THE COSTS OF BURNOUT

Including:

- Exclusive physician survey results
- The financial impact
- The causes — and solutions

Tech
How digital intervention improves patient health

Legal
The malpractice risks of telehealth

Practice Management
Is your waiting room obsolete?

MedicalEconomics.com
Indication
SHINGRIX is a vaccine indicated for prevention of herpes zoster (shingles) in adults aged 50 years and older. SHINGRIX is not indicated for prevention of primary varicella infection (chickenpox).

Important Safety Information
SHINGRIX is contraindicated in anyone with a history of a severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX

- Review immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX
- In a postmarketing observational study, an increased risk of Guillain-Barré syndrome was observed during the 42 days following vaccination with SHINGRIX
- Solicited local adverse reactions in subjects aged 50 years and older were pain (78.0%), redness (38.1%), and swelling (25.9%)
There are certain medical conditions that are normally associated with aging, but **your patients might not even be aware of a potentially serious one—shingles**. And if they’re over 50 years of age, the risk is real. Take a closer look to learn more about the risk of shingles:

**50+ YEARS**

99.5% of people ≥50 years of age are infected with the varicella zoster virus1

In **1 out of 3 people**, the virus reactivates and causes shingles2,3

Shingles—a blistering rash that can be excruciatingly painful2,3

It’s time to prioritize shingles in your practice—**are you considering your patients 50 years and older for vaccination with SHINGRIX?**

See a range of potential patient types at ProfilesSHINGRIX.com

**Important Safety Information (cont’d)**

- Solicited general adverse reactions in subjects aged 50 years and older were myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%)
- SHINGRIX was not studied in pregnant or lactating women, and it is unknown if it is excreted in human milk. Therefore, it cannot be established whether there is vaccine-associated risk with SHINGRIX in pregnant women or if there are effects on breastfed infants or milk production/excretion

- Vaccination with SHINGRIX may not result in protection of all vaccine recipients

**Please see Brief Summary of Prescribing Information for SHINGRIX on the following pages.**

**References:**

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SGXJRNA210012 April 2021
Produced in USA.
BRIEF SUMMARY

SHINGRIX (Zoster Vaccine Recombinant, Adjuvanted)

The following is a brief summary only; see full prescribing information for complete product information.

1 INDICATIONS AND USAGE

SHINGRIX is a vaccine indicated for prevention of herpes zoster (shingles) in adults aged 50 years and older.

Limitations of Use:
• SHINGRIX is not indicated for prevention of primary varicella infection (chickenpox).

2 DOSAGE AND ADMINISTRATION

2.2 Administration Instructions

For intramuscular injection only.

After reconstitution, administer SHINGRIX immediately or store refrigerated between 2° and 8°C (36° and 46°F) and use within 6 hours. Discard reconstituted vaccine if not used within 6 hours.

2.3 Dose and Schedule

Two doses (0.5 mL each) administered intramuscularly according to the following schedule: A first dose (Month 0) followed by a second dose administered anytime between 2 and 6 months later.

4 CONTRAINDICATIONS

Do not administer SHINGRIX to anyone with a history of a severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX [see Description (11) of full prescribing information].

5 WARNINGS AND PRECAUTIONS

5.1 Preventing and Managing Allergic Vaccine Reactions

Prior to administration, the healthcare provider should review the immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX.

5.2 Guillain-Barré Syndrome (GBS)

In a postmarketing observational study, an increased risk of GBS was observed during the 42 days following vaccination with SHINGRIX [see Adverse Reactions (6.2)].

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared with rates in the clinical trials of another vaccine and may not reflect the rates observed in practice. There is the possibility that broad use of SHINGRIX could reveal adverse reactions not observed in clinical trials.

Overall, 17,031 adults aged 50 years and older received at least 1 dose of SHINGRIX in 17 clinical studies. The safety of SHINGRIX was evaluated by pooling data from 2 placebo-controlled clinical studies (Studies 1 and 2) involving 29,305 subjects aged 50 years and older who received at least 1 dose of SHINGRIX (n = 14,645) or saline placebo (n = 14,660) administered according to a 0- and 2-month schedule. At the time of immunization, the mean age of the population was 69 years; 7,286 (24.9%) subjects were aged 50 to 59 years, 4,488 (15.3%) subjects were aged 60 to 69 years, and 17,531 (59.8%) subjects were aged 70 years and older. Both studies were conducted in North America, Latin America, Europe, Asia, and Australia. In the overall population, the majority of subjects were white (74.3%), followed by Asian (18.3%), black (1.4%), and other racial/ethnic groups (6.0%); 58% were female.

Solicited Adverse Events

In Studies 1 and 2, data on solicited local and general adverse events were collected using standardized diary cards for 7 days following each vaccine dose or placebo (i.e., day of vaccination and the next 6 days) in a subset of subjects (n = 4,886 receiving SHINGRIX, n = 4,881 receiving placebo with at least 1 documented dose). Across both studies, the percentages of subjects aged 50 years and older reporting each solicited local adverse reaction and each solicited general adverse event following administration of SHINGRIX (both doses combined) were: pain (78.0%), redness (38.1%), and swelling (25.9%); and myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%), respectively.

The reported frequencies of specific solicited local adverse reactions and general adverse events (overall per subject), by age group, from the 2 studies are presented in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Aged 50-59 Years</th>
<th>Aged 60-69 Years</th>
<th>Aged ≥70 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SHINGRIX %</td>
<td>Placeboa %</td>
<td>SHINGRIX %</td>
</tr>
<tr>
<td>Local adverse reactions</td>
<td>n=1,315</td>
<td>n=1,312</td>
<td>n=1,311</td>
</tr>
<tr>
<td>Pain</td>
<td>88.4</td>
<td>14.4</td>
<td>82.8</td>
</tr>
<tr>
<td>Grade 3</td>
<td>10.3</td>
<td>0.5</td>
<td>6.9</td>
</tr>
<tr>
<td>Headache</td>
<td>38.7</td>
<td>1.2</td>
<td>38.4</td>
</tr>
<tr>
<td>Grade 3</td>
<td>2.8</td>
<td>0.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Swelling</td>
<td>30.5</td>
<td>0.8</td>
<td>26.5</td>
</tr>
<tr>
<td>Grade 3</td>
<td>1.1</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>General adverse events</td>
<td>n=1,315</td>
<td>n=1,312</td>
<td>n=1,309</td>
</tr>
<tr>
<td>Myalgia</td>
<td>56.9</td>
<td>15.2</td>
<td>49.0</td>
</tr>
<tr>
<td>Grade 3</td>
<td>8.9</td>
<td>0.9</td>
<td>5.3</td>
</tr>
<tr>
<td>Fatigue</td>
<td>57.0</td>
<td>19.8</td>
<td>45.7</td>
</tr>
<tr>
<td>Grade 3</td>
<td>8.5</td>
<td>1.8</td>
<td>5.0</td>
</tr>
<tr>
<td>Headache</td>
<td>50.6</td>
<td>21.6</td>
<td>39.6</td>
</tr>
<tr>
<td>Grade 3</td>
<td>6.0</td>
<td>1.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Shivering</td>
<td>35.8</td>
<td>7.4</td>
<td>30.3</td>
</tr>
<tr>
<td>Grade 3</td>
<td>6.8</td>
<td>0.2</td>
<td>4.5</td>
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<tr>
<td>Fever</td>
<td>27.8</td>
<td>3.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Grade 3</td>
<td>0.4</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>GI</td>
<td>24.3</td>
<td>10.7</td>
<td>16.7</td>
</tr>
<tr>
<td>Grade 3</td>
<td>2.1</td>
<td>0.7</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Total vaccinated cohort for safety included all subjects with at least 1 documented dose (n).

* 7 days included day of vaccination and the subsequent 6 days.

Data for subjects aged 50 to 59 years and 60 to 69 years are based on Study 1. Data for subjects 70 years and older are based on pooled data from Study 1: NCT01165177 and Study 2: NCT01165229.

Placebo was a saline solution.

Grade 3 pain: Defined as significant pain at rest; prevents normal everyday activities.

Grade 3 myalgia, fatigue, headache, shivering, GI: Defined as preventing normal activity.

Feber defined as ≥37.5°C/99.5°F for oral, axillary, or tympanic route, or ≥38°C/100.4°F for rectal route; Grade 3 fever defined as ≥39.0°C/102.2°F.

GI = Gastrointestinal symptoms including nausea, vomiting, diarrhea, and/or abdominal pain.

The incidence of solicited local and general symptoms was lower in subjects aged 70 years and older compared with those aged 50 to 69 years.

The majority of solicited local adverse reactions and general adverse events seen with SHINGRIX had a median duration of 2 to 3 days.

There were no differences in the proportions of subjects reporting any or Grade 3 solicited local reactions between Dose 1 and Dose 2. Headache and shivering were reported more frequently by subjects after Dose 2 (28.2% and 21.4%, respectively) compared with Dose 1 (24.4% and 13.8%, respectively). Grade 3 solicited general adverse events (headache, shivering, myalgia, and fatigue) were reported more frequently by subjects after Dose 2 (0.3%, 3.1%, 3.6%, and

(continued on next page)
3.5%, respectively) compared with Dose 1 (1.4%, 1.4%, 2.3%, and 2.4%, respectively).

Unsolicited Adverse Events

Unsolicited adverse events that occurred within 30 days following each vaccination (Day 0 to 29) were recorded on a diary card by all subjects. In the 2 studies, unsolicited adverse events occurring within 30 days of vaccination were reported in 50.5% and 32.0% of subjects who received SHINGRIX (n = 14,645) and placebo (n = 14,660), respectively (Total Vaccinated Cohort). Unsolicited adverse events that occurred in >1% of recipients of SHINGRIX and at a rate at least 1.5-fold higher than placebo included chills (3.5% versus 0.2%), injection site pruri (2.2% versus 0.2%), malaise (1.7% versus 0.3%), arthralgia (1.7% versus 1.2%), nausea (1.4% versus 0.5%), and dizziness (1.2% versus 0.8%).

Gout (including gouty arthritis) was reported by 0.18% (n = 27) versus 0.05% (n = 8) of subjects who received SHINGRIX and placebo, respectively, within 30 days of vaccination; available information is insufficient to determine a causal relationship with SHINGRIX.

Serious Adverse Events (SAEs)

In the 2 studies, SAEs were reported at similar rates in subjects who received SHINGRIX (2.3%) and placebo (2.2%) from the first administered dose up to 30 days post last vaccination. SAEs were reported for 10.1% of subjects who received SHINGRIX and for 10.4% of subjects who received placebo from the first administered dose up to 1 year post last vaccination. One subject (<0.01%) reported lymphadenitis and 1 subject (<0.01%) reported fever greater than 39°C; there was a basis for a causal relationship with SHINGRIX.

Optic ischemic neuropathy was reported in 3 subjects (0.02%) who received SHINGRIX (all within 50 days after vaccination) and in 3 subjects who received placebo; available information is insufficient to determine a causal relationship with SHINGRIX.

Deaths

From the first administered dose up to 30 days post last vaccination, deaths were reported for 0.04% of subjects who received SHINGRIX and 0.05% of subjects who received placebo in the 2 studies. From the first administered dose up to 1 year post last vaccination, deaths were reported for 0.8% of subjects who received SHINGRIX and for 0.9% of subjects who received placebo. Causes of death among subjects were consistent with those generally reported in adult and elderly populations.

Potential Immune-Mediated Diseases

In the 2 studies, new onset potential immune-mediated diseases (pIMDs) or exacerbation of existing pIMDs were reported for 0.6% of subjects who received SHINGRIX and 0.7% of subjects who received placebo from the first administered dose up to 1 year post last vaccination. The most frequently reported pIMDs occurred with comparable frequencies in the group receiving SHINGRIX and the placebo group.

Dosing Schedule

In an open-label clinical study, 238 subjects 50 years and older received SHINGRIX as a 0- and 2-month or 0- and 6-month schedule. The safety profile of SHINGRIX was similar when administered according to a 0- and 2-month or 0- and 6-month schedule and was consistent with that observed in Studies 1 and 2.

6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of SHINGRIX. 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 the vaccine.

General Disorders and Administration Site Conditions

Decreased mobility of the injected arm which may persist for 1 or more weeks.

Immune System Disorders

Hypersensitivity reactions, including angioedema, rash, and urticaria.

Nervous System Disorders

Guillain-Barré syndrome.

Postmarketing Observational Study of the Risk of Guillain-Barré Syndrome following Vaccination with SHINGRIX

The association between vaccination with SHINGRIX and GBS was evaluated among Medicare beneficiaries aged 65 years or older. Using Medicare claims data, from October 2017 through February 2020, vaccinations with SHINGRIX among beneficiaries were identified through National Drug Codes, and potential cases of hospitalized GBS among recipients of SHINGRIX were identified through International Classification of Diseases codes.

The risk of GBS following vaccination with SHINGRIX was assessed in self-controlled case series analyses using a risk window of 1 to 42 days post-vaccination and a control window of 43 to 183 days post-vaccination. The primary analysis (claims-based, all doses) found an increased risk of GBS during the 42 days following vaccination with SHINGRIX, with an estimated 3 excess cases of GBS per million doses administered to adults aged 65 years or older. In secondary analyses, an increased risk of GBS was observed during the 42 days following the first dose of SHINGRIX, with an estimated 6 excess cases of GBS per million doses administered to adults aged 65 years or older, and no increased risk of GBS was observed following the second dose of SHINGRIX. These analyses of GBS diagnoses in claims data were supported by analyses of GBS cases confirmed by medical record review. While the results of this observational study suggest a causal association of GBS with SHINGRIX, available evidence is insufficient to establish a causal relationship.

7 DRUG INTERACTIONS

7.1 Concomitant Vaccine Administration

For concomitant administration of SHINGRIX with inactivated influenza vaccine [see Clinical Studies (14.5) of full prescribing information].

7.2 Immunosuppressive Therapies

Immunosuppressive therapies may reduce the effectiveness of SHINGRIX.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

There are no available human data to establish whether there is vaccine-associated risk with SHINGRIX in pregnant women [see Use in Specific Populations (8.1) of full prescribing information].

8.2 Lactation

It is not known whether SHINGRIX is excreted in human milk. Data are not available to assess the effects of SHINGRIX on the breastfed infant or on milk production/excretion [see Use in Specific Populations (8.2) of full prescribing information].

8.5 Geriatric Use

Of the total number of subjects who received at least 1 dose of SHINGRIX in the 2 efficacy trials (n = 14,645), 2,243 (15.3%) were aged 60 to 69 years, 6,837 (46.7%) were aged 70 to 79 years, and 1,921 (13.1%) were 80 years and older. There were no clinically meaningful differences in efficacy across the age groups or between these subjects and younger subjects [see Clinical Studies (14.1, 14.2, 14.3) of full prescribing information].

The frequencies of solicited local and general adverse events in subjects aged 70 years and older were lower than in younger adults (aged 50 through 69 years) [see Adverse Reactions (6.1)].

17 PATIENT COUNSELING INFORMATION

• Inform patients of the potential benefits and risks of immunization with SHINGRIX and of the importance of completing the 2-dose immunization series according to the schedule.

• Inform patients about the potential for adverse reactions that have been temporally associated with administration of SHINGRIX.

• Provide the Vaccine Information Statements, which are available free of charge at the Centers for Disease Control and Prevention (CDC) website (www.cdc.gov/vaccines).

Storage:

Store vials of Lyophilized gE Antigen and Adjuvant Suspension Components refrigerated between 2° and 8°C (36° and 46°F). Protect vials from light. Do not freeze. Discard if the vials have been frozen.

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Research Triangle Park, NC 27709

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March 2021 SHX:5BRS

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SGXJRNA210012 April 2021

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CHAIRMAN’S LETTER

Why burnout won’t go away

One of you will be surprised by this news: Physicians are burned out, and the problem is only getting worse. Medical Economics® has devoted our September issue to confronting the crisis of physician burnout. The center of our coverage is the results of our 3rd annual burnout and wellness survey. These results are troubling. More than 80% of physicians told us they feel burned out right now, and many say they do not know how to deal with their stress. That's a 10% rise over last year’s results, and we all know 2020 was a year unlike many others.

You may be surprised by this news: The COVID-19 pandemic is not a major cause of this burnout epidemic, at least among physicians in the Medical Economics® audience. The top reasons for burnout continue to be things that predate the pandemic, including administrative and regulatory burdens and electronic health record systems that don't work well enough.

And in general, more physicians have a feeling, hard to dispute, that their careers are increasingly outside of their own control. Physicians increasingly feel there are forces interfering with the reasons they went into medicine in the first place: To treat patients, and to be a trusted partner in their health.

As Medical Economics® Editor-in-Chief L. Allen Dobson, Jr., M.D., writes in his column this month: “What is now clear is that the practice of medicine and the patient relationship has shifted to corporate control. Whether it is large hospital systems, insurance companies or new venture capital-backed, for-profit companies, the doctor-patient relationship has been replaced by the provider-consumer relationship.”

There are difficult issues that our health care industry must solve. And while all are complex and challenging, the best advice I can give to the powers that be is to listen to physicians, and to put them in charge of making a better health care system for both clinicians and patients.

As always, we value your feedback on our coverage, and welcome your story ideas and other thoughts. Please reach out at medec@mjhifesciences.com.

Mike Hennessy Sr.
Chairman and Founder
of MJH Life Sciences
Physician’s Financial News®

**Inflation survival guide**
Two investment experts explain what’s going on with prices and the impact on your portfolio.

**Physician’s Money Digest®**

**Are income taxes going up?**
How to prepare for potential tax hikes.

**Avoid lifestyle creep**
Getting a handle on your spending can be the difference between reaching your goals — or not.

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FROM THE EDITOR IN CHIEF

**We must solve physician burnout**

**Practice Management**

**Is your waiting room obsolete?**
Taking the lessons of COVID-19 and creating a more patient-friendly environment.

**Three real estate pitfalls to avoid**
Don’t make these mistakes when considering property for your practice.

CAREERS

**Physician burnout survey results**
Exclusive data on physician wellness.

**The true cost of burnout**
Why medical organizations still struggle with addressing one of health care’s major problems.

**Is your practice culture causing burnout?**
A recent study examined the links. We talked to the author.
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How to safeguard your business’s IP.

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Don’t let virtual care lead to a lawsuit. Here’s some tips to do it right.

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A new study explains how physicians can actually use technology to improve patient outcomes.

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And how physicians can dispel them.

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COVID-19 COVERAGE CENTRAL

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

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

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

Perfect your telehealth program

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

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

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Physicians Financial News

Inflation survival guide: Forecasts and investment advice for physicians

By Chris Mazzolini
Editorial Director

Inflation is on the rise again. Consumer prices rise again in July, and the all-item Consumer Price Index is up more than 5% year-over-year.

But how concerned should investors be? Physicians Financial News® (PFN) sat down with David B. Mandell, J.D., MBA, and Andrew Taylor, CFP, of OJM Group, a wealth management firm, to discuss what physician investors need to know about inflation. The conversation was edited for length and clarity.

PFN: Let’s start with the basics. What is inflation?
MANDELL: It’s basically describing a general increase in the prices or decline in the purchasing power of money, right? It describes the increasing costs of products, or goods and services. So I think what’s concrete for people, if they’ve ever had to pay for college education over the last 20 years, or medical care, real estate — they can think about their home — as those things go up in value or go up in price, you might say, then that’s an example of inflation.

And what causes it: the simple explanation is too many dollars chasing too few goods or services, so the price goes up.

PFN: There’s been a lot of discussion in the news about inflation increasing. What’s causing this

uptick in the discussion of inflation? What economic trends are at play right now?
TAYLOR: That’s a great question. And it’s actually the question that we get most frequently from clients, and for good reason. So, you know, the federal government’s gone to great lengths to ignite the economy in response to the COVID-19 pandemic. You’ve had forgivable business loans, multiple rounds of stimulus checks to individuals that have added cash into the financial system. The Federal Reserve has also increased the money supply, so they purchase short term treasury bonds and purchase mortgage backed securities, they’ve lowered short-term interest rates to, effectively, zero. We’ve also had the Fed come out and state that they actually want inflation; they like to see the inflation rate at roughly 2%. And finally, investors are actually seeing pockets of inflation in their personal lives. So, if you’ve considered buying a home, if you’re looking at a used car for yourself or your child, or even when going out to dinner, you’ve witnessed significant price jump in all of those categories. So inflation is on the front of everyone’s mind today.

PFN: How does this compare with previous eras?
MANDELL: The 1970s is the period that in the modern, post-war era, that people think about when they bring up inflation. That was much more severe than what we’re talking about now. Andrew just mentioned that 2% is the target, and maybe it’s going to go above that. But in the 1970s, inflation averaged more than 7% annually. So just a totally different order of magnitude. And at that time, interest rates reached 16%, 17% for a brief period. It was a different world.

PFN: What are central banks such as the Federal Reserve saying about the inflation forecasts? And what are some of the strategies that they use to control inflation?
TAYLOR: For the last year, the Fed’s indicated that they’re not particularly concerned about inflation. The Fed has stated over and over again that they believe it’s transitory. Two big factors have driven the level of inflation that we’ve had.
Investing in tech: Outside-the-box ways to earn off the digital revolution

By Dave S. Gilreath, CFP

Market outlooks aplenty make optimistic predictions about the near-term future of autonomous vehicles, but few investors are aware that Caterpillar has been producing the unmanned variety since the 1990s.

These vehicles work in mining, tirelessly, night and day, never stopping for lunch. As no humans are aboard, there isn’t the same handwringing over safety that there is with Teslas, which the company touts as being viable for autonomous fleets to carry non-owning passengers. (Don’t hold your breath waiting for this.)

Though you’ll never summon a behemoth earthmover to take you the dentist and then pick you up after chauffeuring others around, Caterpillar’s autonomous behemoths are arguably tech products. Yet, as they do industrial work, Caterpillar (CAT) is in the industrials sector.

The company also makes semi-autonomous vehicles, including human-driven earthmovers loaded with advanced technology to guide grading to specifications for boundaries, depth and slope-sonic lasers and GPS (eliminating the lines of staked-out string once ubiquitous at construction sites). And the company’s newest tech ventures include 3D printing capabilities to eventually enable the production of parts on job sites to reduce downtime; CAT has a dedicated plant where engineers are testing this technology.

Tech without the category
Caterpillar, founded in 1925, is in a growing category of companies that use technology not as an add-on, but as an integral part of products that are nevertheless viewed by the market as being anything but technical. Some of these companies are developing and/or producing autonomous vehicles and/or systems. Others are pursuing different digital endeavors.

Unlike many new tech companies, these quasi-techs don’t trade at share prices hundreds of times earnings; they don’t carry this onus. Rather, these are long-established companies with real value, real profits and real earnings that keep their P/E ratios down to earth rather instead of up in the stratosphere. (CAT had a forward P/E ratio of about 20 on Aug. 3.) Unlike many high-flying tech companies listed on NASDAQ, Caterpillar didn’t pop up a year or three ago with venture-capital funding aimed at driving share price largely from market sentiment agog over all things tech. In 2025, CAT will celebrate its 100th birthday.

Investing in such companies, where appropriate for your portfolio and goals, can be a lower-risk way to position for returns driven broadly by the ongoing digital revolution—an economic engine that will continue to drive growth in pretty much all stock sectors, not just among tech companies per se, pushing the Dow Jones Industrial Average upward over the next few years.

Potential buying opportunity
The industrials sector stands...
The firm ties this increase in the search for specialists with the population aging and requiring their services. At the same time specialists are, on average, older than primary care physicians and many are nearing retirement which is limiting the supply, the release says.

Overall, the COVID-19 pandemic has suppressed demand for doctors temporarily as the number of search engagements dropped by 25% year-over-year. The same dynamic seems to be having the opposite effect on the market for NPs; which has seen an increase year-over-year.

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**Inflation** continued from page 8 presently. One is disruptions in the supply chain, which is related to COVID-19. And second is pent up demand, which is also related to COVID-19. It's difficult to spend money now even if you want to. So each of these two pressures have been driving inflation over the last few months, are expected to subside some point in the fourth quarter, or potentially early in 2022.

In the last 12 months, the Fed’s also discussed the velocity of money quite frequently, the concern that clients have is, there’s been all this stimulus, and there’s now a drastic increase in the supply of money in the financial system. In fact, that increase has been, to the tune of 30-plus percent over the course of the last two years, with the stimulus that has taken place. So the question is, if we have all this money in the financial system, now, that wasn’t there previously, why don’t we have all this inflation? And the response from the Fed is that we really haven’t seen the velocity of money increase, which is simply an indication of how quickly the money is circulating throughout the financial system. The Fed is monitoring that closely, and the velocity of money has not really moved until recently. And now we’ve seen some of these inflationary reports that have that have caused maybe a little bit of disagreement within the Fed over the interest rate policy that they have been statting for months and months, which is lower rates for longer. In June, for example, the Consumer Price Index rose more than 5%, which is a far cry from the Fed’s 2% mandate. So you’re starting to hear some disagreement amongst the members.

It’s going to be really difficult to justify the policy of lower rates for longer if we have a couple more reports that are pushing that 5% number.

**PFN: From the perspective of physician investors, what are some of the worrying aspects of inflation? And what are the positive aspects?**

**Mandell:** One of negatives is kind of emotional. In that, as a consumer, you are seeing and paying higher prices. So physicians out there who are, for example, trying to buy a used car for one of their children, it’s a bit of a nightmare right now. You might pay almost the same price as a brand new car. That doesn’t make sense, right? When people see that, they get emotional, and ultimately, we’re somewhat rational and somewhat emotional, and part of our job and working with physicians and managing assets and managing, a client’s lifetime savings, is to make sure we cut through some of that emotion as much as we can. So, I think one of the negatives is just impacting people and their attitudes, and how they react. Some people kind of stayed the course with their investments. And some people didn’t, and they may be paying a price about that today.

I think one of the positives, from a more rational point of view, is if you look at historically, usually moderate inflation — not runaway inflation — has usually been positive for stocks. So equities are typically a good hedge against the erosion of purchasing power, as opposed to bonds. So stocks typically do well. Again, historically, what we see is if inflation continues to rise or continue at a high level, typically, interest rates then follow to rise, and that’s what the Fed is going to be dealing with, when that happens that negatively impacts the price of bonds, so, in a sentence, moderate inflation can be good for stocks, could be good for the markets, but it can, over time, be negative for bonds.

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**Digital** continued from page 9 to grow significantly in coming months from increasing demand in the post-pandemic economy, though constricted supply chains may take a while to open up because of the delta variant. Moreover, the infrastructure bill before Congress that, as of early August, seemed likely to pass, would give the sector a boost.

So much for tailwinds. A likely yet temporary market headwind would be a correction (a 10% drop) or a pullback of 5 to 7%. We’re long overdue for a correction, and the chances of this happening every August are increased by people going on vacation, meaning lower trading volume and potentially higher volatility.

A resulting correction or pullback would be a good buying opportunity.

Dave S. Gilreath, CFP, is a 40-year veteran of the financial services industry. He established Sheaff Brock Investment Advisors LLC, a portfolio management company based in Indianapolis, with partner Ron Brock in 2001. The firm manages more than $1 billion in assets nationwide.

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**More online**

Check out the full interview at Physicians Financial News :
https://www.medicaledconomics.com/view/what-physicians-need-to-know-about-inflation

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We must address the causes of burnout

Physician burnout is a major concern for our profession, not only for our present workforce but because the long-term effects stand to jeopardize our future supply of physicians. Burnout is real and so is the terrible mental health toll it inflicts on physicians, healthcare professionals of all types and their families. That’s why learning to identify it and developing strategies to regain your resiliency are so important.

This issue of Medical Economics® will examine burnout. For many older physicians, burnout is not a new subject. I can say from personal experience that burnout becomes an issue for almost everyone sometime during their career. It has been a hidden risk of a career in medicine for decades. But are we better at recognizing it and dealing with it now? I fear we aren’t.

From my personal perspective and from talking to colleagues over the last couple of years, I have become increasingly concerned for our profession. There is so much physician and health care professional dissatisfaction out there. Although the root cause of burnout has changed over the years, its effect has not. Physicians still have higher suicide rates than the general population, and it is estimated that 28% of residents experience a major depressive episode versus only 7-8% of the general population.10

We are also seeing physicians retiring early, changing jobs, and becoming more disengaged. The most worrisome trend is its prevalence among mid-career professionals. Without a concerted effort to reverse the causes of this dissatisfaction, we risk not only our current but the future physician workforce in this country.

I remember well my time in medical education working on primary care workforce development and recruitment. Despite all the effort, initiatives and policy advances, the most striking problem was the difficulty of convincing bright young medical students to enter a career where the physicians they saw in practice were unhappy. I would say the same problem is present now, not affecting career choice while in medical school, but rather whether our best and brightest will even choose medicine as a career at all.

In my early years of practice, physician burnout was most often attributed to long hours, lack of work-life balance, the pressure of clinical responsibility and the burdens of call and leadership. Now the most cited reason in numerous studies and surveys is administrative burden (EHRs, prior approval, administrative tasks). That is followed closely by work hours, lack of control over clinical schedules, loss of clinical autonomy, payment complexities, and lack of respect for the profession in general. These are compounded by a physician access problem and need for more physicians, particularly in rural areas.

But rather than a major effort to increase the supply and distribution of physicians, there are more and more new provider types and ways being used to fill the gap, leaving physicians feeling ever-more devalued. The same can probably be said of our critical shortage of bedside nursing.

There has been talk of moral injury in describing what physicians and other health care professionals are experiencing today. Whether that is the best descriptor is unclear, but what is now clear is that the practice of medicine and the patient relationship has shifted to corporate control. Whether it is large hospital systems, insurance companies or new venture capital-backed, for-profit companies, the doctor-patient relationship has been replaced by the provider-consumer relationship. The practice of medicine has been replaced by the business of medicine. This most certainly has influenced physician satisfaction and sense of respect for the system.

I hope we will take physician and health care professional burnout seriously and provide attention and support for those in need, so we don’t lose this nation’s most valued health care asset. While we absolutely must examine the specific causes of stress and dissatisfaction and make changes, we should also identify the systemic and structural elements and policies that have led to such dissatisfaction among our physicians and health care workforce. »

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The COVID-19 pandemic led to a near-overnight revolution in many parts of health care, and nowhere was this seen more than in the waiting room. Now that things have changed, what does the future hold? Medical Economics sat down with David Berg, president and co-founder of Redirect Health, to discuss the revamped waiting room. The following is a transcript of the interview, edited for length and content.

**Medical Economics** (ME): Is there a need to rethink the waiting room?

**David Berg:** It always needed to change a little bit because it’s hard to manage a waiting room. It’s hard to manage the volume. Sometimes it’s too full. Sometimes it’s too empty. Sometimes you wait too long. It wasn’t always an easy thing to manage. When COVID-19 hit, it had to change. We had no choice. If it was once just an annoying or irritating place to be, the waiting room became a dangerous place to be. We didn’t have the option of ignoring that at the beginning. If you go back to March 2020, when COVID-19 first started, it was really pushed on us overnight. Literally, over a weekend, we had to change the waiting room. [If] we didn’t have COVID-19 in that severity of danger or the concern and uncertainty, I don’t think we would have changed at this point, at least not to the degree we have.

**ME:** What are some of the issues with the traditional waiting room?

**Berg:** You’ve got to keep it clean. You’ve got to manage the volume in it. And, if doctors are on time, it usually works well. But if you get a doctor or two that are behind, then that means that they might have two or three patients up, maybe four, maybe five, and that also affects the parking lot. There are rules around how many parking spots you need per 1,000 square feet of clinic space. They don’t have the same rules for waiting rooms, but it’s the same issues. You’ve got to manage the cars coming in and cars going out. The longer people wait, the more parking spaces you need, because you don’t turn over the parking space. So there’s a logistical challenge to waiting, whether it’s waiting for a parking spot or waiting in a waiting room, and COVID-19 significantly simplified that because people could not wait in the waiting room any longer. But what’s interesting is that the parking lot became part of the waiting room. So the waiting room got bigger. But there was a new uncertainty because we’d never had to manage our parking lot in real time before.

**ME:** How else has COVID-19 changed the way a patient waits for their appointment?

**Berg:** The way I like to think about it, and I think it’s a way that most medical doctors or medical personnel think about it with their own families, [involves] the entire journey of health care, from start to finish.
The waiting room is just one thing in between. It’s one out of 50 things in the middle of it. We’ve got to continue to have the health care journey go from end to end.

Even if we must change one component of that journey — the medication could be a component, the waiting room can be a component, the parking space can be a component. If we think about the office visit, in all its parts, there are easily 50 parts, depending how granular we want to get, so changing the pieces, the parts where necessary. But we didn’t want to stop where the finish line was; people getting the right care using their benefits and not having to pay too much money. The finish line didn’t change, but how we got there had to.

The biggest way we had to change is we had to figure out [which] parts we could do virtually or remotely. We had to figure out how we could do those and separate them from the office visit. For instance, when you walk up to the front desk and you want to ask what your copay is, or you want to pay your copay, there’s no reason that can’t be done over the phone from your home. When the nurse or the medical assistant is confirming your medication list to make sure that they have it right in the chart and the whole chart is prepared correctly, that doesn’t have to happen in the office. That can happen at home over the phone.

There are many parts of the in-office visit that, if we segment it appropriately, can be done beforehand at home. Whether it’s chart prep, taking history or verifying meds, like I mentioned, or even just knowing the problem. “What are you worried about today?” Well, that might not be in the chart. We can do all of that at home. If you think about it, exam rooms and waiting rooms expanded to include your home, your car or your office. So many things we used to do in the exam or waiting room now can happen on your drive in to see us, at work or the day before at home.

We’ve all heard of drive-through COVID-19 testing, which really didn’t happen before. I got my vaccination sitting in my car. I mean a year and a half ago, before COVID-19, both of those things would have been considered highly unprofessional. But it became highly necessary when the exam rooms and waiting rooms became dangerous because of the risk of infection and the uncertainty of it that we are dealing with.

We’re a lot more certain about COVID-19 today than we were a year and a half ago, when it started. There are things we know about it today, even though there are different variants, we are more certain about what we need to do than we were in March 2020.

ME: What can doctors do to make the waiting room experience better for their patients?

Berg: The obvious thing is to eliminate the amount of time in it. An easy way of doing that is letting people sit in their car until you’re ready for them, and then ping them and let them walk up a couple minutes before and take them right back, in which case the car becomes the waiting room. Why is that advantageous? Well, some people like to work while they’re waiting, and it could be easier to be on a phone call in the car than in a waiting room. Some offices don’t even like people talking on cell phones in their waiting rooms, but in the car, you’ve got a lot more freedom to do the things that you want to do. Similarly, at home, you’ve got a lot more freedom to do the things you want to do.

Now that people have gotten used to not waiting for doctors, without being able to replace that with something else valuable or necessary in their life — call it emails or texts or phone calls — I don’t know that people, especially young people, will ever go back. Now they’ve got a little taste of that convenience and that freedom; I don’t think they will go back.

The other thing I will tell you is that pre-COVID-19, the number of people who were in doctors’ offices was disproportionately older than younger. When I say older, I mean older than 40. We were used to going and seeing a doctor when we needed something. Millennials and even younger, they’re used to getting a lot of things, whether it’s pizza or [an] Uber from their phone, so it’s just a normal way of doing things. Younger people never had to use health care to the same degree that older people did pre-COVID-19. When COVID-19 hit, now all of a sudden, they don’t really have the choice of not seeing doctors because of the need for testing for COVID-19 or vaccinations or just dealing with it.

We took care of them, for the most part, virtually. There’s very little with COVID-19 you can’t start at least on the phone, a video or virtually. Now, of course, if you want...
What you’ll learn is that about 70% of the time, you can do all of it virtually and only need to follow up in the office if it didn’t work. There are other things that are more obvious. Maybe you want to listen to the heart [or] the lungs; there’s technology coming out that allow you to do that from your home. It’s not easily available, just as fax machines needed both parties to have all the equipment for it to work. That stuff is not there yet, but the capability is there; we just don’t have the network effect of everybody having the equipment at home. But it’s not that far down the road where we could take care of a lot more things from the home using technology.

I would recommend that doctors separate the office visits into what can be virtual and what doesn’t have to be, and do everything they can to front-load the virtual visits. The challenge is that a lot of the business models that are in play are based on fee-for-service, which means there’s not a payment mechanism in the business model for that. But let’s put the business model aside because there will be one soon, and many of the insurance companies and payers are wise up to this and are rewarding doctors for taking care of people outside of their office.

Up to two years ago, that was not a situation. If you didn’t turn the doorknob and come in my office, I couldn’t get paid. That meant that every time I helped you over the phone, I was doing it for free and probably with an expense; it actually cost me money. The business model has had the chance to change, and COVID-19 has helped that.

ME: What do you see the waiting room looking like in the future?

Berg: I think it’ll be a lot smaller and a lot easier to manage because if we get full, we can always use technology to say, “Hey, just wait in your car and we’ll call you as soon as we’re ready.” We may say the waiting room is full maybe we don’t, and maybe we say we’re running behind, but we can extend the waiting room into the car. That technology was always there, but now it’s being used by everybody.

In our offices, in Phoenix, every single one of our patients is used to the ability to wait in their car. We ping them through a text, and they come right in, and we’re waiting to take them right back to the exam room. They bypass the waiting room except for walking through it. I can’t see how that’s not going to be the way of the future — just eliminating how long you’re in the waiting room or maybe even the size of the waiting rooms. We’re starting to see some innovative concepts today where people with self check-in, where I don’t even know that’s really a waiting room. It’s blurring the lines between the waiting room and the exam room. When you start considering what you can do over your phone from your car sitting in the parking lot, we’ve really blurred the lines.
NOT ALL BREATHLESSNESS IS ASTHMA, COPD, OR CHF

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3 pitfalls to avoid when making real estate decisions for your practice

by Colin Carr Contributing Author

Commercial real estate often occupies the second highest expense on most health care providers’ profit and loss statements. Which means the difference between a properly or poorly negotiated transaction can either cost or benefit a practice tens to hundreds of thousands of dollars over the course of a single deal. With this much at stake, understanding the key strategies to capitalize on, as well as the costly pitfalls to avoid, is imperative. Let’s look at three of the most common mistakes providers should steer clear of to ensure maximum profitability.

Avoid letting the landlord think you only have one option
One colossal mistake in health care real estate transactions is tipping your hand to the landlord or seller by communicating that you only have one property option you’re considering — theirs. When a landlord thinks their property is at the top of your list, or that you’re only negotiating with them, it’s unlikely you’ll get their best terms. Why would they compete for your tenancy, after all, if there’s no one else they’re up against? Instead, they’ll likely assume you’re willing to settle for an inferior deal, bolstering their position and increasing their returns.

Savvy businesses don’t put all their eggs in one landlord’s basket, and neither should you. Make properties compete for your occupancy. Put three or four landlords or sellers up against each other and use competing offers and negotiations to ensure you receive the most competitive terms available. Companies do this by hiring expert agents who specialize in their field of interest, who can take the guesswork out of the process and who can position them to win against property ownership groups.

This concept is even more critical during a lease renewal, as landlords tend to be less flexible compared with other real estate transactions. Many landlords will assume that their tenants don’t want to relocate or have the time or expertise to capitalize on a lease renewal negotiation. They’ll begin the process believing they have the upper hand and that the tenant doesn’t have another viable option. If you have a lease renewal approaching — and we’ve found that 80 percent of health care providers are currently leasing property — and want to gain favorable terms, it’s imperative to obtain offers from viable properties in your immediate market prior to starting any renewal transaction with your current landlord.

Avoid beginning your transaction too early or too late
Too early, and you lose important posture, as landlords don’t typically hold spaces off the market for extended or unreasonable amounts of time. They aren’t bringing their best terms to the table for a deal that won’t commence within 9 to 12 months, as it’s simply too far into the future.

Too late, and you’ve likely missed your target window to evaluate other top property options — leaving you at the mercy of the landlord. Landlords know that it takes time to relocate and build out medical spaces. When they believe you don’t have enough time, they believe they have the upper hand and strongest position in the negotiation — which means they likely won’t get as aggressive with their terms.

Beginning the process within the right time frame lets landlords and agents know that you understand the fundamentals of a commercial real estate transaction, including proper timing of evaluating spaces, negotiating terms and more. The proper timeline — anywhere from 12 to 24 months before the end of your lease, depending on the type of transaction you want to pursue (leasing, purchasing or developing a new building) — will give you enough time to perform your due diligence and research in advance of your target window, while also leaving the right amount of time with the landlord or seller to push the terms and concessions in your favor.

Most landlords want to make deals. Starting the transaction at the right time will increase your ability to secure more favorable terms and position you to win at a higher level.
Avoid working with the landlord or listing agent yourself

The game of health care real estate is unique in that it pits highly sophisticated landlords, ownership groups and trained listing agents against health care providers and administrators who often have little or no formal training in commercial real estate. This creates a distinct advantage for the owner of the property, while putting the health care tenant behind before negotiations even begin. Just as a landlord isn’t equipped to perform their own dentistry, physical therapy or dermatology, rarely are health care providers best equipped to handle their own real estate transactions.

So what can you do to maximize profitability and keep the negotiations in your favor? Hire professional representation — for free, which is what it costs buyers and tenants. Just like residential real estate, commercial real estate commissions are always paid for by the landlord or seller. Make sure the professional you consider specializes in health care tenants and buyers only, doesn’t have any conflicts of interest representing landlords or sellers and someone who truly understands your business.

The largest and most successful companies in the world use professional real estate representation to perform due diligence, identify the top property locations they should consider, and ultimately, to negotiate the most favorable terms possible on their behalf. As a savvy health care provider, emulate these same principals and let an expert level the playing field and protect your interests in your next negotiation.

Colin Carr is the chief executive officer of CARR, the nation’s leading provider of commercial real estate services for health care tenants and buyers. Every year, thousands of health care practices trust CARR to achieve the most favorable terms on their lease and purchase negotiations. CARR’s team of experts assist with start-ups, lease renewals, expansions, relocations, additional offices, purchases, and practice transitions. Health care practices choose CARR to save them a substantial amount of time and money, while ensuring their interests are always first. Visit CARRUS to learn more and find an expert agent representing health care practices in your area.
It’s time to make eliminating physician burnout a priority.

After dealing with more than a year of a pandemic, on top of the normal stressors that come with being a physician, many doctors are burned out and looking for answers.

In the following pages, you’ll find our 3rd Annual Medical Economics® Physician Burnout and Wellness Survey, which includes both survey results and articles and interviews analyzing the scope of the problem and what can be done to make medicine a more healthy and fulfilling career.
Have you felt burned out from practicing medicine at any point during your career?

No: 6%

YES 94%

Do you feel burned out right now?

No: 20%

YES 80%

What has contributed the most to your feelings of burnout?

Too much paperwork and regulations: 31%
Work too many hours/poor work-life balance: 24%
Electronic health records: 11%
Lack of autonomy/career control: 10%
The COVID-19 pandemic: 9%
Overwhelmed by patient needs: 9%
Insufficient pay/declining reimbursements: 3%

How has burnout affected your career?

“At times it does not feel like I’m making the difference I originally wanted to make and I question if all this stress is worth it.”

“As we added more EHRs and more prior authorizations and administrators with their various business models, it has become unbearable. I have cut back hours. I don’t want to practice anymore.”

“I cut my work hours in half.”

“It has made me feel resentful of my career choice and I steer others away from it.”

“I do not feel like I am able to truly appreciate the opportunity I have been given as a primary care physician. I don’t feel satisfied or fulfilled.”

“I might be at my worst state, but I won’t let it affect my patient care adversely.”

“It hasn’t affected my career but I do think my family has been negatively impacted.”
What is the solution to physician burnout?

“Less red tape and regulations and better pay.”

“Higher reimbursement. It would create a fairly valued system and physicians could choose how much to work instead of constant pressure to work longer and bill more.”

“Physicians need more autonomy. Hospital administrators, insurance companies, and lawyers practice medicine and physicians are just the middle men.”

“Practicing medicine with real connections to patients, without incentives to just do procedures and write prescriptions. Enough time to actually deal with patient problems and get them the help they need.”

“We keep focusing on resilience training and wellness when we should be focusing on plans to increase support within the health care workforce.”

“Better communication and collaboration with non-clinician leaders in health care to understand why burnout happens, how to support their staff better, and allow them to be part of the solution and help shape the culture of their organizations. They need to listen to their people then act on recommendations collectively. Physicians are not burning out in isolation!”

“We need the courage to assail the bureaucratic forces that treat physicians as interchangeable drones.”

“How do you cope with burnout?”

“Exercise: 28%”

“Spending time with family and friends: 22%”

“Eating junk food/overeating: 8%”

“Hobbies: 8%”

“Drugs or alcohol: 3%”

OTHER WAYS PHYSICIAN HANDLED BURNOUT:

• Counseling
• Sleep, reading and rest
• Early retirement
• Vacations/time off
• Video games
• Looking for a new job
• Complaining
• Reducing work hours
• Prayer/religion

Do you believe burnout negatively affects your financial earnings and productivity?

Yes: 74%
No: 15%
Not sure: 11%

How do you cope with burnout?
Have you ever discussed feeling burned out with fellow physicians or colleagues?

- **Yes**: 40%
- **No**: 60%

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**Have your feelings of burnout ever made you want to quit practicing medicine?**
- **Yes**: 78%
- **No**: 22%

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**Do you plan to seek or have you sought professional help/counseling to help deal with feelings of burnout?**
- **Yes**: 15%
- **No**: 78%

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**Have you avoided expressing feelings of burnout because you’re concerned about being judged negatively by your peers?**
- **Yes**: 40%
- **No**: 56%

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**Do you think your workplace culture contributes to your own or colleagues’ burnout?**
- **Yes**: 71%
- **No**: 27%
Physician burnout in recent years has gone from a taboo topic to one of great concern in the health care industry. In the past, doctors would avoid even talking about it for fear of being seen as weak by their colleagues, but thanks in part to a greater emphasis on mental health and physicians willing to speak out about it, the problem and its solutions are being openly discussed.

COVID-19 focused further public attention on burnout as overworked doctors suddenly found themselves working even longer hours while simultaneously worrying about their own health and that of their family members. This attention brought a renewed focus to burnout, and has many health care leaders talking about solutions, but doctors often see little progress.

And when solutions are presented, it can often be in the form of yoga classes or wellness programs that focus on the individual rather than the institution and systems that are often at the root of the problem. These classes take up even more physician time, making the problem worse. Health care organizations struggle with burnout because it can be difficult to quantify, and its effects can’t always be directly linked to costs.

**Make ‘cents’ of burnout**

Some costs are easier to measure than others. A burned-out physician that quits or retires early, for example, has a direct effect on the employer through turnover costs in recruiting and training a replacement.

“If we can decrease the rate of turnover, then that’s a huge cost avoidance factor for the organization,” said Terrance McWilliams, M.D., FAAFP, director and chief clinical consultant, HSG, a national health care consulting firm. “There are some estimates that indicate that due to gaps in coverage and the direct costs, recruiting a single physician can cost as much as $1 million. If we have physicians out of commission due to burnout, then we have to look at other forms of coverage, which either decreases efficiencies within the system, or you bring in temporary coverage like locum tenens.”

And then there is the risk to patients. “When physicians are burned out, they are much more likely to make mistakes,” said Christopher Porter, Ph.D., professor of management, and chair of graduate business programs in medicine at Indiana University Kelley School of Business.

Those are just the direct costs. McWilliams pointed out there are secondary costs to the organization. Having a disgruntled and burned-out physician interacting with patients and staff has its own price. “It can lead to staff dissatisfaction and a higher staff turnover rate, but also can affect the patient experience and lead to a loss of patients with its associated patient care revenue,” he said. “The financial impact is huge.”

With physician shortages projected for the coming decades, health care companies will be competing for an increasingly shrinking pool of candidates, who in turn may have to do more work to cover for fewer doctors, creating a rapid downward spiral.

**Personal resiliency or institutional problem?**

Most health care executives recognize there is a burnout problem with physicians, and that it likely hurts...
their bottom line, McWilliams said. “Unfortunately, I think there’s a little bit of a disconnect in some organizations between realizing there could be a problem or might be a problem and implementing a comprehensive program to address the problem,” McWilliams said. “There clearly are some organizations that are making great efforts to not just mitigate burnout risk, but to promote provider and staff wellness.”

But leadership must meet the challenges of daily operations while staying profitable, and when part of the problem is physicians working too many hours, wholesale changes may not always be possible. Organizational aspects contributing to burnout might require a full cultural transformation. “It’s one thing to promote individual resiliency, but it’s another to allow the practice of resiliency,” McWilliams said. “Do we expect our physicians to always be plugged in? How can we balance timely patient access and timely response to patients when there are only so many hours a day?”

Health care leaders often start by thinking the problem is a matter of personal resiliency. Physicians are sometimes expected to be superhuman, putting all patient needs ahead of their own, and this can contribute to unrealistic expectations from themselves and management. Leadership might begin with yoga, mindfulness, or other classes that can help a single person.

“They see it as a defect of the individual, because the system is perfect,” McWilliams said. “What they think they have to do is make it so all the individuals can deal with the system better.”

But with more and more studies identifying the problem as the system and not the person, no amount of resiliency programs aimed at the individual are going to solve the problem.

“The things that get implemented, at least in the health care organizations I’ve worked for are things that are on the ledger on the budget, and burnout isn’t on there,” said Gabe Charbonneau, M.D., a family medicine doctor in Stevensville, Montana, and an advocate for physicians fighting burnout. “It’s never been in the conversations that I’ve been a part of other than, ‘Here’s a wellness program that we’re trying.’” Charbonneau said. “I’m concerned that if it doesn’t get into those budget conversations, and it’s not reflected on our organizational balance sheet, it will continue to be this thing that we know so much about but aren’t really making any difference in it.”

Some organizations are progressively addressing the burnout issue and dialing back expectations, but this in turn leads to concerns about financial sustainability because if all the staffers are doing less, then the organization either needs more staff or less volume. “It’s hard in today’s system, which is still more volume-based than value-based, to be sustainable with the same number of individuals doing less work and therefore having less revenue,” McWilliams said. “It can put leadership between a rock and a hard place to find the right balance.”

**How to measure and address burnout**

Most health care organizations realize their physicians are at risk of burning out because it’s a high-stress job. Some leaders opt to take proactive steps to mitigate the risks without specifically assessing the scope of the problem, while others look to determine how bad the problem is, where efforts should be focused, and measure progress along the way.

Organizations have several tools available to help take the pulse of an organization and track the trends. These run the gamut from a single question “How burned out do you feel?” ranked on a scale to multi-question surveys that dig into the details. The Maslach Burnout Inventory is considered the gold standard for assessing burnout, but there are also options from Mayo Clinic and the American Medical Association.

The challenge is that the results aren’t always tangible. “OK, our burnout factor is seven, but to some-one running a health organization, what does that really mean? How do you translate that into something that affects the bottom line?” Charbonneau said. “It’s hard to translate because the cost is long-term, and you have to retroactively look back over time to see it.”

An organization that is serious about tackling burnout has to be willing to commit resources toward structural change. Adding a wellness officer or mindfulness program is not enough to make a meaningful difference in systemic burnout. “It doesn’t mean they are bad things, but if your commitment to addressing burnout is to try and bolt something to what you’re already doing, but not be willing to change the environment people are practicing medicine in, it’s kind of a nonstarter in terms of actually making a difference,” Charbonneau said.

If reductions in workload can’t be made, focus on ways to give people more control over their work life. While system-wide standards may be in place, doctors can still have team meetings to discuss what is and is not working within their domain that can be improved. It might be the way patients are scheduled or how they meet to discuss what is and is not working within their domain that can be improved. It might be the way patients are scheduled or how they meet to discuss what is and is not working within their domain that can be improved. It might be the way patients are scheduled or how they meet to discuss what is and is not working within their domain that can be improved. It might be the way patients are scheduled or how they meet to discuss what is and is not working within their domain that can be improved.

“I think creative, caring organizations will find ways to continue to use telemedicine to the extent possible and will think about creative ways to allow people to have a little bit more flexibility in their work arrangements,” Porter said. “There may be constraints in what they can do as it relates to workload, but that doesn’t preclude them from making improvements in terms of workflow. Certain doctors are going to spend
the majority of their time with especially demanding cases — is there a way to balance that out?”

It’s also crucial to consider the opinions of physicians who are feeling the burnout. “I think the mistake that is sometimes made is that health care organizations tend to jump to the solutions without really having a full understanding of the problem, and without perhaps going enough to the actual individuals who are affected to get their feedback and even input in solutions,” said Adam Perlman, M.D., M.P.H., chief medical officer and co-founder of meQuilibrium, a software company that measures and tracks employee well-being. “One of the things I’m a strong advocate of is listening sessions, and actually gaining feedback and garnering more detailed information about what the pain points are.”

Charbonneau agrees, but said leaders have to be committed to actually hearing what’s being said. “If you are an executive, and even if you can’t change a damn thing, do your very best to listen to people to make them feel heard, because it makes such a difference,” he said. “I’ve experienced leaders where even if they can’t fix the problem, you know they are doing the best they can and want to hear what you have to say and that you matter to them. And there are others who are just waiting for you to stop talking so they can go back to business as usual and make you go away.”

Leaders also need to look at building more efficiencies into the electronic health record and anything else that can lighten the administrative burden. “These are the things that allow us to spend more time doing what we went into medicine for — really caring for patients and connecting with them,” Perlman said.

Physicians looking to enlighten leadership about the challenges of burnout can start by being a general advocate for provider wellness.

This can help create a culture where physicians can seek help for a variety of issues without being stigmatized as weak, McWilliams said. “You can work toward an environment with realistic expectations and also one with well-accepted interventions for individuals who are experiencing difficulties.”

No matter the rank within an organization, a physician can model the behavior he or she wants others to demonstrate, which includes being open to being vulnerable and starting conversations about the challenges of the job, Porter said.

“Part of the problem is that people don’t always feel safe to talk about what their concerns are,” Charbonneau said. “It’s like for the doctors that complain, the answer is to make that person feel like a troublemaker rather than trying to understand what’s going on.”

**A Turning Tide**

Burnout didn’t become a major problem overnight, nor will a magical solution banish it from medicine. Volume still plays a huge role in how physicians are reimbursed, and as a result, workloads are likely to remain high. But the question that remains is how health care leaders will respond now that they have a better understanding of its scope and effect on physicians. “The outlook is mixed. “I’m hoping that over the next decade, we develop balanced, realistic expectations of each other with mutual accountability, to be able to recognize issues earlier, to be able to intervene with issues earlier, but also have more comprehensive programs more readily accessible to individuals,” McWilliams said.

To be successful, health care organizations are going to have to settle in for a long commitment to cultural change. “It’s not like everyone will look around and say, ‘Yes, we’ve ended burnout,’” Perlman said. “It’s going to take an ongoing effort to continue to create and support a culture that values the well-being of our employees as much as it values the health and well-being of patients. A number of interventions can get us there, but it’s a matter of implementing them and staying on them and being able to pivot as the moment changes.”

Porter is not optimistic health care is up to the challenge. “Hospitals had not done a great job managing physician burnout before the pandemic, and I don’t really have any reason to believe that they’re going to be doing better going forward,” he said.

And while the evidence may suggest burnout has gotten worse, Perlman said he’s optimistic that the focus on mental health and the efforts to streamline technology will create a world where there is less burnout. “Prior to the pandemic, we were on a trajectory that wasn’t probably sustainable,” he said. “This traumatic moment has facilitated us taking a deeper look and coming up with some solutions.”
How practice culture affects physician burnout

by Jeffrey Bendix Senior editor

Efforts to combat physician burnout usually focus on individual doctors through programs aimed at building resiliency and dealing with stress resulting from systemic factors such as heavy workloads and loss of individual autonomy. But a new study suggests that reducing burnout requires an organization-level response — creating medical practice cultures that value qualities such as teamwork, open communications and process improvement.

To learn more about the study and its implications for reducing burnout, Medical Economics® spoke with lead author Samuel Edwards, M.D., who is an assistant professor of medicine at Oregon Health & Science University and a practicing internist with the Veterans Affairs (VA) Portland Health Care System. The interview has been edited for length and clarity.

**ME:** What led you and your colleagues to undertake this study?

**Edwards:** This is part of a larger study, which was an evaluation of the EvidenceNow initiative. EvidenceNow was a large quality improvement initiative funded by the Agency for Healthcare Research and Quality, focused on improving cardiovascular preventative care in small- to medium-sized primary care practices.

Our group in Oregon was part of a large nationwide team funded to do an enterprise evaluation [of EvidenceNow] called ESCALATES, [which stands] for Evaluating System Change to Advance Learning and Take Evidence to Scale.

As part of that, specifically, we did surveys of practices and people in those practices at the start of the initiative in 2015, then several times throughout, and one thing we really wanted to understand was practice climate and burnout since it’s such a common and concerning issue in primary care.

**ME:** What did you find?

**Edwards:** One of the things we were interested in understanding was how much of burnout is a practice level phenomenon versus related to individuals. And we found definite evidence of a practice level effect in burnout. Specifically, we characterized practices by how much burnout they had in them.

What was interesting was we found that in 30% of our sample none of the practice members said they had any burnout. And given the dire descriptions of burnout in medicine today we thought that was an interesting finding, so we chose to focus on characterizing those zero-burnout practices versus a group of practices that were very high burnout to try and understand the differences.

We had this measure of practice culture which we called adaptive reserve. It consists of six domains: facilitative leadership, work environment, teamwork, sense-making, culture of learning and relationship infrastructure. All that stuff is superstrong. These practices used more quality improvement strategies, and they tended to be physician-owned solo practices and didn’t participate in large transformation initiatives like accountable care organizations or the Transforming Clinical Practice Initiative or a number of others. In general, we saw this signal that smaller practices with greater agency and a strong culture tended to have less burnout than other practices.

**ME:** Do you have any thoughts as to why practice culture is such an important factor in the presence and level of burnout?

**Edwards:** I think it’s intuitive to some extent. A place where you have strong leadership and good relationships among practice members have been shown to be associated with low burnout. One
thing that stood out to us was that leadership is so important. Specifically, facilitative leadership, which is not traditional command and control, hierarchical leadership, but more fostering relationships, enhancing communication, attending to power imbalances, focusing on psychological safety and cultivating teamwork.

I think we can all identify with environments where we've felt that everyone's on the same team, working towards a common mission that's meaningful and important, where people like and care about each other, versus places where you don’t feel listened to, and you don’t feel like the work is important.

**ME: I want to explore that term “psychological safety” a bit more. What do you mean by that?**

**Edwards:** Psychological safety is basically the idea that you feel safe bringing things up. Like if there's a problem, you’re willing to bring it up because you don’t feel like you'll be criticized or punished for pointing it out. If you’re in an organization that's trying to improve its performance and everyone’s too scared to say something’s wrong, you’re not going to get anywhere. You have to have that trust, that rich communication, that feeling you’re safe in bringing things up to really make progress. It has a superstrong relationship with burnout.

**ME: Another interesting finding was that zero-burnout practices tended to be ones that didn’t participate in accountable care organizations. I’m wondering if you think that might discourage practices from joining accountable care organizations (ACOs), and if so, what affect that might have on the drive to move practices towards value-based care?**

**Edwards:** That’s a great question. On the one hand it’s important to remember that all these practices were willing to participate in EvidenceNow, so they were already practices ready to engage with a large quality improvement effort. But the signal around ACOs was pretty strong. We’ve cut these data several different ways and this is a pretty strong relationship.

Since this is a cross-sectional analysis the “why” and “how” is difficult to say. But some ideas we had is that maybe it’s kind of an overload for practices, like if you’re involved in too many quality improvement initiatives pulling you in too many different directions that might contribute to burnout. We know that different health plans use different measures and ACOs have different measures and that might lead to burnout.

ACOs vary a lot, too. On the one hand when you put ACO funding together with the independently owned practices and the solo practices you might imagine that ACOs represent a loss of agency for the practices. So practices that have more independent control of what they’re working on and why might have less burnout compared [with] those who are responding to more external demands.

But ACOs are not all monolithic, hospital-driven quality measure machines. A lot of them engage practices in constructive ways. So I don’t think there’s a single lesson here, but I think there’s reason for concern that some of the policy-level levers for improvement could be related to more burnout and we should understand why.

**ME: Have you gotten any pushback to your study from CMS or organizations representing ACOs?**

**Edwards:** No. But I think we all appreciate that fee-for-service primary care medicine is suboptimal and moving towards a system where practices are paid for meaningful work is reasonable. But there’s some evidence that some of these approaches that may be a little more top-down
have the secondary impact of increasing burnout. But again, this is a cross-sectional study so we’re just theorizing based on the associations we see.

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**ME:** You mentioned that a lot of the zero-burnout practices were small and/or clinician-owned. That’s not the kind of environment most primary care doctors practice in today. Can any of the features of zero-burnout practices be replicated in large health care institutions?

**Edwards:** Well, on the one hand there are a surprising number of smaller practices still in existence. But I operate in a large-practice environment and many doctors do nowadays. But it’s certainly possible to maintain a strong practice culture within a large organization. Making larger organizations feel small by having smaller practice groups with more autonomy about how they run their day-to-day operation and have more control can really make a big difference.

I think about our practice in the VA, which is a big federal system, we really take time on our team to build relationships so that we trust each other and work together to get the work done. We all share that common mission about providing primary care to our patients is important and meaningful, and we care about it. A point I mentioned in the paper is the concept of facilitative leadership. We think it’s important for people with formal leadership positions to act that way, but we can also build that culture as a team and have everyone participate in a work environment where there’s open communication and trust.

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**ME:** I suppose if you’re a hospital system the sweet spot is maintaining the efficiencies of a large organization while still giving practices and individual physicians enough autonomy to operate on their own and feel they’re an important part of the larger organization?

**Edwards:** Yeah, and there are so many pressures for these organizations — the financial pressures and quality reporting pressures. Everyone’s getting pushed to do a lot with less. If you give people complete autonomy it probably wouldn’t work. But we’re certainly seeing in primary care things have kind of reached a head, where there’s a lot of turnover, it’s hard to retain and recruit people to environments where they don’t have any control and aren’t inspired by the work. And obviously retention and recruitment is super-expensive, so it’s in their interest to make people happier, want to stay longer and hopefully do a better job.

But we saw examples in our study of larger practices that were able to achieve zero burnout and strong adaptive reserve.

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**ME:** Are you planning any sort of follow-up to this study?

**Edwards:** We have three waves of this survey, so one thing we hope to do is look at the longitudinal data to see if burnout declined over the time of the intervention and maybe look at some of the associations there. Hard to say whether the intervention did it or maybe just the changing context and challenges that continue in primary care. But that’s what we’d like to do.

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**ME:** What are the key takeaways from this study?

**Edwards:** I think burnout is definitely a practice- or organization-level phenomenon and it affects all employees, and that practice-level culture is really important and potentially a place for intervention. So fostering leadership development could be really powerful.

The fact that smaller practices with clinician ownership who don’t participate in ACOs have less burnout really illustrates the importance of agency. So improving agency at the practice level also will help reduce burnout.

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**ME:** You say in the study that too many of the remedies for burnout have been aimed at the individual rather than the practice level and aiming at the individual will only take you so far.

**Edwards:** Absolutely true. And if you look at the burnout literature, it’s been recognized forever that work environments contribute to burnout. But we continue to offer individual-level solutions, even though we know that the organization and the core of the work environment is more of the cause. So I think our study just adds to the literature that organization-wide approaches are essential. »
Are tax hikes coming?
How physicians can prepare themselves

by Julianne F. Andrews, MBA, CFP, AIP contributing author

Today's tax rates are among the lowest in many years, but President Joe Biden made it clear in March that he intends to change that. To fund his large-scale fiscal stimulus, infrastructure initiative and economic reforms, Biden is pushing to increase taxes that are targeted to disproportionately affect the wealthy. Although some of the tenets of this proposal may be difficult to pass and the details could change as the legislation makes its way through Congress, physicians may want to consider the following tax planning strategies regarding their 2021 return.

Let's look at the proposed changes on the table and explore some of the financial planning tips that could help alleviate a higher tax bill for high-earning physicians.

**Income taxes**
Biden has proposed a return to the top individual tax rate, from 37% to 39.6%, for individuals earning over $400,000. This is essentially a reversion to the pre-2017 Tax Cuts and Jobs Act rates for this bracket, which we were expecting to see in 2025 when the bill was set to expire. There are still questions, though, as to whether the $400,000 threshold will be for a single taxpayer or for married filing jointly.

**39.6%**
The Biden Administration’s proposed top marginal income tax rate.
Planning tips: Lowering taxable income will be fundamental in offsetting this potential change. Consider escalating contributions to retirement plans, opening a profit sharing or defined benefit plan, or bunching deductions to counterweigh the liability in the year this provision is passed into law. You may want to speak with your adviser about decreasing income-producing investments or placing them in retirement accounts.

Charitable contributions offer a tried-and-true way to lower taxable income through the use of donor-advised funds, qualified charitable distributions or even donating appreciated stock to charity.

Some physicians may also want to increase municipal bond holdings as they become more valuable when taxes and the tax-equivalent yield increase.

Capital gains and qualified dividends
High-earning physicians may be the most challenged by Biden’s proposal to increase the capital gains rate on income over $1 million from 20% to 39.6%. Combined with the 3.8% Medicare surtax, that could mean a 43.4% federal tax rate on long-term capital gains. This is almost double the current top rate. In effect, high income earners would completely lose the tax benefits of holding capital assets for more than one year because short-term and long-term gains would be taxed at the same rate.

Planning tips: Keep a keen eye on managing capital gains. This could mean accelerating gains into the current year or gifting highly appreciated assets.

Social Security taxes
Biden is also proposing to assess Social Security taxes on wages above $400,000. Currently, employees pay 6.2% toward Social Security, and employers pay another 6.2% on the first $142,800 of wages for each employee. Biden’s proposal would assess these two 6.2% tax rates again once wages exceeded $400,000. This is in addition to the 2.9% and 3.8% Medicare taxes already paid on unlimited wages.

Planning tips: Take a close look at how your practice is structured taxwise. If your practice is an S Corporation, you’ll want to minimize the amount of compensation you receive as wages while still remaining “reasonable” per IRS standards.

C Corporations may have a more difficult time because these practices typically try to eliminate their net taxable income at the corporate level via bonus pay to the owners in the form of W-2 wages. C Corporations may consider a shift in business structure going forward to account for this new tax law.

Itemized deductions
The maximum amount of itemized deductions would be capped at 28% for those earning over $400,000. It is unclear if this provision will be for individuals or those filing jointly, but essentially, these deductions will be worth less to the high-income physician in terms of reducing taxable income.

Planning tips: It may be worthwhile to bunch deductions on property taxes, charitable contributions and health expenses to increase your deduction.

Timing and strategy
The possibility of significant tax law changes on the horizon make forward-looking tax planning especially critical. This is complicated by the fact that we do not know with certainty when, if or how these provisions will become effective. Could any of the laws be retroactive? Or could we be in the clear until later in 2022 or 2023? Only time will tell.

Although these tax laws are not a foregone conclusion, physicians would do well to fortify their tax planning strategies ahead of time to guard against some or all of these possibilities. By making small adjustments now, you can protect against being caught off guard as any new legislation moves into law. «

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Stop lifestyle creep before you’re in too deep

by Jeff Witz, CFP

Are you earning a significant income but still living paycheck to paycheck? This is a common experience for many younger physicians. Most are making substantial incomes, yet still feel as though they are drowning in financial obligations. Many struggled through medical school and residency, and may still be struggling through student loan payments. However, once the higher income started coming in, they started to spend it just as fast. Many looked at their available account balances and projected future wealth and thought it was time to start treating themselves. They have fallen into the trap known as lifestyle creep.

They call it “creep” because it’s sneaky and happens to just about everybody whose earnings increased significantly. It begins innocently enough: You survey your surroundings and decide it’s time to upgrade your home, your car, your furniture, your cuisine, and so on and so on. Soon items that used to be a luxury become the norm. You are spending more because you can, not because it is necessary. You gradually make a complete shift regarding what’s “normal,” and over time things that used to lie quietly in the want category call loudly from the need category.

Unfortunately, we see physicians fall victim to their own desires and get consumed by lifestyle creep far too often. They worry about money every month despite earning hundreds of thousands of dollars because they were not fully prepared for the higher standard of living that they embraced. Stop this phenomenon immediately. Once you creep forward, creeping back is difficult.

Consider the long-term financial effect of your purchasing choices. Do you need to buy a new home with a hefty mortgage right out of residency, or can you live comfortably in a more modest condominium that you will pay off in few years or turn into an investment property when you are ready for a move to a newer home? While the former may be a status symbol, the latter could be the better long-term financial decision. The less expensive condo ensures you are not strangled by mortgage debt. If you decide to change jobs or move to a new location, you can more nimbly navigate that change, instead of being stuck with an expensive home that could take significant time to get off the market. Being more modest with your purchases can free up cash for other important financial goals like saving for your retirement or children’s college education. Being patient and a little cautious with your spending may result in being more prepared and confident to make an appropriate upgrade when the time comes.

You may be asking yourself, “Why work hard to get ahead if I can’t enjoy my money?” You absolutely can and should! However, you should do it in a deliberate manner that fits your overall financial plan. Upgrade your life in such a way that you don’t wind up earning two, three or even four times as much money only to find that finances are tighter than ever. You need to control the creep.

Start by having a budget. Understand your cash flows and the amounts coming in and out. Use your budget to identify your necessary expenses and be honest with yourself about which aspects of your lifestyle are most important. Then construct a financial plan that will keep you dedicated to your most important financial goals. The financial plan will force you to be accountable to yourself and your family. Finally, complete regular checkups. Have you been staying true to your budget? Have any of your financial goals changed that would require an update to your financial plan? Make sure you are not overextending yourself.

Wealth can come in many forms, but the more committed you are to your financial plan, the greater chance you have of becoming truly wealthy.

Jeff Witz, CFP, welcomes readers’ questions. He can be reached at 800-883-8555 or witz@mediqus.com.

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Intellectual property: What every medical practice needs to know

by Martha M. Rumore, Pharm.D., J.D. Contributing Author

As a physician, you know that name and reputation goes a long way toward the success of your practice. But are you aware that intellectual property (IP) is one of the most important business assets you have? Intellectual property refers to the legal field that involves protection of creations of the mind and may take many different forms. Four types of intellectual property exist, and they are detailed in Table 1. More than one type of intellectual property can be used to protect your medical practice. You can have a patent on a drug or device used in a procedure, a trademark on your practice’s name and logo, a copyright on your website content or a publication, and, in some jurisdictions, your patient list may constitute a trade secret.

**Trademarks**

Health care is no longer localized. More and more practices are national or across state lines. Virtually every medical practice, other than those whose name is just that of the owners, should trademark its name. Which is more distinctive? The Children’s Hospital or Komansky Children’s Hospital or Morgan Stanley Children’s Hospital? Urology Associate or the Urology Group versus Institute for Urologic Excellence? A trademarked name and logo brands all of your products and services, ensures that consumers do not get confused, and protects you from counterfeit products as well as imposters. A trademark allows patients to locate you more easily on internet and social media platforms. Trademarks are especially important for startups to create brand recognition. Via an “intent to use” designation they can even be obtained for goods and services which your business is planning to offer in the future. However, the value of trademarks goes way beyond use as a marketing tool. Trademarks are a valuable business asset — a source of revenue through licensing, a crucial component of franchising agreements, and useful for obtaining third-party financing.

**To register or not to register**

Some clients mistakenly believe that because they searched the proposed name of the company when forming their limited liability company (LLC) that they have trademark protection. Without filing for a trademark, all you have is a name for your LLC. There may be some common law rights within a state, but clients will have to jump through more hoops to enforce a common law trademark.

A trademark search is the first step to obtaining and filing a trademark registration with the U.S. Patent and Trademark Office (USPTO) to make sure the trademark is not carved out and in use by someone else already. Federally registered trademarks cost very little to obtain and are much more valuable than common law trademarks in that they are uncontestable after your mark has been registered for five years. This is a valuable asset when selling your practice. Trademark certificates can be valid for unlimited consecutive 10-year periods with a small USPTO maintenance fee.
Enforcing your trademark

2020 saw a fair share of high-profile trademark cases. In Romag Fasteners v. Fossil Group, the Supreme Court addressed the issue of whether “willfulness” is a prerequisite to an award of profits under the Lanham Act. The U.S. Court of Appeals were split on the issue. The Supreme Court resolved the issue and decided that willful infringement is not required “innocent infringers” can have their profits “disgorged” for infringing on someone’s trademark. Modern trademark jurisprudence is designed to protect consumers and brands. The standard for infringement is use of a confusingly similar mark.

Enforcing a trademark consists of scanning for and pursuing adverse users and filing a cease and desist letter. It is also important to use your mark in commerce, so it is not deemed abandoned.

Copyrights

People often use copyrights and trademarks interchangeably, but they are different. Copyrights grant exclusive rights of authorship of original works. If you want to protect a publication, computer software, an entire blog post, your website content or a photo that are original works, you need a copyright. If you want to protect your brand, you use a trademark. Without filing for a copyright, you have no legal leverage against someone who decides to plagiarize your work and passing it off as their own. The better your website is, the more likely a competitor is to copy it. While you can use the copyright (©) symbol even if you have not filed a copyright, you cannot obtain statutory damages and attorney fees if you sue someone for copyright infringement unless you have filed for a copyright with the USPTO. The USPTO fees are minimal. Copyrights last for the life of the author plus 70 years, so a very long time. Then they enter into the public domain. As of 2021, anyone can remix George Gershwin’s “Rhapsody in Blue,” in case you are interested.

When you have working agreements with contractors, such as website developers and software system developers, you need to make it clear as possible who owns what. Be careful with work for hire language. Joint copyright ownership is to be avoided since all owners have equal rights, including the right to commercially exploit the copyright, provided that the other owners get an equal share of the proceeds. Each party can grant nonexclusive licenses and commercialize the content but must share profits (absent an express agreement to the contrary).

A derivative work is a work based upon one or more preexisting works. This can consist of editorial revisions, annotations, elaborations or other modifications, which, as a whole, represent an original work of authorship. Derivative works are improvements to what is copyrighted using the background copyrighted material. The original co-owners are entitled to profits form the derivative work. However, issues often develop as to what amount of the derivative was original copyrighted material and how much of the profits need to be shared.

Patents

Patents grant exclusive (monopoly or exclusionary) rights of making, using, selling, offering for sale inventions, or discovery of any useful process or article or composition, or any new and useful improvement. If you are an inventor, then you need a patent. However, obtaining a patent

### TABLE 1: TYPES OF INTELLECTUAL PROPERTY

- **Trademarks:** A trademark is a distinctive word, name, slogan, symbol, sign, or combination of these that serves to identify the particular source of products or services and distinguish from other similar or competing products.
- **Copyrights:** Copyright protection grants exclusive rights of use to the authorship of an original work.
- **Patents:** Patent protection grants exclusive rights of use to the invention or discovery of any new and useful process, machine, article of manufacture or composition of matter, or any new and useful improvement thereof.
- **Trade Secrets:** Trade secret protection grants exclusive rights of use for any formula, practice, process, design, instrument, pattern or compilation of information, which is not generally known or reasonably ascertainable, by which a business can obtain an economic advantage over competitors or customers.
TABLE 2: PATENTING

- Creates a monopoly for 20 years.
- Utility patent — product or process.
- Design patent — ornamental aspects.
- Beware of marketing an invention before filing a patent application.
- Patentability bars exist like public use, printed publication, offers for sale.
- Can increase profits and prices.
- Patents are best where there is a large or fairly large market.

Patent applications can be high for addressing the USPTO office actions based on prior art. However, in some cases, such as technology that is rapidly changing, you may want to file a full patent application and seek expedited review. Competitors can only be sued for patent infringement once a patent application matures into a patent. Sometimes a competitor who tries to market the product before the patent issues may later become a licensee and have to pay royalties. It is important to understand that the U.S. is a first to file system rather than a first to invent system. Confidentiality agreements must be carefully crafted. Table 2 details some other features for patents.

Trade secrets
A trade secret is information that a company chooses not to share and is only valuable as long as it remains as secret. If you are maintaining some intellectual property as a trade secret, you should have nondisclosure agreements with your contractors, manufacturers, and distributors, as well as anyone else who came into contact with the secret. Disadvantages of trade secrets include the possibility someone will discover your secret by reverse engineering or some other process. Trade secret litigation has been on an upward trajectory each year with the health care sector seeing one of the steepest increases especially for computer technology, customer lists, proprietary pricing and supplier relationships. A well-thought-out analysis is required before you decide to just keep your IP as a trade secret. The advantage is a trade secret can last forever.

The elements of a trade secret are found in Table 3. It is important to keep in mind that all information that qualifies as a trade secret is confidential but not all information that qualifies as confidential is a trade secret.

Using IP as a business asset
Intangible assets, like trademarks and goodwill are of utmost importance when it comes to mergers, acquisitions, sale, licensing and franchising, and can dominate the valuation of businesses. Securities and Exchange Commission filings must correctly reflect the valuation of IP. IP due diligence is mandatory before making a purchase and using a due diligence checklist when reviewing an IP portfolio helps to reach a fair bargain. IP can be offensive (buyer’s side) or defensive (seller’s side). For example, from the seller’s perspective, they must disclose all IP, looking also at the ownership (and any possible third-party owners). If the buyer then uses IP that the seller did not possess, the seller could ultimately be liable if not properly disclosed.

TABLE 3: 3 PRONGS TO TRADE SECRET ELEMENTS

- Not known or readily accessible by competitors (e.g., if it is posted on the internet).
- Commercial value or provides a competitive advantage in the marketplace.
- The owner of the information protects from disclosure through reasonable efforts to maintain its secrecy (e.g., marking “confidential”).

IP creates smart value for your health care business and business ventures through valuation, which is especially important in mergers and acquisitions. IP licensing can involve significant royalty payments and is central to franchising agreements. Is your business IP protected and being leveraged appropriately?

Martha M. Rumore, Pharm.D., J.D., M.S., L.L.M., FAPhA, is senior counsel at Frier Levitt, LLC, and adjunct professor, Maurice A. Deane School of Law at Hofstra University.
Virtual care on the rise: How physicians can protect themselves from litigation risk

Telemedicine and telehealth services were growing before the COVID-19 pandemic, and demand has soared since the March 2020 shutdown as patients and providers alike recognized the efficiencies and convenience of delivering care remotely. However, along with the surge in demand for virtual care comes higher risk of malpractice claims for health care professionals.

Misdiagnosis risk
One of the biggest risks in the act of practicing medicine virtually involves the challenges of virtual examinations: reviewing diagnostics, communicating with the patient and loss of contextual clues, among other factors.

Two-thirds of telemedicine-related claims received between 2014 to 2018 were related to diagnosis, according to CRICO, the risk management arm of the Harvard Medical Institutions.

Physicians conducting a telemedicine appointment must rely on a patient’s description and interpretation of their symptoms to try to make a diagnosis without the benefit of testing and physical examination, as at an in-person clinical visit. That could more easily lead to misdiagnosis, missed symptoms or physical clues, prescription of the wrong medication and the potential consequence of prescribing medication across state lines without conducting an in-person examination (a criminal offense in some states).

Security & technology concerns
Virtual health care can also be prone to security and technology threats. Privacy breaches, software malfunctions, cyber security threats, ransomware and other issues could result in noncompliance with regulations.

Something as simple as a poor internet connection or an older computer with a low-quality camera lens could play a role in misdiagnosis or miscommunication between patient and provider.

Protect yourself
Despite these risks, the standard of care test remains the same for virtual medicine: acceptable medical treatment provided by reasonably prudent health care professionals under like or similar circumstances.

Providers who choose to offer virtual care can reduce their risk by implementing best practices and recommendations from the American Telemedicine Association (ATA) and working with attorneys who are experienced in medical malpractice defense to develop policies and procedures for following those guidelines.

They should be vigilant about patient confidentiality, including written documentation, and ensure their software platforms have encryption, cybersecurity and other safeguards that comply with federal and state privacy laws such as HIPAA and the Health Information Technology for Economic and Clinical Health Act, also known as HITECH.

Providers should educate patients on the proper protocols of virtual visits and describe the possible risks of seeking care remotely. They also need to be mindful that there will be an inherent lack of personal connection and continuity of care, which tend to reduce the risk of litigation in longstanding doctor-patient relationships.

Physicians may need to be more careful in making sure patients follow through on diagnostic testing such as bloodwork or radiology, prescription medications, other recommended treatment or specialized care.

Most important, when a virtual visit doesn’t yield enough information, especially if the patient may have a serious illness or condition or a history of underlying health issues that may cause complications, physicians should document the lack of information and insist on an in-person appointment for a more detailed examination or diagnosis.

Pros and cons
Telemedicine offers many new opportunities and potential benefits for patients and physicians in the increasingly complex health care environment. As it evolves, medical providers must stay alert to the possible risks of litigation, especially when making a new diagnosis or presented with a new symptom or health concern. Work with experienced medical malpractice counsel to create policies and procedures that comply with ATA guidelines, and vigilantly follow best practices.

Remember that virtual care is still in its infancy, and we have much to learn.

James R. Embrey Jr. is a partner at Hall Booth Smith, P.C., who defends businesses in medical malpractice litigation, general liability, and more. Send your questions to medec@mjhlifesciences.com.
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Many physicians intuitively suspect that the key to successful chronic disease management and prevention is to encourage sustained behavior change in their patients. It’s noteworthy when new findings both verify their intuitions and offer new tools to support those changes.

Such are the results of a recent clinical study published in the Journal of Medical Internet Research (JMIR) Diabetes. This retrospective cohort study examined data from 998 people with Type 2 diabetes who used a digital health platform. The goal was to look at the connections between personalization in digital health solutions, sustained behavior alteration, and diabetes outcomes. Interestingly, the research:

1. lends some statistical weight to the idea that supporting sustained behavior change can significantly improve patient outcomes.
2. suggests the need for a hyper-personalized approach to digital health.

**Study findings**

The study was designed to look at the impact of digital engagement on monthly average blood glucose levels during a patient’s first year managing their diabetes on a digital platform. The 998 people reviewed were categorized into one of two groups:

- **engaged users**, defined as those who rarely or never used features of the digital health application but who did measure their blood glucose.
- **highly engaged users**, defined as those who consistently engaged with the application to tag and track their mealtimes, food, exercise, mood, and location along with their blood glucose.

Researchers found that highly engaged users demonstrated statistically significant improvements during the initial period (13%) relative to engaged users (9%). Furthermore, during the initial six-month period, they discovered a 43% drop in monthly average glucose levels in the month following increased digital engagement. Also striking was the fact that *intrapersonal* differences in digital engagement were associated with the reduction in monthly average glucose levels.

**Key takeaways for physicians**

So, what insights should providers draw from these findings?

First, the study offers a ray of hope for providers under intense pressure to improve outcomes. We can counsel patients all day long about the importance of healthy habits, but what happens once those patients step outside of the exam room? They may have every intention to adopt healthier behaviors, but the motivation usually wanes quickly once “real life” starts getting in the way. The JMIR study suggests that there is a way to better manage patients beyond the physician visit. Providers who offer access to digital tools that encourage continual self-management should be able to support healthier patient behavior and outcomes.

There’s a caveat, though. It’s not enough just to hand people an app. According to the JMIR research, driving *sustained* behavior modification requires understanding how people change, what causes those changes, and what helps those changes endure. The digital tools used must be capable of engaging patients dynamically, as each individual’s preferences and attitudes shift.

There are countless instances throughout health care where we try to stratify patients based on demographically derived personas. That’s a great start, but it’s only a start. Truly supporting behavior change demands a deeper, more genuine recognition of each individual’s personal growth.

Ignoring dynamic, intrapersonal change has been a major reason why digital interventions fail to engage patients to the extent necessary to impact outcomes. It makes sense, too. Anyone might be open to trying out a shiny new app. However, they’re not going to continue to engage with it unless it’s easy to use, delivers something that matters to them within the context of their daily lives, and is flexible enough to adapt as their needs change.

The research adds to the growing body of evidence that it is essential to address changes within individuals, not just account for the differences between people.

Omar Manejwala, M.D., is chief medical officer of DarioHealth.

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**Yes, personalized digital interventions actually work**

by Omar Manejwala, M.D.
Overcoming obesity myths: Navigating nutrition conversations with patients

by Sandra Christensen, MSN, ARNP, FOMA Contributing author

When it comes to myths surrounding obesity, the list of misconceptions is as long as the myriad of complications it can cause. Obesity treatment consists of four pillars: Nutrition, physical activity, behavioral counseling and pharmacotherapy.

The first step in treating patients with obesity is broaching the subject, which can be difficult for a spectrum of reasons. Common barriers, which can be real or perceived, include a lack of education about obesity and its treatment, weight bias, lack of knowledge about effective communication strategies, time limitations, reimbursement challenges, fear of making patients uncomfortable, and the assumption that patients aren’t motivated to address their obesity.

It’s important to understand common obesity myths that your patients—and other health care providers—may believe to be true. Here are three common misconceptions about nutrition and obesity:

Obesity is caused by overeating

While overeating may play a role, the development and persistence of obesity is the result of numerous genetic, environmental, and biological factors. In addition to influencing obesity, these factors also affect hunger, satiety, propensity for specific foods, and response to nutritional interventions.

Normal life can resume once obesity is resolved

Many people believe that a perfect diet exists and that once it is identified and implemented, life can resume as normal. In reality, the chronic condition requires a nutritional plan that will need to be continued indefinitely to keep weight and health stable. In fact, an intensification of the entire treatment plan, including nutrition, may be required when the body metabolically adapts to weight loss. Anti-obesity medications may also be needed to enhance adherence to the nutritional plan, induce further weight loss, and/or prevent weight regain.

Weight gain or loss is solely determined by calories

Some believe that weight gain or loss is determined by a simple equation: calories in vs. calories out. On the contrary, weight and appetite are regulated by multiple neurohormonal processes that involve adipose tissue, endocrine organs, gastrointestinal tract peptides, and the peripheral and central nervous systems. The body responds hormonally to the type, quality and quantity of food eaten, which goes beyond calories. Foods that increase insulin levels, such as sugars, starches and other ultra-processed foods, promote lipogenesis and inhibit lipolysis.
Initiate conversations
With misconceptions like these, it can be intimidating for patients to have these conversations so it’s important to remember that broaching the topic of obesity with patients begins with gaining permission. Consider the following phrases: “Do I have your permission to discuss your weight?” “Would it be alright if we discuss your weight?” and “Do you have concerns about your weight?”

Once the patient has granted permission, focus on building a respectful and collaborative partnership. When patients feel that a clinician is on their side, they are much more open to discussing weight and treatment options. The goal of the conversation is to set the stage for further conversation and assess the patient’s readiness for treatment. When patients are not ready, revisit the topic at a later date and invite them to return when they are ready.

Encourage nutritional strategies
When creating a treatment plan for patients with obesity, implement nutritional strategies in increments. It is easier to be successful when eating changes are done one step at a time. Here are some important nutritional elements to discuss with patients:

- Advise patients to keep their environment free of tempting foods. Many don’t recognize the importance of keeping tempting foods out of their vicinity.
- Encourage your patients to find ways to socialize that aren’t food-centric, such as meeting a friend for a walk instead of at a coffee shop full of temptations.
- Provide guidance for navigating eating challenges, such as travel, social events, holidays and stressful periods. This may require referral to a dietitian or nutritionist for specific strategies, but it is still important to broach these topics so patients recognize the value of being prepared for eating challenges.
- Administer anti-obesity medication support, if appropriate, based on ability to adhere to the nutritional plan, hunger, cravings and satiety.
- Help patients connect their food choices to their hunger, cravings, function, energy, focus, sleep and pain level.

Recommend resources
Evidence demonstrates that tracking is associated with weight loss. Tracking can identify indulgences that aren’t remembered, reveal skipped meals, or highlight snacking habits that lead patients to be overly hungry and vulnerable to eating convenient processed carbs and/or overeating. Suggesting ways for patients to track eating habits can be helpful, such as apps, spreadsheets and notebooks.

While wearables can be effective for monitoring physical activity, such as daily step counts, tracking methods that focus on calorie deficits can be problematic. If a patient has expended energy through exercise, the app may tell the patient that they can consume a specific number of calories and still lose weight. This is rarely the case and can lead to indulging in ultra-processed foods that increase insulin and inhibit lipolysis. It is better to use tracking to monitor intake and review the information with the clinician or dietitian, who can assess the effectiveness of the eating plan.

Sandra Christensen, MSN, ARNP, FOMA, is a board-certified nurse practitioner. She owns Integrative Medical Weight Management in Seattle where she provides personalized, comprehensive obesity treatment.
Learning Objectives
Upon successful completion of this activity, you should be better prepared to:
• List recommended diagnostic practices for CKD in patients with T2D
• Discuss the complex pathophysiology of CKD and emerging approaches to intervene in disease progression
• Evaluate the efficacy and safety of nonsteroidal mineralocorticoid receptor antagonists and other therapies under investigation for the treatment of patients with CKD

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Chronic kidney disease (CKD) affects approximately 14% of individuals in the United States.1 Often termed a silent disease, more than 90% of patients in stages 1 to 3 are unaware that they have CKD. Symptoms predominantly manifest in more advanced stages of CKD. Almost half of individuals with CKD also have diabetes, with or without self-reported cardiovascular disease (CVD).1 Early identification of kidney disease can lead to prompt treatment and help slow down disease progression.2 Advancements in the understanding of the complex disease pathology brought about the development and approval of new cardiorenal protective agents. Here are 3 things you should know about coexisting CKD and type 2 diabetes (T2D) and emerging therapies to treat them.

1 Annual screening for CKD is recommended for all patients with type 2 diabetes.

Recent data show that undiagnosed CKD is present in almost half of patients with T2D.3 The criteria for the diagnosis of CKD are based on abnormalities of kidney structure or function present for > 3 months and measured by markers of kidney damage. Both the Kidney Disease: Improving Global Outcomes (KDIGO) 2020 clinical practice guidelines for diabetes management in CKD and the American Diabetes Association 2021 Standards of Clinical Practice recommend annual screening for CKD.4,5

A spot urine sample can be tested for albumin-to-creatinine ratio (ACR) to detect albuminuria and serum creatinine to estimate glomerular filtration rate (eGFR) for all patients with T2D at the time of diagnosis. Cutoff values for the screening tests are urinary ACR of ≥ 30 mg/g and/or sustained reduction in plasma eGFR below 60 mL/min/1.73 m². CKD is then classified to guide further testing and the initiation of treatment; a GFR category and albuminuria category are assigned to determine disease prognosis. Referral to a nephrologist is indicated when the GFR is < 30 mL/min/1.73 m² or ACR is > 300 mg/g.6

2 CKD causes a systemic, chronic proinflammatory state.

Patients with CKD have an elevated CVD risk manifesting as coronary artery disease (CAD), heart failure, arrhythmias, and sudden cardiac death.6 Although the incidence and prevalence of cardiovascular events are significantly higher in patients with early CKD stages (CKD stages 1-3) compared with the general population, patients with advanced CKD stages (CKD stages 4-5) have a markedly elevated risk. CVD rather than end-stage kidney disease (CKD stage 5) is the leading cause of death in this high-risk population.

CVD is the leading cause of death in patients with CKD

Although patients with CKD, particularly those with diabetic kidney disease, commonly have coexisting traditional risk factors for CVD such as hypertension, these do not fully explain the increased incidence of CV events and mortality.7

CKD causes a systemic, chronic proinflammatory state that contributes to vascular and myocardial remodeling processes resulting in atherosclerotic lesions, vascular calcification, and vascular senescence as well as myocardial fibrosis and calcification of cardiac valves. In this respect, CKD mimics an accelerated aging of the cardiovascular system.8 Moreover, microalbuminuria is not merely a determinant of nephropathy in patients with diabetes, but it is also an early and sensitive marker of widespread inflammation and vascular damage with established cardiovascular prognostic value.9

3 Nonsteroidal MRAs target major drivers of CKD progression in T2D.

Currently recommended therapies for CKD in T2D leave inflammation and fibrosis largely unaddressed. There is increasing evidence that mineralocorticoid receptor overactivation in the kidney is a main culprit of the inflammatory state leading to renal fibrosis.10-12 Mineralocorticoid receptor antago-
nists (MRAs) have been available for more than half a century—spironolactone became available in 1959—but steroidal MRAs are associated with adverse effects, including increased risk of hyperkalemia. Eplerenone was subsequently developed as a more selective version of spironolactone. In recent years, third- and fourth generation MRAs that share a nonsteroidal structure have been under investigation, including finerenone, esaxerenone, and apararenone.

In contrast with spironolactone and eplerenone, finerenone is equally distributed in myocardial and kidney tissue. Finerenone binds to the same ligand domain but to different amino acids, leading to a different expression pattern of cardiac genes compared with spironolactone and eplerenone. Finerenone also reduced cardiac fibrosis and inflammation more than eplerenone at a comparable dose in animal experiments.

"Nonsteroidal MRAs have now been added to the armamentarium that nephrologists have to slow progression of kidney disease along with SGLT2 inhibitors, ACE inhibitors, and ARBs. If you have a patient who does not have a potassium problem, and they are already on an SGLT2 inhibitor and ACEi or ARB in good doses and their albuminuria has not been reduced or it is increasing, you can add nonsteroidal MRAs because they’re not going to significantly lower blood pressure. They are not going to affect glucose. And yet you’re going to get the anti-inflammatory benefits to reduce kidney function decline."

George Bakris, MD

Clinical trial results led to recent approval of finerenone to reduce the risk of kidney function decline, kidney failure, cardiovascular death, nonfatal heart attacks, and hospitalization for heart failure in adults with CKD associated with T2D. The phase 3 FIDELIO-DKD renal outcomes study showed that finerenone significantly reduced the combined risk of time to first occurrence of kidney failure, a sustained decrease in eGFR ≥ 40% from baseline over ≥ 4 weeks, or renal death, compared with standard of care plus placebo.

FIGARO-DKD is a randomized trial with similar design as FIDELIO-DKD. However, the FIGARO-DKD trial included more patients with earlier stage CKD and T2D compared with FIDELIO-DKD. The primary outcome of FIGARO-DKD is a composite of CV death, nonfatal myocardial infarction, nonfatal stroke, or hospitalization for congestive heart failure. The study randomized 7354 patients with a median urinary ACR of 312 mg/g. More than 60% of study participants had preserved renal function (eGFR ≥ 60 mL/min/1.73m²). Patients with heart failure with reduced ejection fraction and New York Heart Association stage II to IV were excluded.

Secondary end points in both trials include all-cause hospital admission, all-cause mortality, change in urinary ACR from baseline at 4 months, and a composite end point of occurrence of kidney failure, sustained decrease in eGFR ≥ 57% from baseline for at least 4 weeks, or renal death. Preliminary results show that the primary end point was met, and complete study results are expected to be available in fall 2021.

KEY REFERENCES


For a full list of references go to gotoper.com/go/ada21ckd-medec
1. A 55-year-old woman with type 2 diabetes mellitus (T2D) of 10 years' duration is referred to you with the following lab results and vital signs: BMI 38 kg/m²; blood pressure 147/89 mmHg; HbA₁c 7.7%; creatinine 1.9 mg/dL; eGFR 32 mL/min/1.73². Besides her eGFR, which of the following is needed to make a diagnosis of chronic kidney disease?
   - A 24-hour creatinine clearance
   - B 24-hour urine albumin-to-creatinine ratio (ACR)
   - C Spot urine ACR
   - D Kidney biopsy

2. In the phase 3 FIDELIO-DKD trial that evaluated patients with chronic kidney disease (CKD) and T2D with optimized renin-angiotensin system inhibitor therapy, which of the following statements is true?
   - A Incidence of hyperkalemia was similar to placebo.
   - B Participants had early-stage kidney disease, up to 50% had microalbuminuria, and more than 60% had an eGFR of 45 to 59 mL/min/1.73² or greater.
   - C Participants had moderate-stage kidney disease, up to 75% had microalbuminuria, and 50% had an eGFR of 45 to 59 mL/min/1.73².
   - D Risk of both CKD progression and cardiovascular morbidity and mortality were significantly reduced.

3. Which statement is true regarding the potency and selectivity of mineralocorticoid receptor antagonists?
   - A Finerenone has a high potency and low selectivity.
   - B Spironolactone has a low potency and high selectivity.
   - C Finerenone has no active metabolites and is distributed equally in the heart and kidney.
   - D Spironolactone has no active metabolites and has higher distribution in the kidney.

To learn more about this topic, including information on the management of chronic kidney disease in type 2 diabetes, go to gotoper.com/online-cme-activities/cpc/cpc21ckd
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1,000-2,000 doses — 21-23 cu.ft.

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Advertising in Medical Economics® has accelerated the growth of our business by putting me in contact with health care professionals around the country. It has allowed me to help both my colleagues and my patients.

— Mark J. Nelson, MD  
FACC, MPH

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3 WAYS TO START IMMEDIATELY INCREASING REVENUE

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- Reimburses using 6 CPT codes, National Average = $750 - $1000 per test
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- Reimburses $170/test using 3 CPT codes
- Provides a 1 page summary up to a full 24 page comprehensive report

3 SudoMotor Testing
(can be combined with ANS into 1 full system)
- Takes 3 minutes to analyze a patients’ hands and feet
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- Assesses peripheral nerve health (c-fiber function) and asymmetry between each hand and foot
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