silicone without coating. The use of textured implants increased significantly in the 1990s and continues today. Tissue ingrowth in the porous surface of textured implants is suspected to prolong and exacerbate chronic inflammation. In 2019, Allergan voluntarily recalled BIOCELL textured tissue expanders and implants, although other less aggressively textured implants remain on the market.

2. **The diagnosis and management of BIA-ALCL requires a multidisciplinary team.**

BIA-ALCL is typically a localized malignancy with a good prognosis. BIA-ALCL most commonly presents as swelling of the breast with fluid collection (periprosthetic effusion), resulting in breast asymmetry. Less common presentations include the presence of a mass, regional lymphadenopathy, skin rash, and capsular contracture. Perioperative seroma can persist for 3-6 months following surgery, so diagnostic work-up for suspicion of BIA-ALCL should only be considered for patients who are greater than 1 year post-implant. Patients will generally present to primary care providers with these issues, and not their plastic surgeon, due to the length of time from surgery to symptom presentation.

Early intervention and early diagnosis are critical in the successful treatment of these patients, hence the need for a comprehensive approach that involves health care professionals in various disciplines. Radiologists must be informed about BIA-ALCL diagnosis and be mindful in looking for diagnostic indicators such as the presence of fluid on imaging. Ultrasound-guided fine-needle aspiration is used to collect 50 ml of fluid for the preparation of cytopathology smears, cell block with immunohistochemistry for CD30, as well as flow cytometry and molecular genetic studies. Additional imaging should encompass MRI of the breast for complete imaging, and PET-CT to identify involved lymph nodes. Ideally, each case should be discussed at a multidisciplinary team meeting consisting of surgeons, medical oncologists, radiologists and hematopathologists.

An accurate medical history regarding implants is also a key component of diagnostic work-up, as an apparent case of BIA-ALCL in a patient with a recent or smooth implant is almost always related to prior longer history of implant with a textured device. Additionally, the collaboration of this team is crucial for patients with residual disease that may need adjuvant chemotherapy and/or radiation.
The standard of care for limited disease BIA-ALCL is en bloc resection. In a recent study of patients with BIA-ALCL (N = 70) 80% were found to have limited disease. Limited disease is defined as the presence of a seroma or stage 1 disease. For these patients, the standard of treatment is en bloc resection. En bloc resection aims to remove a tumoral mass in its entirety surrounded by a continuous layer of healthy tissue and includes a capsulectomy, excision, and complete excision of associated masses and any involved lymph nodes. En bloc resection is indicated only for a confirmed diagnosis of BIA-ALCL and is not recommended for suspicious or prophylactic surgeries. National Comprehensive Cancer Network guidelines recommend consideration for the removal of both implants due to the known cases of bilateral disease. Physicians should follow oncologic principles of tumor ablation, including changing instruments when moving to different surgical sites and avoiding contamination of the wound with malignant fluid. Patients with advanced disease may benefit from chemotherapy and/or radiation therapy.

Patient education on the presentation of BIA-ALCL is crucial for the timely diagnosis and treatment of this malignancy. The vast majority of patients will simply require reassurance and a reminder to maintain diligence and consistency with intermittent follow-up. Plastic surgeons need to be on the lookout for any pathology affecting the breast implant or surrounding tissue. Some practices have been sending informational letters to their patients to prompt return for routine follow-up visits. This may be particularly useful for practices that have patients that are many years out from surgery and have been lost to long term follow-up. Patients who have cosmetic breast implant surgery are more likely to be lost to follow-up than patients who have had reconstruction following breast cancer, as patients who have had cancer are more adherent to clinical appointments.

The prophylactic removal of textured breast implants is not recommended. Although en bloc resection has been determined to be the most effective treatment for BIA-ALCL, there are no formal recommendations for the prophylactic removal of breast implants. Instead, patients should be adequately informed about risk prior to surgery, emphasizing that the incidence will be more accurately determined following the collection of case reports and data.

For a full list of references go to: gotoper.com/go/mbcc20bia-alcl
A 45-year-old woman with a history of cosmetic breast augmentation 10 years prior presents to the clinic with painless swelling in the left breast for a duration of one year. Ultrasound and fine needle aspirate reveal ALK-negative CD30+ BIA-ALCL with no lymph node involvement.

What are the most appropriate next steps in treatment for this patient?

A. Concurrent implant removal and reconstruction followed by monitoring
B. Concurrent implant removal and reconstruction followed by chemotherapy
C. En bloc resection of affected implant followed by monitoring
D. En bloc resection of affected implant followed by chemotherapy

Which of the following describes best practices regarding the role of clinicians in the treatment of BIA-ALCL?

A. Surveillance and treatment are mainly a concern for plastic surgeons and surgical oncologists
B. A multidisciplinary team consisting of surgical oncology, plastic surgery, hematopathology, and radiology should all be involved in the care of a patient with BIA-ALCL
C. All patients should be referred to medical oncology for treatment with chemotherapy
D. Primary care physicians rarely encounter patients with BIA-ALCL and need not be concerned with this malignancy

Which of the following statements best describes BIA-ALCL?

A. BIA-ALCL is an indolent malignancy that is associated with textured implants
B. BIA-ALCL is a rapidly progressive malignancy that is associated with textured implants
C. BIA-ALCL is an indolent malignancy associated with smooth implants
D. BIA-ALCL is a rapidly progressive malignancy associated with any type of breast implant

To learn more about this topic and explore it in greater detail go to: gotoper.com/online-cme-activities/cpc/cpc-mbcc20bia-alcl

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Recently, I had a conversation with one of the smartest and most well-respected leaders I know — over Zoom, of course. We were discussing big, complex topics like how to make a difference now, how to keep staff on payroll when facing catastrophic declines in cash flow, and how to work together to support people at the frontline of care.

At some point, there was a break in the conversation, and as the silence carried on, I impulsively asked a simple question. “Are you OK? Not OK? I’m fine, but really OK?” I was unprepared for what came next: the sound of quiet, shaking sobs. The sound of heartbreak, loss, grief.

At first, I looked away, embarrassed. This isn’t what we do in business, right? Especially right now, when we’re supposed to be strong — when, as leaders, we’re supposed to be focused, decisive, reliable, inspiring. But I’m a trained physician; I know how to will myself to face somebody else’s pain and discomfort. I met their gaze, sat in the silence, and then, surprisingly, felt my own pain and fear rise up — my own tears run down my cheeks.

We are at war with an unforgiving virus. As we look over the horizon, we can’t see a logical endgame yet. We are frightened and don’t know what will come next. This is true for all of us. For some, though, the destruction is hitting on many levels — we’re losing loved ones, jobs, businesses, even our identities as the world shifts and what we once relied on to define our lives, disappears.

“I’ve lost everything,” my friend said. “It’s all gone — all the revenue, all the new opportunities. This was going to be a perfect year. Now, we have nothing.” I recognized the voice they were channeling — the voice in my own head ranting out of fear of the unknown, grief, and anger.

Despite the despair, I felt a deep connection with this leader. The connection made me feel brave, gave me a jolt of hope, and reminded me what has gotten me through every other hard time: gratitude.

I realized as I said those words, I was also speaking to myself — and now to everyone who might read this. We are all feeling the despair and grief that my friend was experiencing, on various levels. There’s a reason a recent article titled “That Discomfort You’re Feeling Is Grief” has become one of the most read ever on Harvard Business Review. As the interviewee, grief expert David Kessler, said, “The loss of normalcy; the fear of economic toll; the loss of connection. This is hitting us and we’re grieving. Collectively. And that’s OK, he explains. But we can also turn to hope and gratitude to guide us through.

As leaders, these might be the greatest gifts we can offer right now, but we can’t offer what we don’t have. To sustain ourselves and build our resilience, we first have to do what my friend and I did — make space to acknowledge the fear and grief. It won’t overwhelm us, as long as we also seek out hope and gratitude.

We can cherish our family and friends. We can build connections rather than fall into the trap of isolation, of believing that we shouldn’t talk about our very real fears. We can show ourselves the same compassion we’re showing others. And we can remind ourselves that even though some of our losses will stay with us, this situation is finite — it will end, we will recover.

I think I made a difference for my friend in that conversation, and she made a difference for me. The conversation turned to one of opportunity — the actions we could take and the positive impact we could have. In connecting through our fear and grief, we moved toward gratitude for the roles we could play and our hopes for the future.

Halee Fischer-Wright, M.D., is the president and CEO of the Medical Group Management Association.
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