THE HACKERS ARE COMING
How to defend your practice from a rising tide of cyber crime

LEGAL How to protect yourself from identity theft

CHRONIC CONDITIONS Expert panel on lipid management best practices

TECHNOLOGY Making tech easier for senior patients

PRACTICE MANAGEMENT Why prepping for a practice sale can improve your operations
Align with the guidelines for patients at risk

XIFAXAN was given the highest possible recommendation by AASLD/EASL¹

XIFAXAN earned AASLD/EASL’s highest possible recommendation (GRADE I,A,1) as an add-on therapy to lactulose to reduce the risk of overt HE recurrence after a patient has a recurrence while on lactulose alone.¹

GRADE I:
Proven in randomized, controlled trials¹

GRADE A:
Evidence is “high quality,” and further research is very unlikely to change our confidence in the estimated effect¹

GRADE 1:
Recommendation is “strong,” with factors influencing strength of recommendation including the quality of evidence, presumed patient-important outcomes, and costs¹

References:
XIFAXAN cut the risk of OHE recurrence and HE-related hospitalizations in half²

**Primary Endpoint:** OHE recurrences during 6 months of treatment

- **Placebo:** 46% (n=159)
- **XIFAXAN:** 22% (n=140)

**Secondary Endpoint:** HE-related hospitalizations during 6 months of treatment

- **Placebo:** 23% (n=140)
- **XIFAXAN:** 14% (n=140)

**91% of patients in the placebo and XIFAXAN groups were on lactulose²**

**Study design²,³**
- In a randomized, placebo-controlled, double-blind, multicenter, multinational, 6-month study, the efficacy of XIFAXAN 550 mg (taken orally twice a day) was evaluated in 299 adult patients
- **Inclusion criteria:** Currently in remission (Conn score of 0 or 1) from HE and ≥2 episodes of HE associated with chronic liver disease in the previous 6 months
- **Primary endpoint:** Time to first breakthrough overt HE episode, defined as a marked deterioration in neurological function (an increase in Conn score to grade ≥2 or an increase in Conn score and asterixis grade of 1 each if subject entered study at grade 0)
- **Key secondary endpoint:** HE-related hospitalization

**INDICATION**
XIFAXAN® (rifaximin) 550 mg tablets are indicated for the reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults.

**IMPORTANT SAFETY INFORMATION**
- XIFAXAN is contraindicated in patients with a hypersensitivity to rifaximin, rifamycin antimicrobial agents, or any of the components in XIFAXAN. Hypersensitivity reactions have included exfoliative dermatitis, angioneurotic edema, and anaphylaxis.
- *Clostridium difficile*-associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including XIFAXAN, and may range in severity from mild diarrhea to fatal colitis. If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued.
- There is an increased systemic exposure in patients with severe (Child-Pugh Class C) hepatic impairment. Caution should be exercised when administering XIFAXAN to these patients.
- Caution should be exercised when concomitant use of XIFAXAN and P-glycoprotein (P-gp) and/or OATPs inhibitors is needed. Concomitant administration of cyclosporine, an inhibitor of P-gp and OATPs, significantly increased the systemic exposure of rifaximin. In patients with hepatic impairment, a potential additive effect of reduced metabolism and concomitant P-gp inhibitors may further increase the systemic exposure to rifaximin.
- In a clinical study, the most common adverse reactions for XIFAXAN in HE (≥10%) were peripheral edema (15%), nausea (14%), dizziness (13%), fatigue (12%), and ascites (11%).
- INR changes have been reported in patients receiving rifaximin and warfarin concomitantly. Monitor INR and prothrombin time. Dose adjustment of warfarin may be required.
- XIFAXAN may cause fetal harm. Advise pregnant women of the potential risk to a fetus.

To report SUSPECTED ADVERSE REACTIONS, contact Salix Pharmaceuticals at 1-800-321-4576 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.
1 INDICATIONS AND USAGE
5.2 CONTRAINdications
5.5 Concomitant Use with P-glycoprotein Inhibitors
6 ADVERSE REACTIONS
7.1 P-glycoprotein Inhibitors
7.2 Warfarin
7.3 CYP3A4 Substrates
8 USE IN SPECIFIC POPULATIONS
8.1 Pregnancy
10 OVERDOSAGE
11 NONCLINICAL TOXICOLOGY
17 PATIENT COUNSELING INFORMATION

This Brief Summary does not include all the information reported with use of nearly all antibiotic agents, including XIFAXAN, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibiotic agents alters the normal flora of the colon which may lead to overgrowth of C. difficile. C. difficile produces toxins A and B which contribute to the clinical manifestation of CDAD. Hypertonic productions strains of C. difficile cause increased morbidity and mortality, as these strains usually result in more severe pseudomembranous colitis and may develop into toxic megacolon and death. CDAD must be considered in all patients with fever and diarrhea after antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibiotic agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against C. difficile may need to be discontinued. Appropriate fluid and electrolyte management, and consideration of anti-diarrheal agents as a means of management may also be considered, may be ruled out.

In a 12-week clinical trial of another drug and may not reflect the rates in the clinical trials of a drug cannot be directly compared to rates in the literature. Clinical trials with rifaximin have included exfoliative dermatitis, angioneurotic edema, and urticaria; flushing, pruritus and anaphylaxis have been reported. These events occurred as early as within 15 minutes of drug administration.

7 DRUG INTERACTIONS

2.6 times the recommended dose for HE [1100 mg per day], and approximately 20% of the patients were 65 years old, 61% were female, 9% were White, 23% were Black. Ninety-one percent of the patients in the trial were taking lactulose concomitantly. The most common adverse reactions that occurred at an incidence ≥ 5% and at a higher incidence in XIFAXAN-treated subjects than in the placebo group in the 4-month trial are provided in Table 1.

2.6 times the recommended dose for HE [1100 mg per day], and approximately 1.8 times the recommended dose for IBDS-2 [1600 mg per day] adjusted for body surface area.

There is no information regarding the presence of rifaximin in human milk, the effects of rifaximin on the breastfed infant, and the effects of rifaximin on milk production. The development and health benefits of breastfeeding should be considered along with the mother’s clinical need for XIFAXAN and any potential adverse effects on the breastfed infant from XIFAXAN or from the underlying maternal condition.

3.2 times the recommended dose for HE [1100 mg per day], and approximately 2 times the recommended dose for TD and equivalent to 0.7 to 33 times the recommended daily dose for TD and equivalent to 0.2 to 16 times the recommended dose for TD and equivalent to 0.3 to 32 times the recommended dose for TD and equivalent to 0.1 to 32 times the recommended dose for TD and equivalent to 0.2 to 16 times the recommended daily dose for HE, based on relative body surface area comparisons.

There is no increase in terms of effects on CYP2C19 in rats dosed orally with rifaximin for 2 weeks at ≥ 2000 mg per day and doses equivalent to 0.1 to 5 times the recommended daily dose for TD and equivalent to ≥ 5 times the recommended daily dose for TD.

There is no information regarding the presence of rifaximin in human milk, the effects of rifaximin on the breastfed infant, and the effects of rifaximin on milk production. The development and health benefits of breastfeeding should be considered along with the mother’s clinical need for XIFAXAN and any potential adverse effects on the breastfed infant from XIFAXAN or from the underlying maternal condition.

There are no available data on XIFAXAN use in pregnant women to establish risk of harm to a fetus. Advise pregnant women of the potential risk to a fetus.
CHAIRMAN’S LETTER

Defend your data

The cyber war on health care industries continues. It has become a constant news story: A major health care company had millions of records stolen by a hacker; a hospital is locked out of its record systems unless it pays a ransom. A small medical practice faces a potentially business-ending disaster after an employee clicked on one bad link.

You may think one of those is not like another, that a small medical practice won’t be targeted by hackers, when there’s big fish like an insurance company or a major hospital to target. Think again.

As one cyber security expert we interviewed in this month’s cover story said: “As a hacker, I can spend a couple hours trying to hit this small health care provider, or I could spend weeks or months trying to get into the hospital. In the end, if I hit a whole bunch of smaller practices, I’ll probably walk away with more money.”

But what can a small practice do to help protect yourself from cyber criminals? For starters, read our cover story; it features multiple experts on the front line of the health care cyber war providing practical tips for physicians to protect themselves from a business-altering attack.

We have more great content in this issue beyond our cybersecurity coverage, such as:

- Did you know that physicians who moonlight or work a second job often have less burnout than their colleagues? Find out why in our interview with Suneel Dhand, M.D.
- How has technology improved management of heart health issues, including lipid management? We gathered together three experts in lipidology for a panel discussion on the benefits of telehealth and remote patient monitoring.
- Private equity firms are gobbling up medical practices. You don’t need to sell, though, to benefit from preparing for a potential acquisition — it can turn your practice into a fine-tuned efficiency machine. Find out how inside this issue.

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

Mike Hennessy Sr.
Chairman and Founder
of MJH Life Sciences™
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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To solve the COVID-19 pandemic, we must empower primary care physicians and pharmacists

It is time for an all-hands-on-deck approach.

We have now passed the 1-year anniversary of the pandemic in the United States and more than 28 million Americans have become infected with COVID-19. More than 500,000 have died. Our economy has taken a huge hit — businesses have closed, and millions of people are without work. Our hospitals are stretched to the breaking point.

No one is left untouched by the effects of this pandemic. It is laying bare the inequities of our health care system, the lack of access to basic care and community coordination. It has shined a light the decades of underfunding of our primary care and public health infrastructure.

The solution to the current economic and public disruption starts with getting the pandemic under control. That means vaccinating our citizens as soon as possible.

It will take an all-hands-on-deck approach of vaccine supply, distribution, personnel and access points to accomplish. We must enlist our primary care physicians and pharmacists to take on a larger role in ending this pandemic.

Who provides care in our communities?

Primary care and pharmacy are the backbone of a community's health care system.

Of all outpatients visits to a health care provider, 47% were to a primary care office. That is over 415 million visits to primary care physicians office per year while primary care only represents 31% of the physician population in the United States. Visits to a pharmacy exceed that of all health care providers by an almost 2-to-1 ratio.

Primary care and pharmacy, therefore, clearly represents a major health care access point for the citizens of this country. In addition, that is also where a majority of immunizations are given each year. Of the 174.5 million influenza vaccines given last flu season, primary care and pharmacy was the place of vaccination of over 65% of the vaccines administered.

Rural and underserved communities are also more often served by primary care and pharmacy as their source of health care, making them a vital access point for vaccine administration.

Although mass immunization clinics involving hospitals and health departments were necessary under limited supply and technical requirements in the early days of COVID-19 vaccine availability, it is clear that primary care and pharmacy must be a coordinated part of any successful plan to fully vaccinate U.S. citizens.

The primary care system is at risk

In the last year, primary care practices have experienced a major disruption in patient visits and revenue, and uncertainty in how to best care for their patients and communities. Many practices have suffered significant financial loss. With approximately half of family physicians nationally still in physician-owned practices, this disruption is worrisome.

According to a recent survey by The Larry Green Center, 61% of practices are having severe or near severe stress with 91% experiencing staff shortages due to quarantine or COVID-19 infection. While 57% of their vulnerable patients asking their PCP for the vaccine, only one quarter of practices know where they will get the vaccine when it is available to them. Some are worried about being able to purchase the vaccine to administer to their patients.

Knowing my primary care colleagues, they will answer the call to
get their patients vaccinated despite these difficulties. They just need some help now to get ready.

**COVID-19 vaccination rates need to be higher than flu shot rates**

Our flu vaccination rate last year for adults was 46.8% — nearly half of the U.S. adult population. This community vaccination rate is good, but still nowhere near where we need to be to achieve herd immunity for COVID-19. Some estimates say that we must reach 70% to 85%.

We must act quickly, as our citizens are suffering, and the racial disparity is stark, both in terms of hospitalizations and deaths. COVID-19 hospitalization rates are 3.7-times higher for Black and Hispanic adults than white patients. COVID-19 death rates for both these groups are 2.8-times higher than that for white patients.

Getting the vaccine to these populations is critical, but the challenges loom large, both in terms of access and vaccine hesitancy. Again, using flu shot data for comparison, the vaccination rates for black and Hispanic adults is 38.5% and 37%, respectively.

**Dealing with vaccine hesitancy**

National polls have continued to show significant numbers of patients who are either hesitant or decline to receive the vaccine.

While those numbers have improved during the last month, in order to achieve herd immunity, we must convince most of the hesitant and a few of the refusers to get the vaccine.

In a recent Green Center patient survey, almost half the population distrusted the CDC and public health institutions. But there’s good news here: more than 80% trusted their primary care clinician.

Whether it is by local public appeals or during one-on-one interactions with their patients, our community primary care physicians and pharmacists are our best ambassadors for vaccination and achieving the rates needed to protect patients. As it is for most complex tasks, the last mile is the hardest. We need our primary care physicians leading the charge on the anchor leg of this race.

**Coordination needed — and a call to action**

We need a call to action from our federal and state leaders to get our primary care providers and pharmacies involved. Furthermore, we need short term financial and technical assistance to make sure they are prepared.

In the end, it will be the personal relationships between physicians and pharmacists and their patients and communities that will get us to the herd immunity levels we need to stop this pandemic and get our economy open and moving again.

L. Allen Dobson, Jr. M.D., FAAFP, is a family physician and Editor-in-Chief of Medical Economics®.

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THE CYBERWAR AGAINST HEALTH CARE PRACTICES

How hackers plan to attack your practice — and what you can do about it

by Todd Shryock Managing Editor

While physicians worked to keep their practices financially afloat and dealt with COVID-19, hackers kept busy, too. From January through October of last year, there were 730 publicly disclosed security breaches with more than 22 billion records exposed, according to the cybersecurity firm...
There are a lot of simple things that can be done to improve your protection, minimize the severity of an attack and ensure a speedy recovery.

What to do if hit with ransomware
If a practice experiences a ransomware attack, Matt Reid, senior health IT consultant with the American Medical Association, says there are two actions to take immediately: Contact the FBI and the practice’s IT vendor. “Federal agencies have resources that can support medical practices during a ransomware attack — and that’s clearly an important component — but also work with your health IT vendor or internal IT support staff to try to partition off the segment of the network that has ransomware as fast as possible,” says Reid.

Martin says that all compromised devices, including desktop PCs, laptops and smartphones, should be disconnected from the network by unplugging ethernet cables, disabling Wi-Fi networks and switching to airplane mode.

If a practice has cyber insurance, Ferrante recommends contacting the provider and ensuring all requirements are met. This may involve an assessment of the attack. “If it’s not independently assessed, it may not be covered under the cyber insurance policy,” he says.

Although some experts advise never paying a ransom to regain access to data because doing so just encourages more attacks, that is often more idealistic than practical. “What we find in almost 100% of the cases is that the doctor has to pay because the threat actors are very sophisticated nowadays, and they will find all the backups,” says Salman. “And many of these doctors have their data being backed up into the cloud, and with a majority of the attacks that we’re dealing with right now, the hackers have figured out how to get into the doctor’s cloud backup and destroyed them.”

Physicians often have a false sense of security when it comes to cloud storage. “We see that a lot of people are either in the cloud, or they’re moving to the cloud,” says Ferrante. “Cloud simply means somebody else’s computer. Just because Amazon and Microsoft are secure doesn’t automatically translate to you being secure or your organization being secure. It has to be secured appropriately within those environments.”

During a ransomware attack hackers will also encrypt the server and all workstations, so when the doctors attempt to recover their data from their backups, the data

Tenable. Health care made up 25% of those breaches with nearly 8 million records exposed. Ransomware was by far the most popular attack method in 2020, making up 46% of the breaches.

“The success that cybercriminals had in 2020 extorting sizable payouts from medical practices of all sizes ensures that ransomware will indeed remain the top cybersecurity threat in 2021,” says Dave Martin, senior director, product management, threat response, at cybersecurity firm Open Systems. “Ransoms like the $670,000 paid by University Hospital (in) New Jersey last September only encourage further attacks. And while larger institutions can clearly pay bigger ransoms, cybercriminals do not overlook smaller practices, which can be tempting targets of opportunity — particularly those with lax security.”

With health care workers focused on the pandemic response, experts say hackers are taking advantage and ramping up their attacks, meaning it is vital that practices of all sizes be more vigilant than ever about cybersecurity.

Ransomware — malware that encrypts a practice’s data and demands a fee to unlock the encryption — is entering a new phase that makes a security breach even more costly, says Gary Salman, CEO of Black Talon Security, a cyber defense firm.

“Now doctors are seeing two ransom notes,” says Salman. “The first ransom note says, ‘I’ve locked all your data; if you want (them) back, pay me $50,000.’ The second note says, ‘And by the way, maybe you have a good backup, but guess what. I have all your data and if you don’t pay me an additional $50,000, I’m going to publish all your data.’”

Salman says sites on the dark web are run by these threat groups, and data from doctors’ offices show patient information, including photographs, health history forms and other private details.

Many of these hacker groups operate as businesses and can be very sophisticated, says Matt Ferrante, market leader, cyber and information security services, for Withum. “They sometimes know exactly what your cyber insurance policy is, and they know what’s going to potentially be covered under the policy,” says Ferrante. “And if they don’t know, they’ve often already done the intelligence on your business and they know what it’s worth.”

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During a ransomware attack hackers will also encrypt the server and all workstations, so when the doctors attempt to recover their data from their backups, the data
are not there. “So as a practitioner, you’re basically put into a situation where you have no choice; you have to pay the ransom, because under the HIPAA (Health Insurance Portability and Accountability Act of 1996) laws, the patients’ data (have) to be available,” says Salman.

In most cases, paying the ransom results in the data being released because if the hackers don’t turn over the data, victims won’t pay any more. The more sophisticated players have customer support lines and will offer to fix any data corrupted from their software, Salman says. “They literally have testimonials on their website encouraging you to pay because these people were victims, and they got their data back, so you should pay me too because you’ll get your data back,” he adds.

Following a breach, practices will often go on a cybersecurity shopping spree, buying all kinds of software to prevent it from happening again, but Ferrante says that’s usually not effective. “It has to be applied the right way, and you really need the expertise to make sure that it’s scalable and set up correctly. Otherwise, it’s not going to function properly.”

**New threats to defend against**
Ransomware may constitute the biggest threat to most practices, but it is far from the only one. As regulators require more patient access to data, payers interchange more data with providers, and services like telehealth grow in popularity, avoiding common cybersecurity mistakes

**Q&A:**

**Avoid common cybersecurity mistakes**

*Medical Economics®* spoke with Dave Grootwassink, general manager of the cybersecurity practice for Alaris Threat Mitigation Consultants, about what medical practices need to do to stay safe.

**Medical Economics (ME)®:** What are the most common cybersecurity mistakes medical practices make?

**Dave Grootwassink:** The biggest one is not getting formal training to their people, because that’s where most of this stuff starts. Assuming a practice has the basic stuff in place, like a good firewall, infections and breaches are going to come from somebody doing something like clicking on an email, going to a bad website or something like that. And, you know, bad websites aren’t necessarily, you know, porn.com, because infections can get into websites, and it’s not terribly unusual. If you train your people correctly, and they recognize things that don’t look quite right, then you can kind of keep that chink in the armor closed.

Typically, what a breach will do is somebody will get a little tiny infection, somebody opens an email attachment. And some of these email attachments are really insidious PDFs that look like an invoice or something. If they’ve spoofed the email address that it’s coming from, it may look like it’s coming from one of your regular vendors. There are bugs and holes and things like PDFs that you can use to exploit and put a little bitty piece of malware on your computer. And that little bitty piece of malware then goes out and talks to a command-and-control server out somewhere and then starts downloading the real bad stuff. So, I’d say that the first mistake they make is they don’t do training.

The other thing that they don’t do is a real risk evaluation. A good risk assessment will point out, where do we need to take a look? And where do we need to correct things? Because there’s a lot of stuff that people don’t realize is going on between devices. Every medical device out there has an operating system under it and most people don’t really think about that it’s not just the PC on the administrator’s desk, but there are MRI machines, there is everything else. All those devices have operating systems in there that may or may not have been patched for years. There are still medical devices out there that the underlying operating system is Windows XP, and it hasn’t had a security patch in 10 years. If they train the people and do a good risk assessment, followed up by a mitigation plan, that will take care of 90% of the issues.

**ME:** When a practice is hit with ransomware, how difficult is it to get everything back up and running? And
increases in the number of connected devices will make practices more vulnerable to hackers.

Experts say that the pandemic has created many new threats to a practice because people are working from home. Hackers may use COVID-19 information as the lure for office staffers to click on links that install malware. Emails are made to look like they are from health departments offering the latest on vaccine distribution or other vital information. In other cases, hackers exploit a weak point of the worker’s computer.

An employee’s home computer might be connected to a secure virtual private network, but if it isn’t being monitored, patched and protected with antivirus software, it could put the main network at risk, says Salman. “The network considers that remote computer part of the main network, and information flows freely back and forth,” he says. “Let’s just say your practice manager is working from home and she’s on the same network as her kids’ computers and one of her kids downloads a malicious game. Now that spreads from the child’s computer to the practice manager’s and then from there into the network at the office.”

Reid says cyber hygiene practices used at the office should be replicated for home workers as much as possible, and physicians should not overlook devices like smartphones and tablets as possible entry points. Multifactor authentication — where a user gets a code via text to input along with a password — should be used.

**how long does that process take?**

**Grootwassink:** If you have good backups, a couple of days. But I can’t stress how important it is for good multi-version backup systems that are not attached to the network.

The best way to get back on your feet is proper preparation. If you’ve got everything backed up, and you use a backup system that allows multiple versions—there are some backup systems commercially available that will keep a record and keep backups of all the changes for a period of time or for an amount of space, depending on what that particular arrangement that you have with the backup provider. If you’ve got a good backup in place, and one that has multiple versions, because I’ve run into places where they have a backup system, and they’ve successfully backed up the encrypted file, and the original file is gone. If you have backup that keeps multiple versions. When the file is encrypted from ransomware, and that file is backed up, you have the previous ones available. And some of the other things I’ve seen with ransomware is when people have attached backup systems, they can be as simple as is those little drives you plug into your USB ports. The ransomware will go in and happily encrypt your backups, too. You have to be very careful about how you do backups. I always recommend offsite cloud-based backup systems, and there are a handful out there that are actually HIPAA compliant. So, if you have good backup in place, you can bring yourself back usually to a good spot and it’ll take a little bit of time. The bigger the practice, the bigger and the more systems involved certainly will take more time. But if backups are in place, it can be done.

With that said, I’ve seen where (hackers) are actually exfiltrating all your files, too, and if you don’t pay the ransom, not only do you not get your files back, but they go out and they post them on various sites in the internet in public, which opens up another whole big can have problems for practices. To really combat things like that, you need to have monitoring of what’s going on in your network. When I go in and I set a practice up, one of the things that I install in the practice is something called a honeypot. I set a device up to look like a crippled PC or a crippled server that doesn’t have good security on it. That way, if anything ever hits it, or tries to get into it, I know that they are in there and that the entire network is compromised. We can shut things down and take care of it before everything goes to hell.

**ME: How are the cyber threats evolving? And do practices need to change their defense tactics to keep up?**

**Grootwassink:** From a technical point of view, they change all the time; it’s a whack-a-mole. The good news is, the fundamentals always have to be there: threat assessment, remediation, and putting policies in place to deal with the threats in training. If you keep up with the training, and keep up with your patching, and you do a new threat assessment periodically—it should be done at least once a year or whenever something new comes into the practice. That basic blocking and tackling is what the practices need to do.
whenever possible. “Also, using a home network that is not secure, where the password is easily guessed, or you don’t have a password at all, could be potentially problematic,” he adds.

Boost your cyber protection

Hackers are opportunists and will often target the practice or facility with the lowest level of security.

“I can spend a couple hours trying to hit this small health care provider, or I could spend weeks or months trying to get into the hospital,” says Salman of hacker mindsets. “And in the end, if I hit a whole bunch of smaller practices, I’ll probably walk away with more money. If you take down a big hospital system, you’re going to have every government agency coming after you, but if you take out some smaller businesses, you might fly under the radar if you’re a criminal.”

He says another issue is that practices often put too much faith in their IT vendor, who may not have a depth of security expertise. Physicians are told their practice is protected and assume that’s true.

In one case, an IT vendor’s system was hacked and then was used to attack every health care practice on its customer list because it had access to every network. All the practices had to pay the ransom to get their data back, and the hackers walked away with $1 million.

Experts in the cybersecurity field often recommend a practice conduct a cybersecurity assessment. This will look at all the organization’s digital entry points, and then the cybersecurity firm will do a penetration test, where it acts like hackers would and looks for weak points.

“It’s not just about data loss, it’s about also potentially being able, like a hacker would do, to be able to cripple an organization,” says Matt Ferrante, market leader for cyber and information security services at Withum. “Data shows that about 70% to 75% of backups fail during a critical incident.”

He says many practices don’t do an assessment because they think they are cost prohibitive for smaller organizations. “This sounds like kind of an expensive prospect to have all this done, but it’s not because it’s scalable, and it really depends on the size of your footprint.”

A small practice might have an assessment done for $1,000, which is far less than the cost of the average breach.

Ferrante says assessments should be done by true cybersecurity experts, not just a general IT firm, because just like in medicine, there are general practitioners and specialists, and cybersecurity requires specialization to be done right.

In most cases, experts say an assessment can be done remotely and when complete, the practice is provided a list of vulnerabilities it can address as money allows.”
“What medical practices should be doing is asking their IT companies who’s protecting them,” says Salman. “If hackers break into the IT company and attack the practice, there’s probably nothing that practice can do to defend themselves against that. Ask them if they are being independently audited on a monthly basis by a dedicated cybersecurity firm. If the answer is no, they need to understand why.”

IT vendors also have many employees working from home, and practices need to know how they are being protected, as well. “These are the people who have credentials to your environment,” says Ferrante. If their security is lax, hackers can gain access to a physician’s network by breaching an IT worker’s home computer.

Ferrante adds that a cybersecurity expert should conduct a full assessment of a practice’s vulnerabilities, particularly because of the number of devices utilizing the network during COVID-19.

For practices working with local hospital systems, Reid recommends checking with them about receiving donated cybersecurity services. Thanks to changes in the Stark Laws, hospitals and health systems can now legally offer expertise and assistance to medical practices to help protect patient data.

As practices start to transition back to the office, Reid says, it is important to remember to change network access. To support home workers, extra access may have been granted to IT vendors, electronic health record providers, consultants or support staff who no longer need it. Also, office computers that have sat dormant for months need to be checked to make sure they have been patched with the most current operating system and security updates.

One of the best things a practice can do is budget for cybersecurity, says Salman. “This isn’t 2017, when the risks were a lot lower than they are now,” he says. “They have to implement cybersecurity solutions from a specialty company, not just their IT vendor.”

Preventing a breach in the first place with proper security is far cheaper than dealing with the business disruption and ransom payment, he adds.

Practices also shouldn’t rely solely on cyber insurance. Ferrante says that after a major data breach, a policy may not provide enough money to cover all the expenses and can’t do anything to repair the practice’s reputation.

But above all, a practice always should make sure it has the basics in place, such as antivirus software and firewalls.

“There are a lot of simple things that can be done to improve your protection, minimize the severity of an attack and ensure a speedy recovery,” says Martin. “First off, you need to routinely back up your files to a device that is not connected to the network. This is important because the latest ransomware tools, such as Ryuk, actively seek and delete backups on devices attached to the network. These secure backups will be key to your restoration efforts.”

Avoiding common password mistakes is another way to dramatically improve your practice’s security posture. They should be at least eight characters long and consist of a mix of letters, numbers and symbols, be changed regularly and not reused. Also, be sure to change any default passwords on any devices, says Martin.

“Lastly, be sure to continually remind yourself and your employees to never click on an even remotely questionable link, regardless of who the sender is,” says Martin. “When in doubt, check with the person.”

“I can spend a couple hours trying to hit this small health care provider, or I could spend weeks or months trying to get into the hospital.”

—Gary Salman, CEO, Black Talon Security
How physicians can earn money, expand their careers with moonlighting

by Chris Mazzolini Editorial Director

Physicians are hardworking professionals. But did you know that many of your colleagues work multiple jobs?

In our 2021 Medical Economics Physician Report, nearly one out of three physicians told us that they earn secondary income by moonlighting. The most popular forms of secondary work include consulting, teaching and, perhaps surprisingly, work that does not involve a medical degree. The average income earned from these jobs? About $40,000 per year.

Many physicians may now be wondering: Where do I find these opportunities? And how do I know what is the right fit for me? Medical Economics sat down with Suneel Dhand, M.D., an internist who moonlights and co-founded a company called DocsDox that helps physicians find secondary income opportunities, to discuss ways you can find opportunities for yourself. The transcript has been edited for length and clarity.

ME: How many physicians are taking on secondary income? Is this common? And is there a growing interest in this kind of career diversification?

Dhand: Yes, we are seeing a vast expansion in the number of doctors who are going down this route. It used to be an absolute minority of physicians, especially when we were in the era of physicians basically owning their own practices. Where was there ever time for secondary income? ... Some estimates suggest it’s now the majority of physicians who in some ways are pulling in secondary income.

ME: So how do you find secondary work, as a physician? Where do you go to find good opportunities that may fit your own circumstances?

Dhand: I did it all. From my own networking, I tried to maintain a larger professional network, which I met through previous jobs, at conferences and so forth. I’ll give you an example: My current main outpatient practice is in a wellness and preventive medicine clinic, and I basically found that on LinkedIn. It was random; I didn't go through recruiters. So it really depends on the physicians’ own circumstances, what their network is and what they're looking for.

ME: What are some of the benefits of this work?
**Dhand:** There are lots of benefits for the physician. First, it will give you variety in an era of exploding physician job dissatisfaction and burnout, which we’ll come back to soon. It obviously helps with that. It avoids anything becoming too monotonous in terms of what we do. Also, purely in terms of income — I mean, let’s be realistic from the financial perspective — it can really work out well for the individual doctor.

**ME:** What are some examples of secondary income? What’s out there?

**Dhand:** Physicians, as a group of professionals, don’t understand the value we can bring to many different organizations, even those that are outside medicine. We historically undersell ourselves. We’re not trained in marketing. ... And many doctors end up being one-dimensional thinkers; they think in terms of “I’m going to have this job and go down this route.”

Some examples would be if you’re going down the clinical medicine route, you could find many organizations — probably in your immediate vicinity — that would need your services for exactly what you want to do if you wanted to try something different. Say you are a generalist, and you are working at an internal medicine practice. You could check out urgent care facilities or you could work in educational institutions. As far as nonclinical opportunities go, a myriad of them are available. If it’s your cup of tea, you can work for the insurance industry or you can work in chart reviews. There’s a ton of startups out there that desire the physician perspective. And then you've got the pharmaceutical companies, of course, which will always need physician advisers and a physician perspective, and they value that if you can bring your clinical experience to the table.

**ME:** What factors should physicians consider, broadly speaking, as they’re evaluating different opportunities?

**Dhand:** Well, once a physician decides to go down this route, it’s important to be clear about what you would enjoy. I’ll give you a personal example. I know I’m a very clinical, hands-on person; I like the patient contact. And I know that the secondary income opportunities I choose should be in that field. If I were to, say, do chart reviews, or work for an insurance company, it may be lucrative and it may suit me for a bit, but I know, long term, I wouldn’t be happy. So it’s important for a doctor to really be honest with themselves and ask: What do you enjoy about being a doctor? If they don’t really enjoy clinical medicine ... go down a nonclinical route. Don’t just go for something because it sounds like a cushy opportunity. These opportunities will come physicians’ way. But they’ll realize very quickly if they do that, if it’s not for them, they’re not going to be happy.

**ME:** Let’s stick with the happiness discussion. Earlier you mentioned “Physicians, as a group of professionals, don’t understand the value we can bring to many different organizations, even those that are outside medicine. We historically undersell ourselves.”
rising career dissatisfaction among physicians, and we all have heard about physician burnout. It may sound counterintuitive to some to say that taking on more work may help your burnout. Can you talk a little bit about the relationship there?

Dhand: The explosion in physician burnout and dissatisfaction is clear to everybody out there. I’ve seen research suggesting that the majority — 60% — of all doctors are clinically burned out. We need to take a step back for a moment and ask: Why has this happened?

Well, 30 years ago, doctors used to finish residency and enter practice. They used to be small-business owners and had a lot of autonomy and ownership. In this world of employed medicine, which has escalated over the past 20 years, (most) doctors will finish residency and become employees in large organizations.

I feel that there is an inevitable conflict that will arise because the types of people that go into medicine are very independent thinkers, and the corporate world really doesn’t fit well. And sooner or later, a doctor will reach that conflict in their career where they’re not going to like working for a big organization.

So how can secondary income help? Well, physicians have to again realize everything doesn’t have to be a set career path; they can cut back on their regular clinical work. So it doesn’t mean that your secondary income is necessarily adding to it, and I actually wouldn’t advise doing that if you already work 80 hours a week. And again, using my own example, I was practicing internal medicine, doing the same thing week in, week out, and then decided to pull back on that. I thought: Well, let me think…. What can I do that will be satisfying but also avoid that sense of monotony? ...

... If you can reach that kind of balance, it can really add a lot of variety to your career.

ME: Another factor is volunteering. Are there any ways to approach a volunteer opportunity differently from something that you’re paid for?

Dhand: If a physician is looking for an outlet away from clinical medicine and finances are not an issue, volunteering is always a great thing to do. It’s a wonderful thing to give your time to a good cause, one that you feel passionate about. I know a lot of doctors that volunteer, but I don’t know many, to be honest, that do it so much, that it’s anything more than, say, a few hours a week.

ME: If you are a physician who works for a large organization, what should you check before taking on a secondary gig?

Dhand: The only potential conflict or reason for any concern from an organization would be if you’re going to work with a direct competitor. From what I’ve seen, though, having met thousands of physicians, medicine is usually the last one that is particularly strict about that because there’s just such a need out there. I’m in the Boston area, and lots of doctors will go and moonlight in the neighboring organization, and it’s very rarely a big deal. It’s something that is commonly done.

But yes, you should check with your organization and make sure it’s OK. But rarely will it be an issue as long as you can go and do your own job when you’re paid to do it and not take side phone calls during working hours.

ME: Is there anything that we haven’t talked about that you think is important for physicians to keep in mind as they look for secondary work?

Dhand: If you have that itch to try something different, you feel that your job is not where you want it to be, whether that’s because you’re burned out, or you just feel a general sense of drudgery, go ahead and try secondary work as soon as possible. I wish I had years before I did because there are so many opportunities out there for doctors, we historically undersell ourselves and don’t market and understand our value even in other arenas. So, if you feel the urge to do that, go ahead and do it as soon as possible. Don’t wait, and you will surprise yourself.

If you don’t want to go part time in your current job … try something a couple of evenings a week or on weekends and see whether it suits you first. There’s no point, if you’re already bored or unhappy with your job, (doing something) you know is going to be equally draining for you. Pick something that you’re passionate about. …
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Managing Type 2 diabetes with technology

Welcome to Medical Economics’ Around the Practice. In this installment, our panelists of experts go in depth on treating and managing Type 2 diabetes, including new innovations in diabetes technology, such as insulin pumps, smart insulin pens and continuous glucose monitors (CGMs).

How, then, do physicians put this knowledge into practice? Read the panel’s discussion of how to best incorporate technology into a diabetes treatment regimen. Then, the panelists explore a realistic patient scenario and how they would approach treating and managing this case using technology tools.

This transcript an excerpt of a longer video discussion on this important topic, and has been edited for length and clarity. For the full discussion, visit: medicaleconomics.com/view/insulin-therapy-in-type-2-diabetes
THE BENEFITS AN INSULIN PUMP

PATEL: Let’s talk about diabetes technology and how that can make some of the things our patients are doing a bit easier in that they shift the burden onto the device away from the patient. We now have insulin pumps. We now have CGM. We have smart insulin pens.

Let’s start with what’s really known regarding insulin pumps. When would you typically recommend an insulin pump for a patient with type 2 diabetes?

BUSCH: Let’s talk about a hypothetical patient — they’re on four shots of insulin a day, and they’re forgetting their lunchtime dose. With the burden of remembering to take the four shots a day, that’s when I would automatically bring up the possibility of a pump for the patient with one type of insulin rather than two types of insulin for the convenience that they have the insulin with them at all times. Certainly, if the patient has had hypoglycemia, then pairing the continuous monitoring with the pump and the automatic shutoff feature would be a big improvement to the patients and for safety reasons as well.

ISSACS: People sometimes have this false idea that being on an insulin pump somehow means that you have really bad diabetes or that you’ve failed. I try to break that misconception because insulin pumps are just another way of insulin delivery. For anyone who’s on multiple daily injections, an insulin pump is another way to be able to deliver that insulin. I try to introduce that idea early on to make sure people understand that it can be an option and to learn more about that because I’m a big fan of people knowing about the different options that are out there.

There are some key education points too about understanding how insulin delivers in a pump. I get people with whom I’ve had insulin pump starts, and people come to me and don’t even realize it’s just one insulin going in there. They think that they’re supposed to put their long-acting and their rapid-acting insulin in there. The education about how a pump delivers insulin is important as well as understanding that the pump is the source of insulin delivery.

BRUNTON: An important point is also recognizing that this gives a sense of freedom to the patients. They don’t have to keep worrying all the time if they have their insulin with them. They can adjust easily and discreetly when they need to give themselves insulin. Once a patient gets used to the pump, they’re wondering why they went so long without it.

PATEL: Who are the potential candidate patients who could potentially benefit from this technology?

ISSACS: I have seen too many providers say, “This patient’s A1C [glycated hemoglobin] is over 9% or over 10%, so they can’t do it. They have to get their A1C down first before they can go on a pump.” I don’t think we should ask people or make them earn their right to using a pump.

That being said, there are certain things that will set up a person up for success over others. One is being willing to come in for that education before starting the pump and basic things like understanding how to treat hypoglycemia and doing that appropriately. Those are baseline things I want to make sure a person understands before they start a pump.

I also want to make sure that they can be committed to some form of monitoring because when we go from injections to a pump, we usually start a bit more conservatively because we don’t want to cause hypoglycemia. We need to monitor that to be able to fine-tune their doses, so we need some level of monitoring, whether that’s wearing a CGM or agreeing to do a certain number of finger sticks, as well as making sure that they come in for a follow-up.

PATEL: How do you approach conversations with patients about insulin pumps?

BRUNTON: There are patients who often hear about an insulin pump even when we don’t even bring up, so it’s once again asking them what they’ve heard about a pump and working with that information. That’s always the best way to go. If they haven’t heard it, and they’re on multiple insulin injections, particularly if they’re finding inconvenience of that, those patients from my viewpoint are ideal.

ISSACS: Usually, at the initial training, we’re
doing the basics: teaching them how they use it and how they use bolus insulin, and that in itself offers a lot of conveniences because they don’t have to remember to carry that vial or that insulin pen. It’s on them all the time. They can press a button and give themselves a dose of bolus insulin with their meal or with their snack. It can be very discreet. They can hide the pump and keep it in their pocket. No one has to know they’re wearing it if they don’t want to share it.

**What’s out there?**

**PATEL:** Not all physicians are going to have familiarity with insulin pumps. Can you walk us through what’s out there?

**ISAACS:** I’m a big fan of patient choice: knowing their options, knowing the different types of technologies out there, and being able to make an informed choice on that. When we think about insulin pumps and smart pumps, which are pumps that can do things like calculate insulin doses based on carbohydrate ratios or correction factors and keep track of active insulin time, that’s another benefit that we didn’t talk about. This avoids the phenomenon of stacking insulin where that glucose is high, and a person has the urge to keep giving more. Pumps help to prevent that too because they keep track of how much insulin is working, so a person can make an informed decision if they need to take more insulin or not.

We essentially have 3 main pumps. One is the Omnipod pump, and that is considered a patch pump or a pod. It does not have tubing, and it is controlled through something called a PDM [personal diabetes manager], which is where a person would be able to calculate their insulin doses. We then have the Tandem insulin pump, which is a tubed pump. It has a touch screen, and that has potential integration with the Dexcom CGM and that also has the smart technology to be able to calculate the doses and keep track of active insulin. We then have Medtronic. The 630G in particular has FDA approval for people with type 2 diabetes. That is integrated with Medtronic’s Guardian 3 Sensor with their CGM and has the ability to be able to suspend insulin based on a certain glucose threshold if it’s combined with that sensor. For example, if someone is low, they set it for 70 mg/dL. If they reach that, the insulin will stop that infusion to prevent worsening hypoglycemia.

**PATEL:** With that feature, I can see how that provides comfort for not only the patient but also the extended care team, in this case a parent or a loved one. Diana, I want to go back to a point you mentioned about connectivity. Can you unpack the 630G?

**ISAACS:** One thing I also didn’t say is that with all these pumps, the amazingness is that you can download the data and see what the person is doing. It’s unlike with typical injections where you have no information, and you’re just asking a person, “How many doses do you think you missed?” I can’t tell you how many of my patients have said to me, “I wasn’t sure if I took my mealtime insulin, so I wasn’t sure if I should take it and risk double dosing or if I should just miss it.” What’s great about having an insulin pump is that you can look in the history and see whether the person took the dose. As a clinician, we can download that data, and we can tell how the glucose varied according to the amount of insulin the person was getting. We’re seeing what their breakdown is between that basal insulin, that background insulin, and the bolus insulin doses that they’re given.

To talk specifically about the 630G, when a person is wearing the sensor, the CGM, the Medtronic, is a 7-day sensor wear, and they’re wearing their pump, so they’re communicating directly with each other. A person on their pump can see those CGM readings. It’s certainly easier in terms of bolus insulin dosing for meals because you know exactly what the glucose is. You can use that in those calculations. The other key features are getting those alerts. You can customize it to a certain low or high level to know when that’s happening and be able to take action. That low threshold is really key, and it can be customized. Some people may want to set that at 80 or 90 mg/dL, so they’re alerted to it early and try to minimize. What we’ve seen in practice is that this is groundbreaking in terms of being able to reduce hypoglycemia and be much safer for our patients.

**Technology benefits**

**PATEL:** What happens once a patient is on a pump? What are you doing with the software,
“Certainly an insulin pump could be a good option, but some people have false ideas about it, and one can be let’s just set it and forget it. So we want to make sure she really understands what an insulin pump is and what she would still need to do.”

**ISAACS:** We’re trying to optimize virtual care. Many times, we will bring patients in face-to-face for that initial training and then do the follow-up virtually. We have some patients who even opt to do that initial training virtually, so even that is sometimes done virtually on a case-by-case basis.

There are typically two ways to download data. One is directly downloading it, depending on the device, through either plugging it in or via Bluetooth. What is expanding and is exciting is the use of mobile apps with smartphones. Through Bluetooth connectivity, the data download seamlessly and go to a portal that we clinicians then go into. Our patients’ data are already there because they’re uploading every day through Bluetooth.

**BUSCH:** With the connected pumps with the automatic shutoff, patients who have had nocturnal hypoglycemia in the past were gun shy in trying to optimize their morning reading. Now with that extra security or extra Guardian technique that they have with the automatic shutoff, they can be more aggressive knowing that’s there. That’s a big deal because once someone gets severe hypoglycemia, they’re gun shy, and all the A1C levels will be over 8% for quite a while afterward. Getting them back to control knowing they have that security blanket is important.

**BRUNTON:** I find it empowering for patients because they can take control of their diabetes rather than let their diabetes control them. When you can, if you’re going to have pizza, especially with kids who want to have a pizza party, they can make the appropriate adjustment, so they’re not going to be high and then low. This gives the person a much greater understanding of what their diabetes is and what they can do to manage it. That is very exciting.

**BUSCH:** You’re restoring normal physiology to them. One of my partners called it designer bolus insulin. You’re calling it the extended bolus insulin, but it’s a designer bolus insulin. She customized it for the patient. They love it. They’d come back to me saying, “I extend the bolus insulin when I have pizza, and I do this for other things.” It normalized their life again, which they haven’t had for a while with standard basal bolus insulin therapy. It is also for the patient who is on a basal insulin, but they’re bottoming out at certain times, or even giving a variety of basal insulin doses during the day rather than fixing it and using their basal insulin to tune up their morning. They could have a variety of basal insulins, and that is a big deal as well, aside from the designer bolus insulins.

**ISAACS:** You made a good point about restoring the normal physiology. When we just use a long-acting insulin, we’re assuming that a person needs the exact same amount of background insulin at every hour, every minute of the day. That’s not true physiology. People need different amounts. In the afternoon, they may need a little less, and before waking up, they may need a bit more. With the pump, we can...
customise it. We can break it down to every hour, but we can customise those settings.

BRUNTON: It’s an exciting time to be managing diabetes. For us to be able to talk about what we have, in terms of not just different therapies and the pathophysiology but also the different technology trying to add normalcy to a person’s life. It’s miraculous. When Bob and I were first managing diabetes, you had to look for the ants on the wall for the sugar in the urine, but compared with now, we’ve come a long way.

ISAACS: I totally agree. I tell anyone who has diabetes, “This is the best time in the world to get diabetes if you have to get diabetes.” With where technology is going too, with more integration with CGM [continuous glucose monitoring] and automated insulin dosing with hybrid closed loops, it’s very exciting. The advances are coming quickly.

ISAACS: I’ve been using InPen for a while. They were previously owned by Companion Medical, and it is now part of Medtronic’s portfolio. It’s great because it helps people calculate doses, and its records doses for people who are on multiple daily injections. There’s a smart app that is connected to the smart pen, and within that app, you can customise the settings. This is meant for mealtime, rapid-acting insulin. It can be used with Humalog [insulin lispro], NovoLog [insulin aspart], or Fiasp [insulin aspart]. You can customise the app for carbohydrate counting, mealtime estimates, or to set doses. All that can be decided upon. Similar to an insulin pump, it keeps track of active insulin, meaning if a person recently gave an insulin injection, it tracks that. So, if they want to give more, it’s going to say, “Wait. It’s too early to give more.” The neat thing about it is that, when you give the injection through the pen, the app knows. It knows how much you gave. If it recommended that you give 8 units, and you only gave 6 units, it knows and it’s going to show up on that report. You know what else it knows? It even knows the priming doses. We recommend that patients do a two-unit priming dose before their injections. It knows if that was given, and it knows that it wasn’t part of the regular dose.

PATEL: Where was this when we were looking for that lie detector test when we were asking the same question to our patients 2 or 3 different ways to see if we would get a different answer? You now have a source of truth.

ISAACS: You have a source of truth. It’s good truth for clinicians, and its good truth for patients because in that scenario where they say, “I don’t know if I gave my dose or not,” they can look in their app and see whether they give their dose or did they not give their dose. There are other neat features too. There is a temperature sensor. We know that if insulin gets too hot, it can spoil the insulin. Speaking of lie detectors, it keeps track of whether 28 days have passed, and the insulin has expired. It knows, and it will alert the person. It’s got all these cool features. The reports that it creates are also similar to what we see with insulin pump reports where we get a breakdown of the person’s basal insulin and their bolus insulin. You can see when

“So even though the GLP class has not been studied with pancreatitis, if the cause of pancreatitis is no longer there, I’ve used GLP cautiously in those patients, along with cleaning up their diet and exercise.”

Smart Insulin Pens

PATEL: One thing I’m excited about is smart insulin pens. As many of you know, InPen is the only FDA-cleared smart insulin pen system on the market. Diana, you and I have published a lot on this. Can you walk us through what it is?
they gave their doses. It can be paired with blood glucose monitoring or continuous glucose monitoring. One of the neat things about Medtronic acquiring the InPen is that it’s now compatible with the Guardian Connect CGM. The app updates in real time.

**Introducing Diabetes Technology to Patients**

**Patel:** How do you introduce all this technology to patients?

**Isaacs:** The basics are key. If I have someone who is new and just diagnosed with diabetes, it’s not that I’m trying to get them on all this right away. I like to plant the seed, so I want to make sure the education about the basics is there for things like glucose monitoring and treatment of hypoglycemia, so they understand how to administer the medications and when to take them. I plant the seed. I say, “There are these different types of technologies out there. Just so you know, they’re available, and they are things you can look more into.”

For many of my patients, it has been a natural progression to start with InPen and then go to an insulin pump, but it goes all different ways. Some people go straight to the insulin pump. There are certainly some advantages of the insulin pump over the smart pen in that you’re not having to put that needle in. It’s always on you. With that insulin pump, I big difference is that the insulin pump is serving as both the background and the bolus insulin vs the pen, which you still have to give a long-acting injection with. That’s one of the key differences.

**Patel:** We have a lot of technology options. Let’s give the patient choices and have a shared decision-making conversation. With anything we can do to chip away at that diabetes burden that’s on them and shift it to the device, they’re going to be that much happier and better off.

**A Diabetes Clinical Scenario**

**Patel:** Let’s introduce our scenario. The patient we’re discussing today is a 62-year-old American woman of Mexican heritage. She has a past medical history of obesity, a 16-year history of Type 2 diabetes and presents in your clinic for a follow-up visit with a complaint of elevated blood glucose levels.

Her past medical history: In addition to Type 2 diabetes, the patient has hypertension and dyslipidemia. Luckily, those are both adequately controlled at the moment. She is mindful of her complications. She’s getting her screenings on a regular basis, including eye exams, foot exams and kidney screenings. Her eGFR (estimated glomerular filtration rate) is under a good number right now — it’s greater than 90. And her diabetes is currently being treated by a sulfonylurea, so she’s on glimepiride 2 mg qd, metformin 500 mg twice per day and 45 units of basal insulin. She does have a history of pancreatitis.

She is married with one child. She works full time for an insurance company, consumes maybe one to two alcoholic drinks a week. She has a pretty hectic schedule, and it prevents her from regular exercise.

Here are some details on the physical exam, as well as some pertinent labs. Patient is overweight with a BMI (body mass index) of 35, and (hemoglobin) A1C is 9.2. Fasting blood glucose is about 180. These results are from February 2019.

A little bit about her medications and the current therapy that she’s on: She’s covered with a statin. She’s got an ACE (angiotensin-converting enzyme) inhibitor on board from a diabetes medication standpoint, and like I mentioned, 500 mg twice a day of metformin, 2 mg of glimepiride and 45 units of basal insulin. She takes a multivitamin. Once she was started on that basal insulin, she was eventually added and titrated on to bolus insulin, so she is on 15 units of bolus insulin three times a day.

So you have this patient who’s on multiple daily injections. Her A1C has improved after the addition of the bolus insulin and is currently at 8.7. She’s feeling well. Her A1C has improved a little bit, but she tells you she’s missing bolus insulin doses quite often. She takes them later because her schedule is hectic. She comes in and says, “What can you do to help me with this? I want to do better. Is there something that I can do?” And she asks, “What about an insulin pump?”

**Brunton:** Starting off this, there are a number of issues. If you have a patient who’s uncontrolled like that, the first thing is to ask them
what’s going on. What can we change about your lifestyle so this doesn’t happen?

The other thing I’d really want to know about is hypoglycemia. She’s getting low, so she’s eating a lot more to compensate for that, and that often can result in untoward A1Cs. She’s on a sulfonylurea, which makes it more likely that she is going to have hypoglycemia. So be thinking about that.

The other thing is, I’d try to maximize the metformin. She’s on 1 gram per day, and I would like to get it maximized to 2 grams per day. Then the issue is talking about some of her adherence challenges. So what is it about her lifestyle that’s creating those? She would be an appropriate person to consider having work with a diabetes educator because the issue may be food choice as well.

I work with a large Mexican American population, and I work with two Hispanic physician assistants — and they call it tortilla poisoning. We have to develop a diet that’s going to work for them, so a dietitian will be good, along with the diabetes educator. Then I think we can discuss with the patient the potential appropriateness of an insulin pump.

**BUSCH:** She has pancreatitis, so that throws out our good classes of drugs — GLP-1 (glucagon-like peptide 1) or DPP-4 (dipeptidyl peptidase 4). What was the cause of her pancreatitis? Did she have her gallbladder out, and there were gall stones? Did she drink alcohol, and she doesn’t drink anymore? Were her triglycerides way high, and now her triglyceride level is normal?

So even though the GLP class has not been studied with pancreatitis, if the cause of pancreatitis is no longer there, I’ve used GLP cautiously in those patients, along with cleaning up their diet and exercise and all that. And she hasn’t been on an SGLT2 (sodium-glucose cotransporter 2). You’re not going to get her to goal by just adding an SGLT2 when she’s in the 9 range on A1C and she’s already on insulin. But that may help. She has hypertension and she’s obese, so that’s something I would use unless she’s had yeast infections and comes to me on an antibiotic. So we still have some other stuff we could do. I don’t know if I’d jump in with a glitazone. She needs some tuning up of her diabetes and lifestyle.

**PATEL:** So here we’re just assuming the patient is on basal bolus, but that point you make about the SGLT2. I think digging a little bit more to see if there is actually a reason and some of the points that you highlighted. But at first glance, the patient’s eGFR seems fine, which sometimes is a reason that our patients are excluded on that, but that’s certainly a great point.

**ISAACS:** I would want to explore missing the insulin doses. I completely agree with evaluating the other medications as well as the referral for dietitian and diabetes education specialist. But also I want to make sure she has the right understanding and expectations about an insulin pump. Certainly an insulin pump could be a good option, but some people have false ideas about it, and one can be let’s just set it and forget it. So we want to make sure she really understands what an insulin pump is and what she would still need to do. And so I would want to explore a little more ... the reason for not bolusing to make sure a pump is going to be the right fit for her.

**BRUNTON:** And she may have some concerns about insulin. I see that a lot in my patient population, that they “agree” to go on it, but they try to minimize using it as much as possible. With her being on triple bolus therapy as well, something doesn’t fit, and we do need to penetrate further into what some of her considerations might be.

**PATEL:** Let’s unpack that one a bit. When we’re talking about reasons these patients are on multiple daily injections, what are some things you see that lead to, for example, not reaching the A1C goal? What are some things that you’re seeing or things that you’re suspecting?

**ISAACS:** One big thing that we see is just the inconvenience of taking the insulin, and so that’s a huge barrier. With CGM, what we see in those situations are large postprandial glucose spikes. Some of these patients are over-basaled, so what you see are these big drops. Sometimes there’s hypoglycemia. You can’t go up any more on the basal insulin, but there are these very large hyperglycemia spikes happening at mealtimes or anytime they’re eating a meal or snack. And it’s clear
Stephen A. Brunton, M.D., FAAFP

“This is really where the CGM can be a game changer for us as clinicians to review their profiles but also for the patients to be educated about what they’re doing in their lifestyle.”

that they need those bolus injections.

BRUNTON: This is really where the CGM can be a game changer for us as clinicians to review their profiles but also for the patients to be educated about what they’re doing in their lifestyle, particularly their diet, that’s causing those elevations. Because if they’re measuring their blood sugar — a lot of patients do a basal glucose and that’s it — being able to see what they’re doing provides some unique opportunities, particularly if they’re also keeping a diary. You can work with the patient in terms of counseling them and what can be done differently. That in and of itself often will get a patient back to normal.

BUSCH: Right. If she went to an educator, cleaned up her diet and had a CGM on and sees what the different foods are doing, that can have a dramatic effect on her A1C and normalizing her sugar by maybe just taking enough basal and eating properly, She can jump-start her pancreas by taking away glucose toxicity.

PATEL: Absolutely. We know that behavior and lifestyle component changes to any kind of condition, specifically with diabetes, can have a tremendous impact. So I think those are things that we should definitely suggest.

Now let’s say we’ve done those. We’ve had some success — probably not to an A1C level that Dr. Busch is going to want his patients at — but the patient now needs an insulin pump. Dr. Isaacs, what tool would you pull out of the toolbox as you consider selecting an insulin pump?

ISAACS: I’ve got demos at my site, and I love to just break everything out and show people so they can put their hands on it, see what the menus are like and play around with it… And they can see where it would go on their body, what the actual size of it is and just really see it and feel it for themselves to see how they like it. For a lot of people, they are surprised that it’s smaller than they realized.

So I would share that information and also manage other expectations, which are that every three days, you need to fill it up with insulin and that you do still need, when you’re getting ready to eat, to enter in your carbs. Ideally, with our current insulins and how they work, it is ideal to pre-bolus and do it before you eat. So there is still that education.

One of the nice things with pumps is you can set reminders. So if a person forgets to bolus, you could set an alarm to remind them to do it at certain times of the day. One of the features I really like is when we have that CGM integration. A lot of people have their fear of hypoglycemia, and that is something I would explore with her: Is that sometimes a barrier to taking the insulin? Maybe those 15 units are too much. Maybe she’s given herself the 15 units and dropped really low, and now she’s worried about doing that again. And so that’s where a feature like CGM could really be very beneficial.”
Prepare your practice for a private equity transaction

by Daniel B. Frier, Esq. Contributing author

If you knew you would be engaged in a future physical altercation, you would be best served by getting into shape and learning how to defend yourself well in advance. Even if the altercation never occurred, you would greatly benefit from the exercise and training involved in preparation. The same principle holds true when a medical practice prepares for a PE transaction.

Preparing for a PE transaction can help strengthen your practice’s business structure, even if you ultimately forgo potential PE opportunities. PE funds look for certain characteristics in target practices that maximize the potential for the practice to generate EBIDTA (earnings before interest, depreciation, taxes and amortization), which is essentially a fancy term for profits. If you follow the model of an ideal PE target practice, you will be in the best position to maximize your opportunity for success.

This article addresses five key areas in preparing for a PE transaction:

- Comply with regulations
- Maximize EBIDTA
- Focus on infrastructure
- Know your data
- Revisit corporate/LLC documents

Focusing on these areas will improve your practice whether or not you intend to enter into a PE transaction.

Comply with regulations

PE funds seek investments that maximize profits and minimize risk. A very profitable target practice engaged in questionable regulatory behavior may be viewed less favorably than one that is not as profitable but squeaky clean. Potential recoupment actions by payers, along with possible federal or state government investigations, jeopardize a practice’s stability and future profitability. A practice anticipating a PE transaction should take basic steps to ensure regulatory compliance.

One step is to retain a third-party coding compliance...
Maximizing your practice’s profitability or EBIDTA may seem obvious, but it is often approached in only one direction — working harder and increasing billings. Most PE transactions involve a payment based on some multiple of EBIDTA. If the PE firm pays seven times EBIDTA, every additional $100 of profit yields an incremental $700 in purchase price.

Cutting unnecessary costs has a direct, undiluted effect on a practice’s bottom line. Contact your medical malpractice broker and other insurance broker to see about lowering your premiums. Negotiate with your landlord — COVID-19 has placed pressure on landlords to reduce rent. Review your vendor agreements and try to shave a few percentage points. Review your health insurance and employee benefits plans to maximize benefits while minimizing cost.

Obviously, cutting costs will only go so far, so your focus should also be on changes that increase revenue. Review coding practices to see whether you are being overly conservative. Consider adding ancillary services such as specialty services, laboratory, imaging and in-office procedures. Evaluate whether bringing on an associate will increase the practice’s profitability.

Physicians and midlevel providers should spend as much time as possible performing billable work. Time spent by providers on administrative functions reduces profitability. Look for ways to optimize provider time.

Another critical step in achieving regulatory compliance is to conduct a legal review of the practice’s business relationships. Sublease arrangements can be particularly risky if they are entered into with referral sources or recipients. Contracts with marketing companies or other third-party suppliers of health care services to the practice should also be analyzed. For instance, we have seen many internet marketing services whose compensation structure is tantamount to an illegal kickback scheme. Additionally, there are many providers of services such as mobile imaging and in-office infusion that may, often unwittingly, run afoul of the Office of Inspector General’s suspect joint venture fraud alert. The practice’s performance of in-office services such as physical therapy and laboratory should also be reviewed for compliance with the federal Stark law.

Maximize EBIDTA

Infrastructure consists of staffing, physical plant/equipment and processes. Practice leases should be reviewed and extended, unless the practice intends to move. Equipment should be reviewed to ensure that it is up-to-date and properly maintained. The practice should determine whether the best people are in the right positions, whether it is overstaffed or understaffed and whether the employee manual is current.

The practice should review information technology hardware and software systems, update, upgrade or replace as needed, confirm that it has all necessary software licenses and ensure workers are properly trained on the latest software. If all software user knowledge resides in a single employee, start training at least one other to create redundancy.
“Preparing for a PE transaction can help strengthen your practice’s business structure, even if you ultimately forgo potential PE opportunities.”

Most medical practices have not reviewed their corporate documents in years, sometimes decades. This is a mistake that can cause shareholder disputes and dissuade potential PE suiters. Ownership documents should be reviewed approximately every three to five years. For professional corporations, this means reviewing the shareholders’ agreement, bylaws and shareholders’ employment agreements.

For limited liability companies, this means reviewing the operating agreement. Issues such as management decisions, retirement buyout formulas, termination provisions, restrictive covenants (such as noncompetes), shareholder/owner compensation and distribution formulas for a capital transaction (such as a sale event) should all be carefully reviewed and discussed with experienced legal counsel.

The following are some issues that warrant consideration:

- Do the practice’s voting requirements make it difficult for the practice to effect needed change? Can a single owner veto the will of the majority?
- Does the buyout formula for a retired owner fairly compensate the retiree without overly burdening the practice?
- Is there a noncompete that prohibits a retiree from taking practice patients, opening an office next door and harming the practice? Is the retirement buyout still payable if the retiree competes?
- Are owners fairly compensated for the professional and administrative services they perform?
- Are owners responsible for recoupment actions by third-party payers related to their coding and billing practices?
- Are the company documents clear about how proceeds will be distributed in the event of a sale?
- Are the documents clear about how much notice must be given by a retiring owner, whether that owner can enter a wind-down phase prior to retirement and, if so, what that means in terms of voting rights, etc.?

The above process will likely take several months and require several consultants, including legal, accounting and coding issues. At the end of the process, not only will your practice experience noticeable improvements, but it will position itself to maximize its value to third parties, including PE funds, hospitals and other large practices looking to expand.

Daniel B. Frier, Esq., is cofounder of Frier Levitt, LLC. Send your financial questions to medec@mjhiflsciences.com.

Health care delivery and payment models are increasingly data driven. Practices that understand their data are in a better position to maximize productivity, improve patient care and reduce overall cost of care delivered to patients. Payers have access to claims data but limited access to clinical data. Medical practices have access to both. Frier Levitt works with a number of vendors who can help practices establish a data warehouse consisting of clinical data pulled directly from patient records. We believe that establishing a data warehouse will, if not immediately, at least put practices in a position to better negotiate value-based contracts with third-party payers because they will know how their own practice performs better than the payers do.

Know your data

Revisit corporate/LLC documents
Put lenders to the test: Before taking out a loan, ask these 8 essential questions

Taki ng out a loan is a major financial decision. Whether you own a medical business or are an employed physician, you may need financing for continuing education courses, investing in technology and equipment, funding new initiatives or growth and expansion. Not all lenders or loans are created equal. Asking the right questions in advance can help you find the best solution.

What type of rate do you offer?
Loans will have either a fixed rate or variable rate. This dictates whether the rate will stay consistent for its entire term or will fluctuate based on market conditions. With a fixed rate, you will always know what your interest costs will be, making your payments and monthly budget more predictable.

Do you require personal collateral?
One of the biggest disadvantages with many loans is that they can be challenging to obtain unless you have valuable collateral. Although some lenders require it, others do not, enabling you to safeguard what you own. You worked incredibly hard to acquire your assets — are you really willing to risk them?

Will this loan show up on my credit report?
Applying for a loan could put your credit score at risk. During the application process, some lenders will do a hard credit pull, which provides a full report of your credit history and credit score. This type of inquiry can hurt your credit score and stay on your report for up to two years. Other lenders perform a soft credit pull, which neither affects your credit score nor ends up on your report.

How soon do you make approval decisions?
Establishing the approval timeline can help you anticipate whether the process will take days, weeks or months. This is critical if you urgently need funds.

Do you have experience working with others in my industry?
Physicians have unique needs, so partnering with a lender experienced in the industry matters. Some lenders have a process that does not differentiate a physician from any other borrower, whereas others specialize in working with physicians or with customers whose profiles are similar. Each lender or loan is different. Understanding the fundamental components can help you confidently evaluate loan quality and overall experience. By examining a lender’s expectations about timelines, deliverables and expertise, you will decrease the risk of surprises.

How quickly do you fund upon approval?
Some lenders can take weeks or months to deposit funds into your account after loan approval, whereas others can do so in days. If you need funds by a certain time, ensure the lender’s timeline aligns with yours.

How long do I have to repay what I owe?
The length of your loan dictates how much you will pay each month. Longer terms typically mean your monthly payment will be lower and more manageable. If you need more monthly cash flow, look for a loan that offers longer payback terms.

What is your application process?
As a physician, you deal with a large amount of paperwork. Your time is valuable, so find out how much may be required for the application process. Knowing in advance what paperwork you need to provide can help you estimate the time you will need to commit.

Chris Panebianco is chief marketing officer for Bankers Healthcare Group, a provider of financial solutions for physicians. Send your questions to mjhlifesciences.com.
The last year has been one of the most difficult in history for the physicians and staff of our nation’s medical practices. The COVID-19 pandemic has reportedly put strain on practice finances, led to staffing cuts and furloughs, and other challenges.

We wanted to gather insights on the way the pandemic has impacted practice finances and staffing, so Medical Economics® teamed up with our sister brand, Physicians Practice®, to conduct a survey to ask our physician audiences to explain the impact. Here’s our exclusive survey results.
How would you rate your staffing level before the COVID-19 pandemic?

- Understaffed: 16%
- Adequate: 78%
- Overstaffed: 7%

How has the COVID-19 pandemic affected the level of staff at your practice?

- Reduced staff: 32%
- No change: 60%
- Increased staff: 8%

Did your practice apply for government assistance through the Paycheck Protection Program (PPP) or other similar program to keep employees on the payroll?

- Yes: 78%
- No: 16%
- Not sure: 7%

If you have reduced staff since the COVID-19 pandemic, what method did you use?

- Employees were laid off: 32%

If you practice applied for a PPP loan or other assistance, did you receive assistance?

- Yes: 76%
- No: 13%
- Not sure: 11%

Please specify how your staffing level has changed by position as a result of the COVID-19 pandemic.

- Increased
- Decreased
- Stayed the same

- Physicians: 86%
- Non-physician providers (NPs, PAs): 79%
- Nurses (RNs, LPNs): 80%
- Medical assistants: 65%
- Front-desk staff: 68%
- Billers/Coders: 88%
MONEY / STAFF SALARY SURVEY

Has your practice given raises in the past 2 years?

- Yes: 79%
- No: 17%
- Unsure: 4%

Does your practice plan to give merit or performance-based raises this year?

- Yes: 39%
- No: 33%
- Unsure: 28%

Does your practice plan to give cost of living raises this year?

- Yes: 23%
- No: 43%
- Unsure: 35%

If not, why?

- COVID-19 pandemic has hurt us financially: 45%
- Decreasing reimbursements by payers and patients: 24%
- Uncertainty about the economy: 15%
- Other practice necessities: 2%
- Office investments, (e.g., equipment purchase, renovation, expansion): 1%
- Technology investments, (e.g., software, technology, EHRs): 1%
- Current political climate: 1%
- Other: 11%

Of physicians say they have not given their practice staff raises because of the economic effects of the COVID-19 pandemic.
Where is your practice located?

- Northeast: 14%
- Midwest: 21%
- West: 19%
- South: 46%

What is your specialty?

- Family medicine / family practice: 28.7%
- Pediatrics: 15.8%
- Internal Medicine: 9.3%
- Obstetrics & gynecology: 8.6%
- Psychiatry: 3.4%
- Dermatology: 2.7%
- Neurology: 2.4%
- Emergency medicine: .7%
- Urology: .7%
- Cardiology: .4%
- Anesthesiology: .3%
- Other: 28%

What is the primary reimbursement method at your practice?

- Traditional fee for service: 71% (accepts insurance)
- Both FFS and value-based reimbursement: 20%
- Direct pay / cash only: 4% (patients pay out-of-pocket for service)
- Value-based reimbursement: 1%
- Concierge / membership: 1% (patients pay an additional fee for concierge)
- Other: 3%
Addressing patient health literacy

How primary care physicians can help

by Lisa A. Eramo, M.A. Contributing Author

Physicians can create a treatment plan, but if patients do not understand the what, why and how, they may not be able to adhere, says Natalia Southerland, MD, a family medicine specialist in Waxahachie, Texas. Southerland, who is also a certified personal trainer and health coach, strives to ensure patients are health literate, meaning they can find, understand and use information to make appropriate health decisions.

Addressing health literacy does not necessarily require much of Southerland’s time or effort. For example, she frequently gives patients educational materials and handouts, explaining the information as succinctly as possible. This includes handouts she has created as well as those from organizations like the National Lipid Association.

“I consider myself an educator,” she says. “If I provide information, teach patients how to find credible information and make sure they understand and know how to use that information, they will become independent health care consumers who can take control of their own health.”

Health literacy is also associated with significant cost savings. Improving health literacy for Medicare beneficiaries alone could prevent nearly 1 million hospital visits and save the health care system more than $25 billion annually, according to recent data published by UnitedHealth Group (UHG).

That is because patients who follow treatment plans, take medications correctly, complete needed screenings and receive recommended care are more likely to achieve their best health, says Anne Docimo, MD, chief medical officer at UnitedHealthcare, where she is responsible for the clinical, cost and experience outcomes of more than 50 million members in the company’s commercial, Medicare and Medicaid health plans.

“The extent of limited health literacy is not generally recognized,” says Cindy Brach, M.P.P., senior health care researcher at the Agency for Healthcare Research and Quality’s (AHRQ) Center for Evidence and Practice Improvement and co-chair of the U.S. Department of Health & Human Services Health Literacy Workgroup.

“Limited personal health literacy, which affects more than a third of adults in the United States, is associated with lower receipt of preventive services, poorer ability to demonstrate taking medications appropriately, poorer ability to interpret health messages, greater hospital and emergency care use and, among seniors, poorer overall health status and higher mortality.”

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PATIENT HEALTH LITERACY / PRACTICE MANAGEMENT

Tips for clear communication

Use plain language
“Medicine is a really difficult language with a lot of unfamiliar terms,” says Docimo. “It’s important to simplify. For example, instead of saying ‘hypertension,’ use ‘high blood pressure.’ Or instead of ‘hyperglycemia,’ use ‘high blood sugar.’” Physicians can also direct patients to UHG’s free glossary of thousands of health care terms defined in plain, clear language. The glossary is available in English, Spanish and Portuguese.

Use a team approach to patient education
Train staff to reinforce the care plan and answer patients’ questions, says Docimo. “The whole team needs to help the patient be compliant with what can be a complicated, multistep care plan,” she adds.

Carly Hood-Ronick, M.P.A., M.P.H., an expert on health equity, agrees. “Often a social worker or medical assistant has more time than the physician to sit down with the patient and provide education,” she says.

Use video and other visuals to support patient understanding
“There are simple ways to show the patient and family what’s going on,” says Hydok. For example, physicians can draw a picture, use a model or show an illustration or video online.

Use the teach-back method
For example, Docimo says physicians can say: “I know this is a new diagnosis for you, and I want to make sure you understand all the details. In your own words, can you tell me about your condition and treatment plan?”

Speak slowly
Organize information so the most important details come first and pause to allow patients to digest what you said, says Maureen Hydok, MBA, RN, senior director at Huron, a consulting group.

Provide educational materials
For example, physicians can download and print or provide online links to educational materials from the American Diabetes Association, American Hospital Association, American Cancer Association and other reputable organizations that publish patient-friendly brochures and fact sheets. In addition, many specialty societies publish pamphlets for common conditions, and these materials are available in multiple languages.

Ask patients to read these materials, make a list of questions and schedule a follow-up appointment, says Hydok.

Address language differences
“Assuming that everyone speaks or understands English is not appropriate and not effective,” says Ronick. Instead, ask patients what language they prefer to speak and read, and whether they would like an interpreter. Plan for interpreter services in advance. Consider scheduling appointments on specific days or times when appropriate interpreter services are available — for example, Spanish interpreters available Thursdays from 1 to 5 p.m.

Also try to match patients with qualified bilingual clinicians or staff members, if possible. For example, Hydok worked with one clinic that scheduled patients of a particular ethnic background on days when a culturally informed medical assistant was working. “You really need to understand a person’s culture and be able to communicate with them in a way they’ll understand so you can get them to change,” she adds.
What is important for physicians to remember, Docimo says, is that health literacy is not only about a static population, such as individuals for whom English is a second language. Someone with relatively high health literacy could face challenges when trying to understand a new diagnosis, she adds.

It is also important for physicians to realize that unlike other social determinants of health such as food or housing insecurity — solutions that require significant investment and partnership with other organizations — they and their staff can improve health literacy using simple strategies, says Brach.

**Telehealth and health literacy**

Experts agree that telehealth presents opportunities to improve health literacy. “The access alone can improve it because you don’t have barriers related to transportation and physically getting from your home to the doctor’s office,” says Docimo. Physicians can also use visual aids just as they would in person, she adds.

“In this day and age when everyone wears a mask, it’s almost easier to do a telemedicine appointment because you can see the patient’s facial expression,” says Hydok. “Sometimes you even get a glimpse of the patient’s home — and that can give you more information.” For example, a physician can ask patients to show where they keep their medication. If they see unrefrigerated insulin on the counter next to various pill bottles, they know there has been a communication breakdown.

**Health literacy and COVID-19**

Populations struggling with health literacy before COVID-19 will struggle during the pandemic, says Southerland, who tries to stave off misinformation by providing patients with links to credible websites such as the Centers for Disease Control and Prevention. She also curates some of that information herself so patients do not become overwhelmed by the volume of content available. For example, she compiles answers to questions her patients ask most frequently (such as “If I’m exposed, do I need to get a test?” or “When can I go back to work after testing positive?”) and then sends mass communications through the portal to educate patients.

“There’s going to be a need for coordinating care, educating patients and staying on it to make sure they complete the series of two vaccines — the initial one and the booster,” says Docimo.

This is especially true for patients with low health literacy who are part of diverse communities, says Ronick. “Many populations in the U.S. today speak different languages at home and have different cultural practices than the dominant White culture,” she says. “As we look at administering the COVID-19 vaccine, we won’t be successful unless we address potential cultural barriers.”
Improve senior patient communication with technology

We know relationship building is critical to improving patient outcomes, and strong communication is especially important. Good communication can result not only in more efficient, effective care, but also greater patient satisfaction with treatment, and this is particularly true with aging patients.

Although the manner in which physicians communicate with patients is incredibly important for better outcomes, the means by which they do so also have a big impact on care. One of the primary ways provider-patient communication has evolved, particularly this past year as a result of COVID-19, is through the rise of technology-driven communications, specifically virtual care and telehealth.

Many may argue that virtual care and telehealth will never fully replace in-person care for seniors, and research shows that is likely true even after increased adoption during the pandemic. According to a June 2020 survey of adults 50 to 80 years old by the University of Michigan, more than 50% of respondents still perceive office visits as providing higher overall quality of care, and barriers to adoption and accessibility of technology remain for many seniors. Even if they do not become the primary sources of health care for seniors in the immediate future, telehealth is providing an opportunity to improve communications to meet the needs of this rapidly growing patient population.

Filling the gaps in care
An obvious way technology can improve patient communication is by making it more accessible. Physicians can meet in person with a limited number of patients each day, and many seniors face transportation challenges. Telemedicine in the form of traditional, video-enabled primary care doctor visits alleviates many of those challenges and makes it easier for patients to connect with physicians or support staff between appointments. According to the same University of Michigan poll, 72% of respondents expressed interest in using telemedicine for follow-up questions with a doctor they had already seen. Offering telemedicine as a supplemental method of communication with patients helps open more channels of communication throughout the care journey.

Enlisting support
Another benefit of virtual communication is its ability to drive better care plan adoption among patients. For example, a study looked at patients’ understanding of newly prescribed medications after hospital discharge. It found that although 86% of patients were aware they had been prescribed new medications, only 64% could identify the name of the medication and merely 11% could recall being told of potential adverse effects. Digital communication can better ensure patient adherence through increased follow-ups, whether through physicians and support staff personally checking on a patient’s status or automated call or text messages about medication reminders or lifestyle changes. Increased engagement can also enable providers and patients to bring more stakeholders into the conversation, including family members or caretakers.

Real-time window
One of the most significant advantages to virtual care is the real-time lens it provides into a patient’s home life and social determinants that may exist. Whether it is the clutter that may increase a patient’s risk of falling or the isolation that may negatively affect mental health, the information you can gather by connecting with a patient in their home environment can have an important impact on care plan adherence and overall health outcomes. Most importantly, these real-time insights enable providers to intervene more quickly and collaborate with other members of the patient’s care team to develop solutions before deterioration or hospitalization occur. With close to 75% of Medicare hospital readmissions being identified as preventable, the real-time insights gained from various aspects of virtual care can play an important role in necessary proactive care management.

Higher satisfaction
Many aspects of virtual care can lead patients to feel more in control of their health care journeys. Empowering patients to decide where, when and how they prefer to engage with their care team means they are more likely to have a satisfying care experience. Rest of all, increased payer reimbursement and revenue sources for telehealth means practices no longer can have greater confidence in pursuing virtual health, and reap the many benefits of virtual patient communications, a win-win for all stakeholders involved.

David Hunt is the founder at Cosán Group. Send your technology questions to medec@mjlifesciences.com.
How physicians can assist patients on proper heart health

by Keith Loria Contributing Author

The American Heart Association warns that cardiovascular disease — be it coronary heart disease, heart attack, congestive heart failure or congenital heart disease — is the leading cause of death for men and women in the United States.

Proper prevention includes not smoking, lowering cholesterol, controlling high blood pressure, maintaining healthy weight and exercising. However, many patients are not going to make these life-changing moves without some persuasion.

According to the United States Preventive Services Task Force, there is convincing evidence that counseling interventions improve blood pressure, lipid and fasting blood glucose levels, body weight/adiposity and eating habits. Improvement in these areas will strengthen heart health. Changing behavior can be difficult, so physicians must have conversations to ensure their patients stay healthy. Such relationships can help patients and providers work through health challenges and reach desired outcomes.

Nicole Harkin, M.D., FACC, founder and cardiologist at Whole Heart Cardiology in San Francisco, says up to 80% of heart disease is considered preventable, so these conversations can literally save lives. “It’s so important to talk with patients about heart disease because it is the No. 1 cause of death in the United States for both men and women,” Harkin says. “We know from studies that patients are more successful with personalized plans. Generalized health guidance is rarely successful, and most people need advice that is applicable and customizable.”

Erica Savage-Jeter, M.D., a primary care physician practicing in South Carolina and regional medical director for Partners in Primary Care, a senior-focused medical practice, notes creating dialogue with patients is vital to establishing relationships and building trust. “In my counseling, it is my goal to understand the patients’ perspective when talking about interventions that lead to proper heart health,” she says. “I need to understand their sense-making related to their health. Until patients have buy-in and feel the advice I am providing is meaningful to their health, I will have very little impact.”

David Cutler, M.D., family medicine physician in Santa Monica, California, says the keys to bringing up the topic of cardiovascular health are being a good listener, providing accurate information and making the discussion relevant to the patient. “Active listening requires putting the patient’s concerns above those of the health care provider,” he says. “Dispelling inaccurate myths is important to maintain credibility. And recognizing that the cardiovascular health needs of a 40-year-old male with a family history of premature cardiac death are different than a 90-year-old nursing home resident with dementia means a ‘one-size-fits-all’ approach to heart health will not work. Diet, medication and activity modifications must be individualized.”

When talking to patients and their families about heart health, Cutler notes it is important to spend more time listening than talking. “Only after eliciting all their health concerns, prior experiences and fears associated with treatment
and changing behaviors is it likely to achieve positive results,” he says. “A comprehensive and continuous approach to care will provide reassurance to them, and they will have a partner in the process of achieving better heart health.”

**Heart health during COVID-19**

Tiffany Sizemore, D.O., FACC, a cardiologist in Fort Lauderdale, Florida, notes heart disease was proved to be a risk factor for COVID-19, so physicians must do all they can to prevent heart disease. “Seeing that 2020 has been the year of illness, I hope that we have learned the importance of preventive health,” she says. “I encourage all my patients to know their blood pressure, know their blood sugar, know their cholesterol and take charge of their health.”

**Adverse social determinants linked to coronary heart disease**

by Grace Halsey Senior Editor

Results of a recent study suggest a simple clinical approach to assessing individuals at high risk of CHD who would benefit from targeted intervention. The study by researchers at Weill Cornell Medicine describes a correlation between the burden of adverse social determinants of health (SDH) and fatal cardiovascular disease (CVD) and non-fatal myocardial (MI) infarction. Safford and colleagues found that among adults without coronary heart disease (CHD) at baseline, a graded increase in risk for both fatal incident CHD and nonfatal MI was associated with the number of poor SDH.

Study authors note that indices reflecting social deprivation that are used for population management are difficult to operationalize in clinical care. To explore a simplified model that might be appropriate for use on an individual level, they examined whether a simple count of SDH is associated with both fatal and nonfatal coronary events.

Data were extracted from the prospective longitudinal REGARDS (REasons for Geographic And Racial Differences in Stroke) study, a national population-based sample of community-dwelling Black and white adults older than 45 years recruited from 2003-2007. There were 22,152 individuals free of CHD at baseline (58% women, 42% Black).

Seven adverse SDH were selected from the Center for Disease Control’s 5 Healthy People 2020 domains and their correlation was measured with CVD death and non-fatal MI:

- Social context (Black race, social isolation).
- Education (educational attainment).
- Economic stability (annual household income).
- Neighborhood (living in a ZIP code with high poverty).
- Health care (lacking health insurance, living in one of the nine U.S. states with the least public health infrastructure).

For patients with more than three SDHs, rates of fatal incident CHD and nonfatal MI were higher than those without SDH.

The authors conclude that a greater burden of SDH is associated with a graded increase in risk of incident CHD, with greater magnitude and independent associations for fatal incident CHD. Counting the number of SDHs could be a simple, straightforward approach easily incorporated into clinical care to identify individuals at high risk of CHD who would benefit from targeted preventive interventions.

The findings were published online December 3, 2020, in the journal *Circulation*.  

*ConsultantLive*
of their own health. Unlike many illnesses, heart disease is preventable in the vast majority of people.”

Cardiologist and internist Leonard Pianko, M.D., working in Aventura, Florida, says COVID-19 is a vascular disease, so it affects blood vessels, big and small, and it is important to remain focused on all leading causes of health impairment during the pandemic. “By cutting down on the risk factors for COVID, including losing weight, monitoring your blood pressure and cholesterol, etc., you are lowering your risk not only for COVID but also for cardiovascular disease,” he says.

Pianko notes the media has made it easy to bring up the subject with patients, who are confronted daily with sobering statistics on the number of individuals hospitalized with COVID-19 or who have died from the disease. “The COVID conversation provides an easy segue to prevention tips for heart health,” he says. “Even when the vaccine is readily available, it might be anywhere up to (a) year for us to achieve herd immunity. It is unpredictable who will have COVID as well as who will survive COVID.”

Proper health tips have not changed with COVID-19, but patients are more receptive because of ongoing concern about the disease. “My top tip for discussing proper heart health with my patients is tailoring the conversation to their specific health needs,” Pianko says. “By knowing their personal history and their family history as well, I can personalize the experience and focus specifically on those tips that will make a difference in their lives. It’s the investment of time and energy into the doctor-patient relationship which promotes success.”

**Tips for the talk**

To have dialogue with patients, Savage-Jeter says it is important to create a cadence with appointments to provide that opportunity. “Episodic care does not allow patients the occasion to spend time with their providers that may not be related to an acute issue,” she says. “Creating routine follow-up allows for discussions that are more relaxed and may not compete with pressing issues.”

She also tries to empower her patients to help them succeed. “I want my patients to understand their medical problems, learn how to manage them and avoid complications, and be aware of signs of decompensation or sequelae,” she says. “Empowering my patients will lead to overall increased satisfaction with care, improved adherence to self-management of the treatment and better clinical outcomes.”

Harkin says conversations about heart health should be as patient centered as possible, covering goals, where the patient wants to start and barriers to improving heart health. “Meeting the patient where they are at and working toward incorporating small changes within their current lifestyle are the keys to establishing long-term, sustainable habits,” she says. “I use a lot of motivational interviewing in counseling patients. I also think that focusing on small, sustained goals that are measurable by the next appointment can be great motivators.”

Sizemore says the key to bringing up heart health is to focus on what causes heart disease. “As physicians, we refer to these as modifiable and nonmodifiable risk factors,” she says. “Modifiable risk factors include things we can control, such as high blood pressure, cholesterol and blood sugar. Nonmodifiable risk factors include family history, gender and age. By addressing each risk factor individually, we can help patients to help themselves and understand what they can do on their own to prevent heart disease.” She also feels it is imperative to focus on the positive — for instance, saying things like “you have lost 10 pounds” or “you stopped smoking, good for you.”

“When we focus on the positive, we create a healthier system of reinforcement moving forward for patients,” Sizemore says. “I always tell my patients, ‘I can prescribe a medication, but I can’t make you take it.’ That is my way of saying that the patient ultimately controls their own destiny. I am always happy to and encourage patients to ask questions. I always want them to 100% understand anything that we discuss.”

More frequent appointments in the beginning stages of change are helpful, Harkin notes, and she also recommends a team approach to total heart health. “I love working with registered dieticians and health coaches who can work with the patient more frequently in moving the heart health plan forward, so I always recommend referrals for more focused counseling,” she says.

Cutler conducts yearly wellness evaluations to address obesity, high blood pressure, high cholesterol, diabetes, smoking and family history, all of which can contribute to heart health problems. “We personally notify patients of all their results and make ourselves available with follow-up appointments, virtual visits and telephone consultations to review results, answer questions and plan ongoing care,” he says. “The essence of good primary care is being accessible, comprehensive, continuous and high quality. This certainly applies to heart health, but equally to all aspects of patient care.”

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The role of technology in lipid management

by Patrick Campbell Senior Editor, Practical Cardiology®

Telehealth has advanced by leaps and bounds in the last year, as medical practices adjust to the COVID-19 pandemic. Virtual visits, remote patient monitoring (RPM), continuous glucose monitoring (CGM) and other tools are helping physicians meet their patients where they are needed.

So, what role does telehealth play in heart health, particularly lipid management? Medical Economics®, with the assistance of our partner brand at Practical Cardiology®, put together a panel of lipid management experts, to talk about the role of technology in helping patients manage their heart health. The transcript was edited for length and clarity.

Meet the panel

Guy Mintz, M.D.
board-certified lipidologist and director of cardiovascular health and lipidology at Sandra Atlas Bass Heart Hospital at North Shore University Hospital, Northwell Health

Brett Nowlan, M.D.
board-certified lipidologist and non-invasive cardiologist at a private practice in Connecticut

Lucia Novak, CRNP
board-certified nurse practitioner, co-executive director of Capital Health and Metabolic Center at Capital Diabetes and Endocrine Associates, and associate editor of the ADA’s Clinical Diabetes journal

Medical Economics® (ME): In terms of remote monitoring and telehealth, what role did it have in managing your patients with diabetes and other heart conditions? How did you use it?

Novak: It saved our practice. And it really enabled us to continue to provide the quality care our patients needed when we couldn’t have them in front of us. So, in an endocrine practice, what we are typically monitoring is glucose. And a lot of our patients now are using continuous glucose monitoring and delivering insulin via pump. And usually, the two of those are communicating. And all of this technology is available via Bluetooth into the cloud and then into the cloud into our server. And then we can access the data without the patient actually needing to be there. And having that kind of information at your fingertips allows you to make the necessary adjustments in treatment, to have those important discussions about lifestyle and everything else, especially because in the COVID-19 world, the patients who were the most hard hit with the poor outcomes were those that had pre-existing type 2 diabetes and other cardiovascular
“I think if you have (your goals) clearly in your mind when picking things like vendors and products rather than the next shiny toy ... that can be very, very helpful.”

—Brett Nowlan, M.D.

issues. And so, having the ability to manage our patients, when we could not see them directly really made a big difference. And I think it actually accentuated the importance of making sure your patients are connected in some way — that if they’re using blood pressure monitors or apps on their phones that are keeping track of sleep and activity, that we have an ability to capture that data so that we as clinicians can use that information in a positive way.

Mintz: The most important thing is staying connected with your patients. In terms of the cardiovascular arena, lifestyle modification can very easily be achieved through telemedicine. Certainly, you get to see what the patient’s eating in their house. You know, I have patients who walk around with a smartphone and show me their refrigerator, their pantry, and other things. So, you get to see what they’re doing. You get to see how they’re living, and you get to really counsel them. Certainly, in the lipid lowering world, we can achieve all this counseling through telehealth.

ME: How do you see the in-person visits and the telehealth visits complementing each other?

Nowlan: There’s no question this has been extremely helpful. If you had to pick a silver lining out the pandemic is that we had to turn on a dime and adopt this. And I know in our office, within 24 hours we were saying, ‘We need telehealth, we have to pick a service.’ And we were doing it the next day. And so, it allowed us to really turn quickly. And what’s interesting is how good it is for some things.

You mentioned lipid management, and able to see lab results, the patient sees lab results, were reviewing side-effects. You don’t need hands on — although that is nice — but you don’t need it to achieve 95% of what you’re trying to achieve there. What I’ve found is that the in-office visits and the data we’re getting is starting to homogenize with what’s happening as an outpatient. Say your blood pressure is high today. Well, I’m not going to pull the trigger and make a decision that you’re hypertensive today. Instead, we’re going to monitor your blood pressure. And you’ll get back to me and you’ll document. Why don’t we do another telehealth appointment in two weeks and you give me the numbers? And so, the two approaches are complimentary.

Mintz: It also allows a role within the practice for your allied health professionals and nurse practitioners to assist in the telehealth, telehealth world.

ME: What advice do you have for physicians trying to get started using remote patient monitoring telehealth to manage heart conditions at their practices?

Mintz: First, if you’re just starting up, you want to pick a platform that’s secure. You want to pick a platform that’s easy. You have to educate the patient how to use it. And certainly, the staff needs to be educated on how to use it.

It was many a time where my staff had set me up to do a telehealth visit, and the patients had their computer on mute. And I could see them, and they couldn’t hear me, and telehealth video conference became, let’s just talk on the phone. So, all that needs to be figured out.

The other things that we matured on as time went on — and we asked our patients about this — we realized many patients don’t have an ambulatory blood pressure cuff. And so, we recommended that they get one. I also recommend they get a pulse oximeter, so they can measure their O2 saturation and their pulse.

The other thing we recommended for certain patients that have arrhythmias or a lot of palpitations during this COVID pandemic was the cardio device, which can transmit an EKG to their smartphone and then it gets emailed to us. We also utilized home blood drawing, so patients never had to leave the house, they were comfortable with someone coming to the home. So, making a laundry list of what we needed to get patients to have at home to make our job even better.

Nowlan: I think there’s all these goals that one can achieve if you’re using remote patient monitoring. And you know, we all think about improved health outcomes. And of course, it’s very important. We want patients to have a better experience when they access us. And we want to either reduce costs or we want to improve revenue. The one aspect I think often gets ignored is we as providers should have increased satisfaction. I think it’s very important, we have to look
after ourselves in our practice, so that we are providing good care for patients. And having all of those things, including our ease of treating patients, in mind is a good thing to always have front and center when you’re deciding which avenue you’re going to go down to adopt this technology.

It’s also about starting with the end in mind. For example, in a hypothetical office, hypertension treatment is not great, we’re not getting data, we’re not sure if patients are measuring on their own. So, the end in mind is excellent blood pressure control, that’s measurable, something that we can hold patients accountable to, and that’s easy for me as a provider to employ. And I think if you have those things clearly in your mind when picking things like vendors and products rather than sort of the next shiny toy that comes to the door, that can be very, very helpful.

**Novak:** In my practice, it was about hand holding. We really tried to take the time to contact them and walk them through the steps of what they needed to do with the devices, especially our older. Just knowing where the camera was on their phone, trying to get other family involved to assist. It really does take a village.

And I think once they figured it out, they were very engaged. At first, we had a lot of patients that were like, ‘Oh, no, I’ll wait until the office is open.’ Everyone thought we were going to be closed until Easter and then we were going to beat them again. And that didn’t happen. And so, once they realized that this was it, and they were starting to get more anxious, they really wanted that connection with their health care provider, and then learned how to do it.

I will reiterate what Dr Nowlan said: it’s really important that when you are looking at using remote patient monitoring that you to make sure you carefully choose a platform that may be able to offload the burden of all of that data coming in and the requirements of how that data has to be monitored for you. That’s so you are able to get reimbursement. There are some really good platforms that have that ability to do a lot of that for you. It does not do the clinician’s work, it does not take away from what you offer your patient, but it takes away the nuts and bolts so that you can practice more effectively, and still render a profit for that extra service.

I really recommend that you look into the AMA’s playbook on RPM; they go through step-by-step recommendations on what you can do for your practice, small or large. You can apply it and figure out how it can best work for you.

**ME:** What does the future for remote patient monitoring look like for lipid management?

**Nowlan:** I think the future absolutely lives within cloud-based data analysis, with artificial intelligence, neural network style analysis, something that’s done in a very sophisticated fashion, independent of the condition, that delivers that information to the clinician in a useful fashion.

**Novak:** We definitely will see artificial intelligence and how it’s helping patients. Along those lines, computer assisted decision making for clinicians to help put all those pieces together. How do you identify risk? How do you identify therapies to best reduce that risk? All of those calculators will be put into some kind of an algorithm, maybe integrated in EHRs. And it would be great if we could have an EHR that really was universal and communicated.

“(Telehealth) saved our practice. And it really enabled us to continue to provide the quality care our patients needed when we couldn’t have them.”

—Lucia Novak, CRNP
Identity theft risk is spiking

by Ike Devji, J.D. Contributing Author

An unexpected consequence of COVID-19 is a significant rise in identity theft and related cybercrimes. Here are the most common traps to watch for and a response plan in case it happens to you or someone you know.

There has been discussion of numerous risks related to the pandemic, including the need to reexamine liability insurance coverage, the importance of effective mask-usage policies, the ways COVID threatens medical practices and how to survive its effects on your income and the economy.

One risk we anticipated, although not to the extent to which it happened, has been a spike in identity theft. The statistics are shocking. It happens every two seconds, has affected 30% of the United States population. Here’s what you need to know about these scams.

Scams Fall Into Three Major Categories

1. Getting you to reveal personal identifying information by phone, online or text message or through some other form of phishing that often imitates a vendor, bank or business.

2. Using malware to infect your computer or smartphone to get your passwords and other personal information or using ransomware to lock you out of your computers and files. This may include the use of malicious links and attachments in emails and text messages, asking you to call a fake customer service number or directing you to a fake login page where you are asked to enter or confirm your information.

3. Getting you to send money to or make purchases from organizations that are not legitimate in one or more ways.

Some COVID-19 scams

There are a variety of consumer, security and financial industry articles on this issue, but one of the most concise summaries of pandemic-specific threats I have seen and one I have saved to share with my clients is from PNC Bank. Their list includes the following:

1. **PPE and medical supply scams:** Beware of fraudulent websites offering PPE, vaccines, testing kits or other scarce supplies at prices too good to be true. In some cases, they will bill but never deliver; deliver counterfeit, expired or nonconforming goods; or simply steal the credit card information.

2. **Remote work scams:** This goes both ways, so remote workers and their employers should be vigilant about checking details like return email addresses and should verify any unfamiliar, private or new email addresses with the sender by phone before disclosing any sensitive information.

3. **Impersonation:** Scammers pretend to be a real medical or health organization while selling products that falsely claim to prevent, diagnose or treat COVID-19.

What to Do if It Happens

For most Americans, it is a now question of when, not if, identity theft will affect you, a family member or a colleague. Fortunately, the Federal Trade Commission (FTC) has a nicely designed government website that makes the identity theft reporting process simple. It provides a step-by-step checklist and online progress tracking system, including an online report form you can fill out in minutes. There also are prefilled forms you may need with financial institutions and links to credit agencies and others you will need to access, make reports to and get your credit report from.

**Basic Steps to Take Immediately**

- Call the company or government agency where the fraud occurred and file a formal report.
- Place a fraud alert on your credit report or freeze and get your credit reports.
- Report identity theft to the FTC using the website and get a report number.
- File a report with local police.
- Review your credit reports with all three credit agencies, correct any mistakes and dispute any fraudulent reports or accounts (links at FTC website).
- Notify banks of any fake accounts opened in your name.
- Change your passwords.
- Stay vigilant.

Ike Devji, J.D., has practiced law in the areas of asset protection and risk management. Send questions to medec@mjhlifesciences.com.
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