PHYSICIAN BURNOUT
The COVID-19 TOLL
> Why burnout is surging
> What needs to change
> How to fix it

PLUS
TECHNOLOGY
Telehealth’s long term payment outlook

AND
CHRONIC CONDITIONS
Social determinants: Help patients to improve outcomes

PRACTICE MANAGEMENT
Tips for compassionate collections

LEGAL
Managing liability risks after COVID-19

MedicalEconomics.com
**Indication**

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

*Data from the Phase 3 ZOE-50 (≥50 years of age) trial and pooled data in individuals ≥70 years of age from the Phase 3 ZOE-70 and ZOE-50 trials from subjects randomized to receive 2 doses of SHINGRIX (N=7698 and 8250, respectively) or placebo (N=7713 and 8346, respectively).1,4 CDC=Centers for Disease Control and Prevention.

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SGX RNA190014 August 2019
Produced in USA.

**Important Safety Information**

- SHINGRIX is contraindicated in anyone with a history of a severe allergic reaction (eg, anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX
- Review immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX
- Solicited local adverse reactions in subjects aged 50 years and older were pain (78.0%), redness (38.1%), and swelling (25.9%)
SHINGRIX
(ZOSTER VACCINE RECOMBINANT, ADJUVANTED)

HOW MANY PATIENTS CAN YOU PROTECT FROM SHINGLES?

• Age-related decline in immunity is a dominant driver of shingles

• SHINGRIX is recommended by the CDC for the prevention of shingles

Learn how YOU can protect your patients at ExploreSHINGRIXHCP.com

• Solicited general adverse reactions in subjects aged 50 years and older were myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%)

• SHINGRIX was not studied in pregnant or lactating women, and it is unknown if it is excreted in human milk. Therefore, it cannot be established whether there is vaccine-associated risk with SHINGRIX in pregnant women or if there are effects on breastfed infants or milk production/excretion

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

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

BRIEF SUMMARY

SHINGRIX (Zoster Vaccine Recombinant, Adjuvanted)

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

1 INDICATIONS AND USAGE

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

Limitations of Use:

SHINGRIX is not indicated for prevention of primary varicella infection (chickenpox).

2 DOSAGE AND ADMINISTRATION

2.2 Administration Instructions

For intramuscular injection only.

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

2.3 Dose and Schedule

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

4 CONTRAINDICATIONS

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

5 WARNINGS AND PRECAUTIONS

5.1 Preventing and Managing Allergic Vaccine Reactions

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

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

Overall, 17,041 adults aged 50 years and older received at least 1 dose of SHINGRIX in 17 clinical studies.

The safety of SHINGRIX was evaluated by pooling data from 2 placebo-controlled clinical studies (Studies 1 and 2) involving 29,305 subjects aged 50 years and older who received at least 1 dose of SHINGRIX (n = 14,645) or saline placebo (n = 14,660), administered according to a 0- and 2-month schedule. At the time of vaccination, the mean age of the population was 69 years; 7,286 (24.9%) subjects were aged 50 to 59 years, 4,488 (15.3%) subjects were aged 60 to 69 years, and 17,531 (59.8%) subjects were aged 70 years and older. Both studies were conducted in North America, Latin America, Europe, Asia, and Australia. In the overall population, the majority of subjects were white (74.3%), followed by Asian (18.3%), black (1.4%), and other racial/ethnic groups (8.0%); 58% were female.

Solicited Adverse Events

In Studies 1 and 2, data on solicited local and general adverse events were collected using standardized diary cards for 7 days following each vaccine dose or placebo (i.e., day of vaccination and the next 6 days) in a subset of subjects (n = 4,886 receiving SHINGRIX, n = 4,881 receiving placebo with at least 1 documented dose). Across both studies, the percentages of subjects aged 50 years and older reporting each solicited local adverse reaction and each solicited general adverse event following administration of SHINGRIX (both doses combined) were pain (78.0%), redness (38.1%), and swelling (23.5%); and myalgia (44.7%), fatigue (44.5%), headache (37.7%), shivering (26.8%), fever (20.5%), and gastrointestinal symptoms (17.3%), respectively.

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

Table 1. Percentage of Subjects with Solicited Local Adverse Reactions and General Adverse Events within 7 Days* of Vaccination in Adults Aged 50 to 59 Years, 60 to 69 Years, and 70 Years and Older** (Total Vaccinated Cohort with 7-Day Diary Card)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>SHINGRIX %</th>
<th>Placebob %</th>
<th>SHINGRIX %</th>
<th>Placebob %</th>
<th>SHINGRIX %</th>
<th>Placebob %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Adverse Reactions</td>
<td>n=1,315</td>
<td>n=1,312</td>
<td>n=1,311</td>
<td>n=1,305</td>
<td>n=2,258</td>
<td>n=2,263</td>
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<tr>
<td>Pain</td>
<td>88.4</td>
<td>14.4</td>
<td>82.8</td>
<td>11.1</td>
<td>69.2</td>
<td>8.8</td>
</tr>
<tr>
<td>Pain, Grade 3</td>
<td>10.3</td>
<td>0.5</td>
<td>6.9</td>
<td>0.5</td>
<td>4.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Redness</td>
<td>38.7</td>
<td>1.2</td>
<td>38.4</td>
<td>1.6</td>
<td>37.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Redness, &gt;100 mm</td>
<td>2.8</td>
<td>0.0</td>
<td>2.6</td>
<td>0.0</td>
<td>3.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Swelling</td>
<td>30.5</td>
<td>0.8</td>
<td>26.5</td>
<td>1.0</td>
<td>23.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Swelling, &gt;100 mm</td>
<td>1.1</td>
<td>0.0</td>
<td>0.5</td>
<td>0.0</td>
<td>1.3</td>
<td>0.0</td>
</tr>
<tr>
<td>General Adverse Events</td>
<td>n=1,315</td>
<td>n=1,312</td>
<td>n=1,309</td>
<td>n=1,305</td>
<td>n=2,252</td>
<td>n=2,264</td>
</tr>
<tr>
<td>Myalgia</td>
<td>56.9</td>
<td>15.2</td>
<td>49.0</td>
<td>11.2</td>
<td>35.1</td>
<td>9.9</td>
</tr>
<tr>
<td>Myalgia, Grade 3</td>
<td>8.9</td>
<td>0.9</td>
<td>5.3</td>
<td>0.8</td>
<td>2.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Fatigue</td>
<td>57.0</td>
<td>19.8</td>
<td>45.7</td>
<td>16.8</td>
<td>36.6</td>
<td>14.4</td>
</tr>
<tr>
<td>Fatigue, Grade 3</td>
<td>8.5</td>
<td>1.8</td>
<td>5.0</td>
<td>0.8</td>
<td>3.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Headache</td>
<td>50.6</td>
<td>21.6</td>
<td>39.6</td>
<td>15.6</td>
<td>29.0</td>
<td>11.8</td>
</tr>
<tr>
<td>Headache, Grade 3</td>
<td>6.0</td>
<td>1.7</td>
<td>3.7</td>
<td>0.2</td>
<td>1.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Shivering</td>
<td>35.8</td>
<td>7.4</td>
<td>30.3</td>
<td>5.7</td>
<td>19.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Shivering, Grade 3</td>
<td>6.8</td>
<td>0.2</td>
<td>4.5</td>
<td>0.3</td>
<td>2.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Fever</td>
<td>27.8</td>
<td>3.0</td>
<td>23.9</td>
<td>3.4</td>
<td>14.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Fever, Grade 3</td>
<td>0.4</td>
<td>0.2</td>
<td>0.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Gl*</td>
<td>24.3</td>
<td>10.7</td>
<td>16.7</td>
<td>8.7</td>
<td>13.5</td>
<td>7.6</td>
</tr>
<tr>
<td>Gl, Grade 3</td>
<td>2.1</td>
<td>0.7</td>
<td>0.9</td>
<td>0.6</td>
<td>1.2</td>
<td>0.4</td>
</tr>
</tbody>
</table>

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

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

b Data for subjects aged 50 to 59 years and 60 to 69 years are based on Study 1. Data for subjects 70 years and older are based on pooled data from Study 1: NCT01165177 and Study 2: NCT0165229.

Placebo was a saline solution.

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

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

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

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

(continued on next page)
The incidence of solicited local and general symptoms was lower in subjects aged 70 years and older compared with those aged 50 to 69 years.

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

There were no differences in the proportions of subjects reporting any or Grade 3 solicited local reactions between Dose 1 and Dose 2. Headache and shivering were reported more frequently by subjects after Dose 2 (28.2% and 21.4%, respectively) compared with Dose 1 (24.4% and 13.8%, respectively). Grade 3 solicited general adverse events (headache, shivering, myalgia, and fatigue) were reported more frequently by subjects after Dose 2 (2.3%, 3.1%, 3.6%, and 3.5%, respectively) compared with Dose 1 (1.4%, 2.3%, 2.5%, and 2.4%, respectively).

Unsolicited Adverse Events

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

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

Serious Adverse Events (SAEs)

In the 2 studies, SAEs were reported at similar rates in subjects who received SHINGRIX (2.3%) and placebo (2.2%) from the first administered dose up to 50 days following the last vaccination. SAEs were reported for 10.1% of subjects who received SHINGRIX and for 10.4% of subjects who received placebo from the first administered dose up to 1 year post last vaccination. One subject (<0.01%) reported lymphadenitis and 1 subject (<0.01%) reported fever greater than 39°C; there was a basis for a causal relationship with SHINGRIX.

Optic ischemic neuropathy was reported in 3 subjects (0.02%) who received SHINGRIX (all within 50 days after vaccination) and 0 subjects who received placebo; available information is insufficient to determine a causal relationship with SHINGRIX.

Deaths

From the first administered dose up to 30 days post last vaccination, deaths were reported for 0.04% of subjects who received SHINGRIX and 0.05% of subjects who received placebo in the 2 studies. From the first administered dose up to 1 year post last vaccination, deaths were reported for 0.13% of subjects who received SHINGRIX and for 0.9% of subjects who received placebo. Causes of death among subjects were consistent with those generally reported in adult and elderly populations.

Potential Immune-Mediated Diseases

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

Dosing Schedule

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

6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of SHINGRIX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to the vaccine.

General Disorders and Administration Site Conditions
Decreased mobility of the injected arm which may persist for 1 or more weeks.

Immune System Disorders
Hypersensitivity reactions, including angioedema, rash, and urticaria.

7 DRUG INTERACTIONS

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

7.2 Immunosuppressive Therapies
Immunosuppressive therapies may reduce the effectiveness of SHINGRIX.

8 USE IN SPECIFIC POPULATIONS

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

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

8.5 Geriatric Use
Of the total number of subjects who received at least 1 dose of SHINGRIX in the 2 efficacy trials (n = 14,645), 2,243 (15.3%) were aged 60 to 69 years, 6,837 (46.7%) were aged 70 to 79 years, and 1,921 (13.1%) were 80 years and older. There were no clinically meaningful differences in efficacy across the age groups or between these subjects and younger subjects [see Clinical Studies (14.1, 14.2, 14.3) of full prescribing information]. The frequencies of solicited local and general adverse events in subjects aged 70 years and older were lower than in younger adults (aged 50 through 69 years) [see Adverse Reactions (6.1)].

17 PATIENT COUNSELING INFORMATION
• Inform patients of the potential benefits and risks of immunization with SHINGRIX and of the importance of completing the 2-dose immunization series according to the schedule.
• Inform patients about the potential for adverse reactions that have been temporally associated with administration of SHINGRIX.
• Provide the Vaccine Information Statements, which are available free of charge, at the Centers for Disease Control and Prevention (CDC) website (www.cdc.gov/vaccines).

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

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The COVID-19 toll on physicians

It’s no mystery why physicians are feeling burned out. In addition to the stress of treating their patients — a stress they welcome as a calling — physicians deal with constant challenges that get in the way with them following that calling. Administrative burdens such as prior authorizations make physicians feel as though their judgement is constantly being questioned. EHR systems don’t work nearly well enough. And regulations covering all aspects of health care multiply each year, creating a maze of complexity that doctors must navigate.

On top of that, there’s a pandemic, which has put physicians’ physical, mental, and financial health at risk. Medical Economics® has devoted our September issue to confronting the crisis of physician burnout. The center of our coverage is the results of our 2nd annual burnout and wellness survey. These results are sobering. More than 70% of physicians told us they feel burned out right now, and many say they do not know how to deal with their stress.

Wendy Dean, M.D., a physician who believes feelings of “burnout” are better labeled as moral injury, says in a column in this issue that physicians essentially feel abandoned by the health care system, which only exacerbates the dislocation they feel between the ideals of the profession — care for every patient, to the best of your ability, no matter what — with the stark reality of our fragmented care system.

“Clinicians are bombarded with daily evidence of brazen betrayal at every level — local, state and federal,” Dean writes.

Many physicians are undoubtedly tired of hearing and reading about burnout. It’s one of those issues that doesn’t feel like it will ever go away, because the source of the problem is multifactorial and exceedingly complex. Sometimes it feels easier to just wake up, grit your teeth, and start treating your patients.

But other physicians believe it’s vital to talk about these problems, because resigning to them doesn’t help anyone. “Physicians often suffer in silence,” says Bob Piccinini, D.O., a psychiatrist we interviewed in our cover story. “We got away from showing problems, because resigning to them doesn’t help anyone. “Physicians often suffer in silence,” says Bob Piccinini, D.O., a psychiatrist we interviewed in our cover story. “We got away from showing problems, because resigning to them doesn’t help anyone. “Physicians often suffer in silence,” says Bob Piccinini, D.O., a psychiatrist we interviewed in our cover story. “We got away from showing problems, because resigning to them doesn’t help anyone. “Physicians often suffer in silence,” says Bob Piccinini, D.O., a psychiatrist we interviewed in our cover story. “We got away from showing problems, because resigning to them doesn’t help anyone. “Physicians often suffer in silence,” says Bob Piccinini, D.O., a psychiatrist we interviewed in our cover story. “We got away from showing problems, because resigning to them doesn’t help anyone. “Physicians often suffer in silence,” says Bob Piccinini, D.O., a psychiatrist we interviewed in our cover story.

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

Stay safe!
Covid-19 Coverage Central

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

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

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

Building a virtual practice

Jon Regis, M.D., discusses how his practice uses remote patient monitoring to both boost revenue and keep patients engaged in their treatment.

Watch this video and others at: bit.ly/MedEcVideo
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Physicians explain how the pandemic is affecting their stress — and what they are doing to manage.

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Wendy Dean, M.D., writes about the true cause of physician stress.

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How to align reimbursement with the needs of primary care physicians and patients.

Practice Management

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Nine strategies for collecting patient balances for virtual services.

35 Automating accounts payable
The benefits — and how to get started.

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Enlarged Prostate (BPH) affects over 40 million men in the United States. Symptoms may include interrupted sleep and urinary problems as well as loss of productivity, depression and decreased quality of life.2

If your patients have symptoms of an enlarged prostate, introduce them to the UroLift® System. Here’s why I chose UroLift System and recommend it to my patients.

**Proven** minimally invasive approach to treating enlarged prostate that provides rapid symptom relief and recovery3,4

**An earlier alternative** to medical therapy that provides symptom relief better than reported for medication3,5

**Durability** through 5 years6

**Over 175,000** men have been treated with the UroLift System worldwide

The procedure is covered by Medicare and all major private insurers when medical criteria are met.

Learn more and check out the data at UroLift.com/info

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*Dr. Walter is UroLift System faculty and a paid consultant for NeoTract|Teleflex
**Management estimate based on product sales and average units per procedure


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Even if a hospital is a competitor, there are reasons to make a deal.
CMS recommends permanent expansion of telehealth benefits

The Centers for Medicare & Medicaid Services (CMS) is proposing that telehealth benefits continue — for good. According to a news release, the move comes as part of the Fostering Innovation and Rethinking Rural Health strategic initiative, which aims to modernize Medicare through private sector innovation. The push for telehealth started in 2019, when CMS approved payments to physicians for virtual check-ins.

Since the beginning of the COVID-19 coronavirus pandemic, CMS has expanded payment for telehealth services and implemented other flexibilities to bring care to Medicare beneficiaries without the risk of infection. Before the pandemic, only 14,000 beneficiaries received Medicare telehealth service in a week; during the pandemic, from mid-March to early July, more than 10.1 million beneficiaries received the service, the release states.

“Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for Americas seniors,” CMS administrator Seema Verma stated in the release. “The Trump administration’s unprecedented expansion of telemedicine during the pandemic represents a revolution in health care delivery, one to which the health care system has adapted quickly and effectively.”

During the COVID-19 public health emergency, CMS added 135 services that can be paid for when delivered by telehealth. The proposed rule would permanently allow some of those services to continue being delivered via telehealth, including home visits for evaluation and management of patients and certain visits for patients with cognitive impairments, the release states. — Keith A. Reynolds, associate editor

Proposed Physician Fee Schedule calls for more than 10% decrease

The Centers for Medicare & Medicaid Services (CMS) released the proposed Medicare annual payment rule for 2021, including the Physician Fee Schedule and updates to the Merit-based Incentive Payment System (MIPS).

This year’s conversion factor contains a significant budget neutrality adjustment that is required by law. The proposed 2021 PFS conversion factor is $32.26, a decrease of $3.83, or more than 10%, from last year’s schedule.

CMS also proposes allowing nurse practitioners, clinical nurse specialists, physician assistants and certified nurse midwives to supervise the performance of diagnostic tests, in addition to physicians. This flexibility was granted during the pandemic, but the agency is now looking at making it permanent.

The policy allowing teaching physicians to supervise residents using telehealth, instituted during COVID-19, is being considered for permanent implementation.

When it comes to MIPS, CMS is granting hardship exemptions on a case-by-case basis. A clinician or group can request an exemption from all four performance categories. CMS proposes to reduce the quality category weight from 45% to 40% and increase the cost category from 15% to 20%. By law, the quality and cost categories must each be weighted at 30% starting in 2022. — Todd Shryock, managing editor
PHYSICIANS IN CRISIS

Medical Economics® 2020 Physician Burnout and Wellness Survey results

by Medical Economics® Staff

Physician burnout was already at a crisis level. Has COVID-19 made it worse?

For the second year, Medical Economics® has asked our physician audience to tell us how burnout affects them, both professionally and personally.

This year, physicians have had to deal with all of the normal difficulty that often lead to burnout, with an unprecedented crisis looming over it all in the form of the COVID-19 pandemic.

Below you will find the complete and exclusive results of our survey, including physicians detailing how COVID-19 has affected them — in their own words.

Have you felt burned out from practicing medicine at any point during your career?

91% YES

9% NO
Do you feel burned out right now?

Yes: 71%
No: 29%

What has contributed the most to your feelings of burnout?

- Too much paperwork and government/payer regulations: 31%
- Poor work-life balance/work too many hours: 15%
- The COVID-19 pandemic: 12%
- EHRs: 12%
- Lack of autonomy/career control: 11%
- I don’t feel burned out: 7%
- Insufficient pay/declining reimbursements: 7%
- Overwhelmed by patient needs: 5%
- Nonadherent patients: 1%

How has the COVID-19 pandemic impacted your feelings of burnout?

- It’s made me feel more burned out: 65%
- It hasn’t had any effect on my level of burnout: 26%
- It’s reduced my feelings of burnout: 9%

What aspects of the COVID-19 pandemic have caused you feelings of stress or burnout?

- Not being able to care for my patients in the way I would like to: 41%
- Financial concern (either for practice or personal): 50%
- Concern for my own health/health of my family: 47%
- General feelings of helplessness: 32%
- Lack of adequate PPE: 30%
- I’m not feeling more stressed/burned out than before the pandemic: 18%
**How do you cope with burnout?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td>36%</td>
</tr>
<tr>
<td>Spending time with family and friends</td>
<td>19%</td>
</tr>
<tr>
<td>I don’t feel I’m coping</td>
<td>12%</td>
</tr>
<tr>
<td>Hobbies</td>
<td>8%</td>
</tr>
<tr>
<td>I don’t feel burned out</td>
<td>7%</td>
</tr>
<tr>
<td>Eating junk food/overeating</td>
<td>6%</td>
</tr>
<tr>
<td>Practicing yoga/mindfulness/meditation</td>
<td>5%</td>
</tr>
<tr>
<td>Drugs or alcohol</td>
<td>1%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Have you ever talked to fellow physicians/colleagues about feeling burned out?*

- **Yes**: 55%
- **No**: 45%

*Have you avoided expressing feelings of burnout because you’re concerned about being judged negatively by peers?*

- **Yes**: 36%
- **Prefer not to answer**: 5%

*Do you plan to seek or have you sought professional help/counseling dealing with burnout?*

- **Yes**: 14%
- **Prefer not to answer**: 7%

*Have your feelings of burnout ever made you want to quit practicing medicine?*

- **Yes**: 73%
- **No**: 27%

*Getting involved in advocacy and activism. Taking care of my own health and my family. I have a coach.***

*Prayer, sitting outside and watching the birds and nature.***

*Planning for a switch to direct primary care.***

*Lots of TV.***

*I do yoga but I also decrease my work hours when I feel burnout setting in.***

12% of physicians said they do not feel they are coping appropriately with burnout.
How has the COVID-19 pandemic affected your feelings of burnout/mental health?

“Already burned out — and then COVID. I’m part of a two physician household. Our responsibility doubled while reimbursement and safety cut in half.”

“I do have some fears about becoming infected with COVID-19 or infecting my family. It is cumbersome to wear a mask, gown, gloves when seeing patients. It is difficult but surprisingly enjoyable to do telemedicine. I have concerns about my employees too.”

“The notion of working thru a pandemic in which all of humanity is susceptible has been a bit overwhelming. But what has really hurt is the drastic fall in my already precarious income.”

“Highlighted the pitfalls of healthcare systems planning narrowly for profit.”

“Aside from the human toll, the spectacle of public health measures being rendered ineffective by poor public leadership and contradictory messaging has added to the moral injury.”

“My private practice had financial challenges prior to the pandemic but the pandemic has made the situation more dire. It seems too risky to be in private practice and I plan to get out at my next opportunity and look for something different.”
How many years have you been practicing?

<table>
<thead>
<tr>
<th>Years</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5</td>
<td>1%</td>
</tr>
<tr>
<td>6–10</td>
<td>3%</td>
</tr>
<tr>
<td>11–20</td>
<td>21%</td>
</tr>
<tr>
<td>21–30</td>
<td>34%</td>
</tr>
<tr>
<td>More than 30</td>
<td>41%</td>
</tr>
</tbody>
</table>

What is your gender?

- Male: 64%
- Female: 33%
- Choose not to say: 3%

What do you believe is the solution to physician burnout?

- “I don’t know. I just know that every single day I go to the office and I have people every single day that I dread seeing, and the amount of paperwork we have to do in the documentation is just unreal.”
- “As the practice of medicine moves farther out of the control of physicians, treating this work just as a job will be necessary. Those who still consider themselves as professional, who give their all to medicine, will continue to burnout. It’s hard to justify missing most holidays and many of your children’s milestones for this.”
- “Autonomy!! Let us decide how to care for our own patients! Trust us with medical decisions.”
- “Better pay and respect.”
- “Decrease regulation, decrease paperwork, increase kindness and care for physicians. Reclaim our identities as altruistic.”
- “A single payer system.”
- “Take healthcare back from insurance companies and the government. Let us decide when, how, and where to practice medicine.”
- “Redesign the EHRs to make them work for physicians rather than the other way around.”
- “Think about why you became a physician in the first place and be happy.”

Do you have an ownership stake in your practice?

- Yes: 47%
- No: 53%
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Account Executive
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440-891-2615

Early on in the COVID-19 pandemic, Gabe Charbonneau, M.D., a family doctor in Stevensville, Montana, completed a shift at an urgent care facility that was serving as the local COVID-19 clinic. “I saw one patient that day who had enough symptoms for me to think that they potentially could have COVID,” Charbonneau says. “I remember driving home and thinking about how I was going to make sure I didn’t bring this home to my family or community. That’s a scary thought — that there’s this potentially lethal infection that we really don’t know that much about spreading around.”

Still, Charbonneau feels fortunate. Montana has a relatively low infection rate, and his urgent care shift was a one-time volunteer event. But the pandemic has created a host of other issues for him and other physicians across the country. Doctors in hot spots saw massive increases in COVID-19-related cases, whereas those outside hot spots saw patient visits dry up. Layoffs and furloughs became common in health care, and telehealth had to be learned practically overnight to keep revenue coming in.

“Because it was such a financial hit, there was a lot of pressure for us to figure that out and start to actually get people back in the practice,” Charbonneau says. “There’s more work, and it’s really hard. And what about the stress from wondering if your patients are going to be safe when they come in or the safety of your staff, yourself or your family?”

Charbonneau, the founder of FightBurnout.org, has watched all these COVID-19-related issues pile on top of what physicians were already dealing with daily and knows it’s made burnout worse. “There are definitely days where it’s completely overwhelming to me and our staff,” he says. And he knows that, unfortunately, he’s not alone.

How COVID-19 made a bad problem worse

In the Medical Economics® 2020 Physician Burnout Survey, 65% of physicians indicated that the COVID-19 pandemic has increased
their feelings of burnout.

A big contributing factor to burnout in any profession is a lost sense of autonomy, and 32% of the doctors surveyed indicated that COVID-19 had contributed to a general feeling of helplessness. Physicians were already dealing with insurance companies about courses of treatment for patients prior to COVID-19, as well as being pressured to see more patients either by administrators or just to keep their practice open. The pandemic has added another layer.

“Many doctors had to sign a contract that said they could be deployed anywhere, sort of like they were in the army,” Charbonneau says. Doctors from many specialties in hot spots suddenly found themselves reassigned to the emergency department, treating patients with conditions they hadn’t seen since medical school. “You don’t really have a choice other than to not have a job, and that’s a big hit to your autonomy,” Charbonneau adds.

“Before COVID, we had physicians working long hours, not being in control, being told what to do, being devalued, being demeaned,” says Lynette Charity, M.D., a retired anesthesiologist and a physician advocate who speaks nationwide about the issue. “They don’t like their job, but they feel now they can’t leave, because they have to be there to take care of all these COVID cases. So in addition to what we were seeing with burnout before because of bureaucratic tasks, bad EHRs, no scribes and all the things that were going on, now we have the secondary situation of being on the front lines and seeing more death and destruction while being put in harm’s way.”

Shortages of personal protective equipment hit many health systems (39.9% of those surveyed indicated this was a problem), leaving doctors feeling dangerously exposed but fearful of speaking up. “If they speak out, they felt like they would be fired,” Charity says. “They feel like they have to work to take care of their families, but in the back of their mind, they are wondering if they’ll ever make it home to see them.”

For independent physicians, burnout was exacerbated by financial strain. According to the Medical Group Management Association (MGMA), 90% of medical groups have not been seeing patients who have COVID-19, and for them, patient volume dropped between 75% and 90% when the pandemic first hit the U.S. “On top of the traditional causes of burnout, we added one massive and overarching one, which is ‘Can I stay in business?’” says Andy Swanson, M.P.A., CMPE, vice president of industry insights for MGMA. Physicians had to worry about job security for themselves and their staff, which isn’t something most have had to deal with.

In the Medical Economics® survey, just over half (50.4%) of respondents indicated that financial strain brought on by the pandemic contributed to their burnout. “Then there’s obviously the health and safety issue of workers, which adds this just enormous weight on people’s shoulders,” Swanson says; in the Medical Economics® survey, 46.9% of physicians indicated that this concern was a problem.

What needs to change
Eventually, COVID-19 will be brought under control, but burnout will remain. Physicians will face the aftermath of a pandemic along with obtuse electronic health records, too much administrative work and too much third-party interference. According to Charbonneau, burnout needs to be measured so progress can be tracked. “I don’t think we’ve been very good at quantifying burnout,” he says. “I really would like to see that kind of data where every three months, we’re checking a burnout inventory so we could directly see how things have changed.”

Categories such as workload and documentation burden could be measured along with a physician’s general feelings regarding work, he says. “To have a positive effect on burnout, we need to not look at the individual but look at the workplace and the factors in the workplace that are driving burnout,” Charbonneau says. “My concern is that there’s

Physicians often suffer in silence. We got away from showing that we are human. Talking about burnout can be a great way of helping deal with it.”

— Bob Piccinini, D.O., psychiatrist, Sterling Heights, Michigan
CAREERS / COVID-19 AND BURNOUT

lots of talk about burnout but very little accountability. Unless there is sort of a financial impact that is directly connected to the bottom line, I don’t imagine it will change.”

A new system is needed that focuses on time with the patient, not on volume. “We say we value time with a patient, but what really drives the machine is RVUs (relative value units),” Charbonneau says. “The way to get more RVUs is either do more care or do more procedures.” That contributes to more burnout, he adds.

But with a pandemic sweeping across the country, is now the right time? “I can’t come up with a really good reason why you have to wait,” says Charbonneau, noting that the physician suicide rate is higher than that of the general population and that the hazards and workload of COVID-19 have many doctors looking for different careers. “I think saying we have to wait until the pandemic is over to solve it is probably going to be too late.”

How to cope

Although an individual physician may feel hopeless to change the health care system, their employer or their situation, there are strategies to recognize signs of trouble and take action.

First, a physician shouldn’t

Don’t assume help isn’t out there

Physicians struggling under the strains of the pandemic, regardless of whether they are treating a constant stream of patients in a hot spot or wondering when anyone will return to their office, often think they cannot seek professional counseling.

Fear of losing their state medical license is a big deterrent against getting professional help, but those fears may be misplaced. “Every physician has to look at their state guidelines,” says Andy Swan- son, M.P.H., CMPE, vice president of industry insights for the Medical Group Management Association. “The majority of states now have changed their licensure requirements and how they are addressing the mental health of physicians. They have evolved significantly in the past decade.”

He says physicians should not rely on the historical norm of saying nothing or else they’ll lose their license. “Those are rapidly becoming kind of antiquated, old-school thoughts. Doctors need to educate themselves on what rules they are being governed by and then make sure they are living within those rules,” he says.

Many medical schools are devoting more time to physicians’ mental health and wellness and even encouraging counseling in off hours, says Swanson says. “It’s far from perfect, for sure, but I think the environment in medicine is becoming far more conducive to physicians getting the help they need through this,” he adds.
assume that he or she is the only one who is feeling burned out, says Bob Piccinini, D.O., a practicing psychiatrist in Sterling Heights, Michigan. “What we usually see when physicians are burned out is they look around and say, ‘Yeah, but everybody else is doing the same thing as I am and working long hours, and it doesn’t seem to affect them,’” he says. Others may be just as burned out but not saying anything because they, too, think they are alone in their feelings, Piccinini says.

Performance might also be affected, according to Piccinini: “Burnout often causes people to have poor decision-making capacity, make more mistakes in treatment and practice poor self-care.”

Common burnout signs include exhaustion, a reduced sense of accomplishment, a feeling of dread, increased irritability, inability to sleep, or using drugs or alcohol to cope, he says. Another sign: yelling at colleagues or overreacting when something doesn’t go right. “A lot of times in medicine, as much as we want to address our concerns about a colleague, we just don’t,” Piccinini says. “We give them a wider berth and just let them act out.”

Piccinini suggests taking a self-inventory to start the day. “What are my fears today?” he says. “Just identifying the emotion can help reduce anxiety.” Physicians dealing with a heavy COVID-19-related workload should try to pause for a short time between cases. “When the cases become blurred, they seem insurmountable. Try to deal with one thing at a time rather than everything at once,” he says.

Taking the time to check in on each other is the best thing physicians can do, Piccinini says. An informal “How are you doing?” after a critical incident can spark a conversation that helps alleviate emotions that would otherwise be internalized and fuel burnout. “Physicians often suffer in silence,” he says. “We got away from showing that we are human. Talking about burnout can be a great way of helping deal with it.”

Swanson advises that employed physicians focus on solutions when talking to administrators about the issues they are facing. “It’s rare in the workplace that anybody wants to sit with the curmudgeon or complainer and just listen to a gripe session for a half hour,” he says. “But people do empathize with hearing and listening to what some of the current issues and causes of burnout are, and are especially wanting to partner when that conversation turns quickly to what could be done to make it better.”

For a practice with a dearth of patients, physicians can use the extra time to invest in training that can alleviate burnout in the long term, when appointments return to a more normal level, Swanson says. If the EHR is a major point of frustration, find training sessions that can aid mastery of features, shortcuts and capabilities. “A doctor needs to make sure that this tool, as clunky as it may be for them, is as efficient as possible,” he says. “If someone can teach you one or two shortcuts or quick tricks, that can help ease the burden a little bit and put the physician more in control of how they use the tool.”

Outside of work, it’s important to find a focus other than medicine, whether it’s a project around the house or pursuing a hobby. “Even as terrifying as the world is right now, there is still a lot of beauty and things to be appreciative of, and once you start to condition yourself to that, it can go a long way toward maintaining your health,” Piccinini says. 

“Because it was such a financial hit, there was a lot of pressure for us to figure that out and start to actually get people back in the practice. There’s more work, and it’s really hard. And what about the stress from wondering if your patients are going to be safe when they come in or the safety of your staff, yourself or your family?”

—Gabe Charbonneau, M.D., family physician, Stevensville, Montana
What COVID-19 reveals about physician moral injury

The pandemic hit a health care system — and physicians — already in crisis

The figurative ills of the nation are made manifest in our health care. COVID-19 has laid bare the fractures and injustices in the systems that serve people at their most vulnerable. It reveals that the financial framework of care depends inordinately on elective procedures and that a splintered, privatized health care system fares poorly when coordination is paramount.

Our collective failure to invest in public health and preparedness means the nation, as a whole, is unprepared for the coronavirus crisis. Everyone is at risk. But it exacts the highest tolls in places and populations already challenged by scarce resources and least able to protect themselves by isolating — low-income areas, those chronically underserved with social services and health care, and communities of color. For too many, these challenges overlap and compound one another.

Physicians watched the first wave approach, helpless to stop the devastation they read about in China and Italy. They were angry that the disparities and skewed priorities they had known and fought against for decades were putting individual patients and populations they care deeply about in serious danger. They are watching, helpless again, as the country opens up and unmarks, failing to heed the dire warnings sent mere weeks ago from overwhelmed hospitals in New York City, New Jersey and Seattle. COVID-19 hit health care systems already in crisis. Nearly half of clinicians in the U.S. reported at least one symptom of distress last year. Trust had eroded between health care staff and organizations as financial constraints cut staffing, supplies and space to the bone; staff members were micromanaged and hypermonitored to drive optimum efficiency; and leadership offered tea carts, lunchtime yoga and mindfulness meditation as reparation.

Those offerings, though well intentioned, were often perceived as either performative or patronizing. The pandemic is highlighting the vulnerabilities in health care organizations, increasing tension with staff and sometimes devolving into painfully public breaks in decorum.

“NO LONGER IS THERE A QUESTION ABOUT THE HARM DONE TO CLINICIANS, PATIENTS AND THE NATION AT LARGE BY THE FINANCIAL FRAMEWORK OF HEALTH CARE. THE EVIDENCE IS EVERYWHERE.”

Resource constraints also foist unimaginable choices onto clinicians: How are scarce resources such as ICU beds or ventilators allocated? Such discussions are anathema to U.S. health care, and clinicians, therefore, are not well-versed in applying the principles. Most are not psychologically prepared to engage in those ethically charged decisions. Physicians are left taking responsibility for those exquisitely painful decisions alone.

At the same time, tens of thousands of physicians were sidelined as elective procedures shut down. Those clinicians struggled with...
what one called an identity crisis. How could their exceptional care, the dramatic improvements in quality of life they offered patients, be so readily abandoned? They struggled with the prospect of closing long-standing practices, furloughing staff and coping with personal financial devastation. The deep irony of health care workers facing job insecurity in the midst of a pandemic was not lost on them.

The language of clinician distress has shifted in recent years from burnout to moral injury, as clinicians have adopted a framework that better expresses their experience. Jonathan Shay, M.D., Ph.D., in his book “Achilles in Vietnam,” defines moral injury as a “betrayal of what’s right, by a person who holds legitimate authority in a high-stakes situation.” Shay’s definition applies to soldiers in combat, but the COVID-19 crisis neatly fits that definition and has propelled the adoption of the term, as evidenced by the crude metric of Google alerts. Those alerts have gone from an average of one or two articles several times a week to three to five articles nearly every day during the pandemic. Clearly, the concept of moral injury resonates in the context of COVID-19.

Clinicians are bombarded with daily evidence of brazen betrayal at every level — local, state and federal. Hospitals failed to heed warnings about the massive need for personal protective equipment (PPE). When those predictions came true and stores ran low, safety standards quickly shifted from optimum to minimum, and federal guidelines supported the shift. Clinicians wade into the breach without sufficient protection, even as their pay is cut, their protests gagged and their employment threatened and as they watch their colleagues and friends fall ill. No longer is there a question about the harm done to clinicians, patients and the nation at large by the financial framework of health care. The evidence is everywhere.

Now, in the wake of the response to the coronavirus’s proverbial shot across the bow, physicians are reckoning with all they have observed and experienced, personally or vicariously. They see what the virus can do firsthand, read the accounts or talk to doctor friends in epicenters. If they have not seen it yet, they know it is only a matter of time before they do. They are doing the hard work of integrating the risk posed by this virus with the cavalier disregard exhibited by too much of the public and too many public figures — yet more betrayal and moral injury on top of that already perpetrated.

They are struggling with a litany of losses — patients, colleagues, personal safety, job security — and the prospect that this may be just the beginning of a brutally long campaign. Ideally, this is an opportunity for leadership to recommit to doing the right things for staff and patients: ensuring enough PPE, providing professional support for psychological recovery, working together to address operational challenges and easing up on those who are in the thick of COVID-19 care. But, at the very least, most clinicians would happily trade hero worship for universal masking in public until this is truly over. 

Wendy Dean, M.D., is a psychiatrist and the president and co-founder of Moral Injury of Healthcare.

“The language of clinician distress has shifted in recent years from burnout to moral injury, as clinicians have adopted a framework that better expresses their experience.”
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How should primary care physicians be paid? Page 29

2020 Coding Guide
Address coding vulnerabilities to protect practice revenue

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

There's nothing more frustrating than rendering a service and not being paid. Sometimes the problem comes down to a single code. Nuanced coding rules are difficult to understand, and physicians aren't taught this information in medical school. Still, health care is a business. As business owners, physicians need to know how they're paid, including what codes to use, what modifiers to append and what details to document. Brushing up on common coding mistakes helps avoid costly recoupments and denials. We asked several experts, all certified professional coders, for their best advice on how physicians can maintain compliance and collect all the revenue to which they're entitled.

Part 2

Evaluation and management

Office visit evaluation and management (E/M) coding is the bread and butter for practices nationwide. Yet experts say physicians continue to make mistakes that cost them thousands or even hundreds of thousands of dollars annually.

It all goes back to the three critical components of an E/M code: history, exam and medical decision-making (MDM), says Deborah Grider, senior health care consultant at KarenZupko & Associates.
Inc. in Chicago. Every office visit E/M code has its own requirements for each component, with medical necessity being the ultimate deciding factor for which E/M level to assign.

Physicians often oversimplify E/M coding, Grider says, making them easy targets for post-payment audits. For example, they incorrectly assign 99213 (established patient level three office visit) if a patient has three diagnoses and 99214 (level four) for four diagnoses. “That’s not the way it works,” she says, emphasizing the need to follow Common Procedural Terminology (CPT) guidelines that dictate specific requirements.

Consider these three common reasons for post-payment recoupments and advice on how to maintain compliance.

**Post-payment audit:** The reason for the visit doesn’t support the level of E/M code assigned. In other words, the service wasn’t medically necessary.

**How to avoid it:** “I always tell doctors to take a step back and look at their documentation,” Grider says. “Does the level make sense given the problem they’re addressing and managing?”

For example, physicians should not assign 99214 for a patient with allergic rhinitis. However, if they see an obstruction in the nose and recommend an MRI to make sure it isn’t a tumor, 99214 may be warranted. To report 99214, physicians must perform and document a detailed history, examination and moderate complexity MDM.

Angela Jordan, senior clinical documentation improvement consultant at Trusted i10, agrees. For example, physicians shouldn’t bill a level four or five E/M service for a patient with stable chronic conditions that don’t warrant testing or medication changes. “An E/M leveling tool may map it to a 99214, but if you know in your gut that it’s not a level four, then don’t go with it. Your gut instinct is probably right,” she says.

Physicians who rely on the E/M calculator in their electronic health record (EHR) should ask a certified coder or external consultant to vet the tool and determine its accuracy, according to Jordan. “I don’t want to make a blanket statement that all these tools are bad, because they’re not,” she says. “However, an audit of the tool will tell you what it does well and what could pose problems.”

**Post-payment audit:** History doesn’t support a higher-level E/M service.

**How to avoid it:** Ensure that documentation reflects the detailed conversation with the patient, says Sonal Patel, a health care coder and compliance consultant with Nexsen Pruet LLC, a business law firm in Charleston, South Carolina.

For example, when billing a level four or five E/M service for a new patient or a level five E/M service for an established patient, physicians need to document a comprehensive history. This includes a chief complaint, an extended history of present illness (HPI) and a complete review of systems, including those directly related to the problem identified in the HPI, as well as all additional body systems and a complete past, family and social history.

**MAJOR E/M CHANGES ARE RIGHT AROUND THE CORNER**

Four key revisions to evaluation and management (E/M) coding are set to take place January 1, 2021:

1. Codes for office or other outpatient consultations will be based on time (including face-to-face and non-face-to-face time rendered by the E/M provider) or medical decision-making (MDM). This change does not apply to any other E/M service (i.e., hospital observation; hospital inpatient; critical care; nursing facility; or domiciliary, rest home, or custodial care services). Physicians must continue to assign the latter based on history, exam and MDM.

2. CPT code 99201 (new patient level one E/M) will be deleted.

3. Codes 99202 to 99215 will include new descriptors and time thresholds.

4. A new MDM table gives credit for each unique test ordered and reviewed, review of prior external notes from each source, and more. The table also provides specificity regarding low, moderate and high risk, including diagnosis or treatment significantly limited by social determinants of health.

**MORE ONLINE:**

To learn more about these and other changes for 2021, visit bit.ly/3gGqm5D
When billing a level four E/M service for an established patient, a detailed history must be documented, including the chief complaint, an extended HPI, an extended review of systems and a pertinent past, family and/or social history directly related to the problem.

Typically, each of these scenarios lacks the extended HPI — either the status of three chronic conditions or four or more of the following elements: quality, location, duration, severity, timing, context, modifying factors and associated signs/symptoms.

“You can easily get four elements in the HPI just by hearing the patient talk about their pain or the particular problem that brought them in,” Patel says. “We know that the physician is touching the patient and talking with them, but if it’s not being documented, an auditor can’t score it.”

Post-payment audit: Documentation doesn’t support time-based billing.

How to avoid it: Document the specific details of counseling and coordination of care that dominated at least 50% of the visit, says Patel, noting what you discuss and with whom. “An auditor wants to see why this extra time was spent. What was the greater purpose?” she adds.

Chronic care management

Experts say chronic care management (CCM) — care coordination services given to patients with two or more chronic conditions that are expected to last at least 12 months and place the patient at significant risk of death, acute exacerbation/decompensation or functional decline — can help improve patient outcomes and generate revenue for the practice.

“As we’re ramping back up from COVID-19, I’m telling practices to think about CCM,” says Sandy Giangreco Brown, director of coding and revenue integrity at CliftonLarsonAllen LLP in Loveland, Colorado. “It’s totally feasible, and you can provide better care for your patients.”

Consider the following CCM codes and average Medicare payments:

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
<th>TIME</th>
<th>2020 NATIONAL AVERAGE MEDICARE PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490</td>
<td>CCM provided by clinical staff directed by a physician or other qualified health care professional</td>
<td>20 minutes per calendar month</td>
<td>$42.22</td>
</tr>
<tr>
<td>G2058*</td>
<td>CCM provided by clinical staff directed by a physician or other qualified health care professional</td>
<td>Each additional 20 minutes per calendar month (may be billed twice a month)</td>
<td>$37.89</td>
</tr>
<tr>
<td>99491</td>
<td>CCM provided personally by a physician or other qualified health care professional</td>
<td>30 minutes per calendar month</td>
<td>$84.09</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM provided by a physician, other qualified health care professional or clinical staff under the direction of a physician or other qualified health care professional</td>
<td>60 minutes per calendar month</td>
<td>$92.39</td>
</tr>
<tr>
<td>99489</td>
<td>Complex CCM provided by a physician, other qualified health care professional or clinical staff under the direction of a physician or other qualified health care professional</td>
<td>Each additional 30 minutes per calendar month</td>
<td>$44.75</td>
</tr>
</tbody>
</table>

*Effective as of January 1, 2020.
Not sure about return on investment? Think again, says Brown. A physician who bills 99491 for 250 patients every month for a year could generate $252,270 annually. That can more than cover the salary of a nurse whose sole responsibility is to communicate with the patient, assess for medication adherence, identify community and health resources, facilitate access to care, and more, she adds.

However, experts say CCM can also pose compliance risk when physicians don’t code and document it correctly. Consider the following four reasons for denial and how to avoid them:

**Reason for denial:** There is no separate documentation of CCM services.

**How to avoid it:** Create a separate note tracking the provider’s work related to CCM, says Manny Oliverez, CEO of Capture Billing & Consulting Inc. in Leesburg, Virginia. Don’t add this information to an existing note, he adds.

Physicians can also work with their EHR vendor to create a CCM template that includes documentation requirements and helps physicians and their staff track time spent rendering CCM services, Brown says.

**Reason for denial:** Another provider already billed CCM.

**How to avoid it:** “Only one provider per month can be reimbursed for CCM,” Oliverez says. He provides the example of a patient with end-stage renal disease in a skilled nursing facility who is managed by the facility’s medical director, a primary care physician and a nephrologist. Each provider can technically bill CCM; however, to avoid denials and costly rework, they should agree on who will bill it. The billing provider should be the one who ultimately performs all or a majority of the care management activities, including addressing the patient’s psychosocial needs, Oliverez adds.

**Reason for denial:** The wrong codes, depending on who provided the service, were billed.

**How to avoid it:** When medical-directed clinical staff perform CCM, report 99490, says Oliverez. When physicians perform it, report 99491.

**Reason for denial:** Complex CCM was billed when it wasn’t warranted.

**How to avoid it:** Document specific changes in the care plan, as well as medication or treatment changes, Oliverez says. Physicians or other qualified health care professionals can’t report complex CCM when the care plan is unchanged or requires minimal change (e.g., only a medication is changed or an adjustment in a treatment modality is ordered), he adds.

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**Modifiers 25 and 59**

CPT modifiers communicate important information to payers, and physicians must ensure the message they send is accurate, says Rhonda Buckholtz, CPC, CPMA, owner of Coding and Reimbursement Experts LLC in Pittsburgh, Pennsylvania. Consider the following:

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DEFINITION</th>
<th>MESSAGE TO THE PAYER</th>
</tr>
</thead>
<tbody>
<tr>
<td>25:</td>
<td>The physician performed a significant and separately identifiable E/M service on the same day as another procedure or service.</td>
<td>Pay for both services because the E/M service went above and beyond the usual pre- and post-operative work.</td>
</tr>
<tr>
<td>59:</td>
<td>A distinct procedural service was done.</td>
<td>Pay for two or more procedures/services because they were performed during different sessions or on different anatomical sites, organ systems or lesions or for different injuries.</td>
</tr>
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</table>
Sending the wrong message could lead to costly post-payment audits and recoupments, Buckholtz says. Consider these myths and truths about modifiers 25 and 59, commonly used in primary care/internal medicine:

**Modifier 25**

**Myth:** Physicians should automatically report an E/M code with modifier 25 in addition to a procedure when the physician documents a history, an exam and an MDM.

**Truth:** Report modifier 25 only when the E/M service goes above and beyond the usual pre- and post-operative work associated with a procedure that has a global fee period, Grider says. For example, an otherwise healthy patient with knee pain presents for a second routine injection in a series of three injections; physicians can’t bill a separate E/M with modifier 25 because the physician didn’t perform additional workup. “That E/M service should be part of the pre-evaluation workup and not billed separately,” she adds.

Buckholtz agrees. When the decision to perform the procedure has already been made and the patient presents for that scheduled procedure, physicians can’t bill a separate E/M service, she adds.

Grider offers this example of when an E/M service with modifier 25 may be warranted: A patient with diabetes and knee pain presents for a joint injection, and the physician changes the patient’s insulin regimen based on blood sugar levels.

The same is true for a patient who presents for an immunization but also complains of headaches, Buckholtz says. When the physician performs and documents a history, an exam and an MDM related to the headaches, they may be able to bill an E/M code with modifier 25 in addition to the joint injection. “This modifier is always heavily scrutinized by payers,” she says. “It must be clearly documented that the E/M service isn’t what the patient originally came in for.”

**Myth:** Physicians need two different diagnoses to report a procedure in addition to an E/M service with modifier 25.

**Truth:** The diagnoses for the procedure and the E/M service may be the same. Buckholtz’s example: A patient presents with knee pain; the physician performs a workup to determine that a cortisone injection is necessary and administers the injection. When the decision to perform the procedure is made the same day it is done, the physician can bill both the procedure and the E/M service with modifier 25: The diagnosis code for each service is knee pain.

**Modifier 59**

**Myth:** When payers deny a service, practices should automatically submit the service with modifier 59 to bypass payer edits.

**Truth:** Modifier 59 should be a last resort because it’s likely that a different modifier is more appropriate, Buckholtz says. Other options: RT (right), LT (left) or 50 (bilateral procedure). Payers may also accept modifiers XE (separate encounter), XS (separate organ or structure), XU (unusual nonoverlapping service) or XP (separate practitioner). Each payer policy will dictate what modifiers it requires in each circumstance. An encoder that includes payer-specific policies can help practices maintain compliance, she adds.

**Myth:** Once published, payer policies for modifier 59 remain largely unchanged.

**Truth:** Payer policies change frequently, and these revisions are often communicated via electronic remittance advice, Buckholtz says. For example, a payer may add and delete codes for which modifier 59 is appropriate. “If nobody is paying attention to these remittance advice communications, that’s when you get into trouble, because you’re billing per an old policy,” she says.

She shares these tips to help practices stay on top of policy changes:

- **Appoint someone in the practice (e.g., a coder or practice manager) to check the policies monthly.**
- **Print each payer policy. Make sure the printed policy includes the date it was printed.**
- **Read the entire policy. “People often go straight to the coding information, and that information is not valid unless you’ve met all the other criteria in the policy,” Buckholtz says.**
How should primary care physicians be paid?

The COVID-19 pandemic may have permanently changed the reimbursement landscape

by Todd Shryock Managing Editor

Primary care plays a vital role in maintaining the patients’ health but is often undervalued, with physicians paid less for it than for other specialties. With an increasing focus on health care costs in this country, combined with primary care practices taking a big financial hit because of the COVID-19 crisis, reimbursement is coming under greater scrutiny.

Medical Economics® spoke with Christopher Crow, M.D., founder and CEO of Catalyst Health Network in Texas, to discuss the state of primary care reimbursement and what needs to change. The transcript has been edited for length and clarity.

Medical Economics®: What’s wrong with how we pay for primary care today?

Christopher Crow: In short, you could say that there are incongruent incentives. There needs to be some agreement there that we’re trying to incentivize what people have called the triple aim and maybe even the quadruple aim, which is: How do we get better clinical outcomes for patients, a better experience for patients, a lower cost of care or a more valuable cost of care for the system? And then the providers who are providing that care have to have a satisfaction level with the work that they do. Right now, the way fee for service works for primary care, there’s an incongruence with how that’s paid for the care that’s delivered, if you want to actually achieve those outcomes.

Right now, fee for service means that you have to come into my 10-by-10 exam room for me to actually get reimbursed for caring for you. But that’s not the only way or the best way to get better clinical outcomes. It certainly is not the only way or the best way to have a good patient experience. And then, from the provider standpoint, we hear about burnout going up and up for the physicians.

Good primary care involves a relational-based care model. Physicians and their patients in primary care stay with each other for years. It’s not an episode. It’s not a one-time thing. It’s potentially a multiyear, multidecade, multigenerational, lifetime relationship, and therefore, it should be paid more smoothly over time — what we call proactive payment or prospective payment rather than this reactive care. If we’re only going to do reactive care, then we’re not going to get all the benefits of encouraging people to get better. The relationship of fee for service is such that it doesn’t allow for the proactive nature of care delivery that primary care is trained to do to take care of the whole person, but the payment model requires a 10-by-10 room with an in-person visit with that physician. So those really need to be unlocked from each other.

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Medical Economics®: How does the prospective payment model fix these faults, and how is it different from what’s been tried before?

Crow: Let’s go back to the ’90s, when people were using words like “capitation” that scared people. The difference between now and then is dramatic. No. 1, the technology we have today is drastically different from what we had 30 years ago. There are data and information that we can have on both sides of the transaction that weren’t there before to learn if there’s involvement with a patient. We also now have exploding health care costs, so there’s a heightened sense from all purchasers, whether it be the...
government or employers or a patient, about the cost of care. Right now, in Medicare Advantage, we’re already seeing this payment model happen, and we have for the past five or 10 years, with a fairly high growth of the Medicare Advantage product across America. The reason it’s growing, in my opinion, is that it does align the incentives with a prospective payment model to the primary care physician to align the right outcomes and be incentivized for it.

It’s not necessarily a silver bullet, but it gets you onto the right field of play, for sure. Attaching a care delivery model with the appropriate financing model is the key right now. It’s primary care as a relational, longitudinal-based care model, that then in a prospective payment model would organize care not only episodically in a 10-by-10 exam room but also let you become more team based in how you do things. Right now, there’s nothing in fee-for-service that pays for team-based care and nothing that pays for coordination of care. We all know that teams perform better than individuals. Why wouldn’t we do it in any care setting that makes sense, including the home?

A prospective payment model unlocks so much of the rigor of today’s model that doesn’t get the outcomes we want. It puts the incentive on the patient to go ahead and engage more with the physician and their team and affords the physician and the team the incentive to engage more proactively with the patient, because you actually have a payment model that’s paying you for ongoing care. So it really does bring together the care delivery model and the financing model to a more congruent state to deliver the outcomes.

Now, you still have to build the right incentives and the right outcomes that you’re measuring, but at least now you’re on the right playing field. COVID-19 has shown what a destruction in that congruence can do, because all of a sudden, we’re told across the country to shelter at home, which is the right thing to do for our health. The only way that physicians can get paid most of the time is in the 10-by-10 exam room, and that’s no longer available. We’ve absolutely crushed the primary care layer of health care in America. I mean, it’s absolutely decimated. That happens to be the layer that’s needed at all times, but especially in the COVID-19 moment, to help people with all their extra issues around coordinating care, getting medications and making sure their chronic diseases are being monitored. We need our primary care layer more than ever, yet the incongruence of the payment model and delivery model have absolutely decimated it in this moment.

ME: Will a prospective payment model allow small and rural practices to survive, and will they have to change how they do business?

Crow: I don’t think this switch from fee for service to prospective payment necessarily has a strong geographic or size difference in practice impact. I would say that the smaller businesses, the smaller practices, will want to be connected to something that allows them to dock into some teams and technology. If you are being paid prospectively and the patients are wanting to see you in new and different ways, from a technology standpoint and modality standpoint, you need to be able to provide those services and have that type of technology. So, if you’re in a smaller rural setting, you want to be able to attach to an organization that can help you in that way. The physicians in small towns, big towns — no matter what, they’re going to
need that capability to better care for the patients they serve.

ME: What are the benefits to the patient under the prospective payment model?

Crow: There are three stakeholders: the payer, the provider and the patient. From the patient advocacy standpoint, with a prospective payment, first off, it's a reorientation from “I only worry about my health care and when it’s bad enough that I’ll go have to pay some dollars to take care of it.” We all have different socioeconomic statuses, and that’s why we see these disparities that happen: because people are delaying care; because of the way we reactively have to pay for it. In a prospective payment model, it’s more like a subscription. If you can align the incentives right, when the financial burdens are spread out and don’t hit you every time you’re sick, in the worst moment, you can start to think about your health differently. With COVID-19, we’re finding that people who are unhealthy or overweight are disproportionately affected by this disease. So there’s a heightened sense now of “I need to care about my health in a different way.” Is that email? Is that text? Is that video? Is that going into the office? It could be any of those, depending on the circumstances. You could choose the right context, depending on your health, and you can use any location, as well. You don’t necessarily have to be tied to the to the physician’s office.

Right now we hear about surprise billings all the time; primary care should have no barriers to patients getting good primary care. The way we actually get to a better cost structure in America is to invest upstream in primary care, have the alignment happen with the care delivery model and the prospective payment so that patients and physicians alike and their teams will want to work together to lower downstream costs by creating better health on the front end.

ME: During the pandemic, many patients with chronic conditions have delayed their-care. What effect will this have on primary care physicians as we move forward?

Crow: That’s going to be a really interesting thing to watch. In one sense, there’s a worry that all of a sudden there will be a flood of people. In another sense, chronic disease kind of has this slow roll. That happens. And so everyone’s chronic disease may have just hit a new curve of getting worse over time faster, kind of a compounding effect. It’s another reason prospective payment is so important: If you could actually take care of people in multiple modalities right now, those relationships would compound positively rather than what we’re seeing now — the health of people compounding negatively because they’re not able to get into a physician’s office.

I think in the beginning, the power of teams versus individuals is really important in this, because it’s going to take a multimodality of a team-based care environment and primary care to help these people get back to a certain level of health. If it comes bombarding back all at once, that would be very difficult. Now, part of me also thinks that it’s not going to come back anyway, that there’s a big piece of America that is scared to get out and about these days, especially those with chronic disease and elderly people. It’s going to be harder if we require them to be in this fee-for-service model that means we have to see them physically in our 10-by-10 exam room, so they’re just not going to come back, which means they’re going to sit in their house and continue to get worse and worse and worse.

ME: Do you see any major changes facing primary care once we get through the COVID-19 crisis?

Crow: If we’re going to stay in the fee-for-service model, that’s going to be very, very difficult. There’ll be more prospective payment for sure. So, living in both of those models at the same time is going to be difficult. We’re going to have to make sure that we have good telehealth capabilities. We really need to lock that in, because it’s absolutely ridiculous that we would ever go back to the only form of payment a physician practice can get being through a 10-by-10 office visit. It’s punitive to the physician, it’s punitive to the patient, and it’s punitive to whoever’s paying for it. We need to open up all the channels we have to achieve the best possible care delivery and outcomes for patients. Those types of technologies need to be in place and locked in, and that’s potentially a challenge as some of the public health emergency things that got removed, like HIPAA, come back online. We’ll have to make sure we’re in compliance with some of those things, and that could be difficult.
COVID-19 and virtual services:

Nine tips for collecting patient balances

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

Practices have been creative during COVID-19 to ensure safe patient access: Telephone visits. Curbside immunizations. Drive-up virus testing. Even checking patients in for their in-office visits while they wait in the car. However, each of these scenarios poses one significant challenge: Collecting copayments and coinsurance.

“With COVID-19, you’ve got to find ways to meaningfully engage the patient,” says Denny Flint, chief commercial officer at Millennia, a tech-enabled patient engagement company specializing in the recovery of end-to-end patient financial obligation. “That’s the key to a successful collections strategy.”

Experts provide nine tips to help practices successfully collect patient balances during COVID-19 and beyond:

1 EDUCATE PATIENTS ABOUT THE COST OF VIRTUAL SERVICES

This includes having a conversation at the time of booking about how much each service will cost, says Flint.

Although some payers may waive cost-sharing for virtual services during the pandemic, those waivers will likely expire at some point, making it critical for patients to understand their financial responsibilities. For example, patients may not understand why they need to pay for a telephone appointment or why a telehealth visit costs the same as an in-person one. Explain that these services require provider time and expertise, which is why payers consider them compensable.

2 DECIDE WHETHER THE PRACTICE WILL REQUIRE UPFRONT COLLECTIONS

Many practices became lax during COVID-19 because they simply wanted to maintain or rebuild patient volumes. Now it’s time to revisit their strategy, says Reed Tinsley, CPA, health care consultant in Houston, Texas. “A medical practice is a business,” says Tinsley. “You need to have cash coming in to pay expenses.”

Cheryl Mongillo, practice manager in Wilmington, Delaware, says her family medicine practice has been less aggressive with upfront collections during COVID-19 because payer policies regarding patient financial responsibility have changed so frequently. “It’s very complicated,” she says. “Depending on who the carrier is, it’s a different rule — even for the same payer.”

She spends an hour each day monitoring payer websites for changes. She also taps into resources through a listserv managed by the Professional Association of Health Care Office Managers (PAHCOM), an organization that includes thousands of medical office managers, practice administrators and physicians managing their own private practices.

“Not collecting these amounts upfront has increased our accounts receivable, but we’re willing to work with that for a little while,” she says,
adding that federal funds continue to help. Her practice received $63,000 through the first round of Medicare advanced payments. They also received financial assistance through the Paycheck Protection Program.

Mongillo’s staff continue ask for an upfront copayment either in person or ahead of time when confirming appointments via phone, but they don’t insist on it. “We don’t want to alienate patients because this is a stressful time for them,” she says.

One challenge with upfront collections is that the clinical circumstances of the visit are frequently unknown before the encounter, says Flint. This makes it difficult to know exactly how much patients will owe, he adds.

For example, a patient may come in for a simple follow-up appointment. However, during the appointment, the physician might perform a minor procedure that’s separately billable (e.g., a biopsy or lesion removal). Another example is a level three office visit that turns into a level four because it requires more complex medical decision making.

With that said, practices should strive to avoid over-collecting from patients so they don’t end up owing money they’ve already spent on salaries and supplies, says Flint. He says to calculate 90% of the Medicare fee schedule amount (which is typically the lowest fee schedule among federal and commercial payers), and then apply the patient’s insurance. “You’re going to underbill, but at least you’re getting the patient invested in their care upfront,” he adds.

Also print an aging of accounts receivable (credit balances only) report on a monthly basis so the practice can refund patients in a timely manner and according to payer requirements, says Tinsley. Medicare, for example, requires providers to refund patients within 30 days of the payment date, he adds.

3 MAKE IT EASY FOR PATIENTS TO PAY

“If a small practice wants to survive, it can’t just send a statement and hope patients pay,” says Flint, adding that practices must tailor patient financial engagement strategies to fit the age and tech-savviness of the demographics they serve.

“Portal-driven online bill-pay and mobile payment methods may attract the millennials and Gen-Xers who are comfortable with DIY technology,” says Flint. “However, baby boomers generally prefer the human touch delivered by a U.S.-based call center that gently informs and educates them about why they owe what they owe. COVID-19 has taught us our goal is a seamless, personalized billing experience where one size does not fit all.”

Mongillo’s practice sends a text message to patients as soon as their account includes a patient responsibility. Patients simply click through the link to a secure site.
where they can make the payment. She says this technology has increased their collections by 30% in the last year and a half.

Obtaining patient consent to receive these messages is easy because Delaware law doesn’t require providers to ask patients whether they want to opt in to receiving these messages. It only requires them to let patients opt out. Mongillo says many patients don’t opt out because they want to receive appointment reminders and payment receipts via text as well.

4 OFFER A PAYMENT PLAN
Mongillo doesn’t want patients to forgo or delay care because they can’t afford it. “Most of our patients who are on these plans are people we’ve seen for 20 or 25 years who have fallen on some rough times,” she says.

However, remember that the longer it takes patients to pay off their debt, the less value that money has to the clinic because of overhead, salaries and other expenses, says Sergio Quiej, Texas-based independent revenue cycle consultant who recommends three or four monthly installments.

5 CONTINUE POST-VISIT COLLECTIONS CALLS … BUT WITH SENSITIVITY
Flint suggests calling patients after the same invoice remains unpaid after two billing cycles to make sure they received it, answer any questions they have and try to connect in some way.

To minimize questions, be sure to send a clear and concise invoice. This includes the service date, location, provider, description of the service rendered, amount insurance paid (including primary and any secondary insurance), and the amount the patient owes, says Flint. Differentiate between copayment and co-insurance amounts, he adds.

However, don’t just call and ask for money, says Quiej. Inquire about the patient’s family and job — even if it takes a few extra minutes. “The way you treat the patient directly impacts how they’ll react to the debt,” he says.

Tinsley agrees. “What I tell all of my clients is don’t change your process,” he says. “Send out your statements, make your collection calls, and forge ahead.” Temporarily relaxing your processes can have a negative effect in the long-run because patients may come to expect and even demand that leniency indefinitely, he adds.

6 EMPLOY ENOUGH BILLERS OR CONSIDER OUTSOURCING
Many practices may have laid off staff when patient volumes decreased. However, once volumes resume, they need to make sure they have enough staff for timely billing and collections, says Flint. In some cases, it may make more sense to outsource revenue cycle management (RCM) to a company that is a branded extension of the practice and staff. Working with an external vendor also helps practices avoid internal staffing challenges as patient volumes continue to ebb and flow during a potential second wave of the virus.

Flint provides these tips for negotiating a favorable contract with an RCM vendor:
- **Require the vendor to charge only a percentage of what they collect.**
- **Ask the vendor to waive its implementation fee.**
- **Demand an easy-out contract.** “If the vendor doesn’t perform within six months, you should be able to walk away without cause or penalty,” he adds.

7 KEEP A CREDIT CARD ON FILE
This enables practices to simply charge the card once a patient responsibility is assigned, says Flint. However, there are caveats. “If your practice intends to accept card payment as well as store, process, and transmit cardholder data, you need to host your data securely with a Payment Card Industry (PCI)-compliant hosting provider that ensures the data is encrypted, password protected and compliant with PCI Data Security Standards,” he adds. These standards cover technical aspects of handling and managing cardholder data.

8 CONSIDER SETTLEMENT RIGHTS
If the practice makes a reasonable effort to collect from a patient who is experiencing financial hardship (e.g., job loss due to COVID-19), providers may be able to offer a discount (e.g., settle for 70% of the amount owed) without violating Stark Law, says Tinsley. “But remember that just because even if someone doesn’t have a job, they could still have money,” he adds. “There are a lot of people out there with big savings accounts.”

9 PROVIDE TRAINING TO FRONT-OFFICE STAFF
“It’s uncomfortable for people to ask patients for money,” says Tinsley. Provide training on how to communicate effectively to increase the likelihood of collections while maintaining positive patient relationships, he adds.

Think of COVID-19 as an opportunity to improve patient collections and the patient financial experience, says Quiej. “This is an opportunity to create and develop relationships with patients — to learn how to approach each patient,” he adds. »
Automating accounts payable: How to start

The practice I work for, Family Allergy & Asthma, was founded in 1979 and is a group of board-certified allergy and asthma specialists with offices in Kentucky, Indiana, Ohio and Tennessee. We currently operate more than 50 clinics with over 30 Board-certified allergists and physicians.

Like many businesses, we are continually looking for ways to streamline our operations, maximize cash flow and create better processes. One thing we have recently tackled is our accounts payable (AP) process.

We regularly work with hundreds of vendors from immunotherapy drug manufacturers for things like wasp serum, to medical suppliers to Staples for office supplies. But, none of our transactions are PO-based, as departments place orders as needed directly with vendors.

As such, our finance team has had little insight into the AP pipeline. Until recently, we didn’t have any visibility into invoices until the order arrived. With the majority of our 400 monthly invoices coming in via postal mail, processing was manual and slow. Our accountant hand-coded each invoice.

We knew there must be a better way, so a few months ago we began looking for new technologies to help. It was especially important that any new solution would integrate with our enterprise resource planning (ERP) system.

The COVID-19 pandemic came in just as we were implementing our new automated solution, Stampli. Fortunately, we were able to get set up in about one day and our 15 invoice approvers trained quickly.

Automating our AP function has fundamentally changed how we do business.

Big changes — like pivoting to telemedicine — are less painful

Right after our invoices were automated, our IT director was tasked with rolling out telemedicine to enable providers to treat patients who were sheltering in place. Suddenly he had a huge project to implement, and at the same time a growing number of invoices to approve. With full visibility into all invoices, we were able to identify which ones needed his approval, reduce his load, and enable him to focus on other projects.

The combination of the pandemic and how much our AP process has improved has shown our company the need for digital automation. From an accounting systems’ perspective, we’re at the beginning of what we will do with automation and new we have the foundation to establish future growth.

A few tips for practices and physician offices looking to automate some of their financial processes:

- Find solutions that integrate with your accounting system. Avoid implementing multiple systems that do not communicate.
- Secure buy-in from the accounts payable team that is performing the day-day work.
- Make the case to the powers that be in dollars and cents (i.e. how much automation will save).

Zachary Kulow is the financial controller at Family Allergy and Asthma. Send your financial questions to medec@mjhlifesciences.com.

We have reduced our invoice lifecycle from 10 to 3 days

Our invoice lifecycle used to take up to 10 days, and with that came the risk of late payments and potential fees. Now it’s been shortened to about one day per approver, so three days total — that’s a 70 percent cut in the invoice lifecycle.

We are 90 percent faster getting invoices into Intacct

We’ve gone from 10 days to just one day to get all invoices into our existing ERP system, and that’s a huge value add because it gives my team insight into all invoices so we can better plan. Additionally, with the COVID-19 crisis, cash flow management has become more critical, and our solution’s search capabilities allowed our team to quickly manage it by identifying outstanding invoices for payment.

Approvals now move quickly

We can easily and quickly identify who has what invoice and its status in the approval process. It’s easy for our approvers to ask and answer questions in real time, track approvals, and establish an audit trail — all without anyone having to be onsite.
Address social determinants improve patient outcomes

by Jordan Rosenfeld Contributing Author

There is a growing recognition in health care that many chronic conditions can be improved by addressing social determinants of health (SDOH) first.

“Social determinants of health are those aspects of how we grow, how we live, how we play and how we worship that affect our overhaul health, in addition to the systems and resources set up to provide that,” says Jeffrey F. Hines, M.D., medical director of diversity, inclusion and health equity for Wellstar Health System in Atlanta.

SDOH encompass critical socioeconomic aspects such as access to food, transportation issues, housing conditions, education, neighborhood and environment conditions, access to health care and ethnicity, Hines explains. Experts recommend that, to better help patients with chronic illness, physicians learn more about these potential obstacles to health and how to identify patients struggling with them.

Get educated on the effects of SDOH

Physicians can begin by gaining an understanding of SDOH’s measurable impact on health, if they haven’t already studied it, says Alexandra Schweitzer, M.P.P., a senior fellow at the Mossavar-Rahmani Center for Business and Government at Harvard Kennedy School in Cambridge, Massachusetts.

“IT is well documented that unstable housing, inadequate nutrition, social isolation and other social determinants of health worsen
chronic conditions like diabetes, heart disease and mental illness,” Schweitzer says. “Physicians in primary care and emergency departments can and do help patients by screening them for social needs, connecting them to community health workers, referring them to social service agencies and helping them navigate through the social services system.”

SDOH tend to affect marginalized and underserved communities the hardest, such as people of color — especially African Americans, who are already at increased risk of a number of chronic illnesses, from hypertension to diabetes — members of the LGBTQ community and the homeless, Hines says. “Because of systems of disparities that have been in place for decades, those communities continue to have higher incidences of chronic illnesses, which affords them [poorer] health outcomes than appropriately resourced communities,” he says.

A 2018 study in The Permanente Journal states that “upwards of 70% of health outcomes are driven by factors beyond health care and that poverty is associated with more years of lost life than smoking and obesity combined.” In addition, a 2014 study in “Public Health Reports” suggests that health behaviors, linked to increased risk of illness and mortality, “are strongly shaped by social factors, including income, education and employment.”

The proof that SDOH affect health is perhaps better represented by the successes that follow when these needs are addressed, Schweitzer says. She notes that fixing a problem related to, for example, housing or food insecurity can change a person’s health outcome. She references a case study of a homeless woman with diabetes whom she calls “Regina.” When Regina got into public housing at age 46, her diabetes improved. She was able to refrigerate her insulin and had a safe space to give herself injections, and she could prepare and eat healthy food on a regular basis.

“That’s one way housing has a ripple effect on diabetes,” Schweitzer says. “By addressing housing, and with a lot of case management, [Regina] was able to get into a much more sensible routine of prevention.”

**Set up seamless screening**

Although physicians cannot solve their patients’ socioeconomic problems alone, they can use SDOH screening questions to get to know their patients’ needs better and connect with community resources and care navigators, if appropriate, Schweitzer says.

“The best way to integrate this work into their practices is to build it into what they are already doing; for example, by using medical assistants to do screening and documenting results in the electronic medical record,” Schweitzer says.

Erin Jospe, M.D., M.P.H., a psychiatrist at Kyruus, a provider data management platform in Boston, says physicians need not create their own SDOH screening documents; a number of options already exist. These include:

- The Hunger Vital Sign, a two-question screening method to determine food insecurity.
- The Everyone Project, organized by the American Association of Family Physicians (AAFP), a series of tools that focus on social needs.
- A toolkit from the American Academy of Pediatrics to assess SDOH in children.
- A guide by the American Hospital Association to help physicians create their own SDOH screening protocols.

For physicians who want support in building their SDOH screening tools, Schweitzer recommends an AAFP publication titled “The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned.” The authors recommend the following steps:

- **Determine readiness to start screening; the guide offers a related checklist.**
- **Identify the community’s specific SDOH needs.**
- **Create relevant screening questions.**
- **Build connections with community resources and develop a strong team to work together on these issues.**
- **Build the screening into the workflow so it is seamless.**
- **Start small, with just a few questions.**
- **Make a plan to sustain follow-up with patients over time.**

The Centers for Medicare & Medicaid Services began a program in 2016 called the Accountable Health Communities Model, which promotes clinic-community collaboration around SDOH, to screen and report on health outcomes. Jospe recommends that physicians “assume nothing” about who might be experiencing hardship in which area and screen every patient for SDOH in the same way.

If physicians who make recommendations find that their patients don’t seem to be improving, Nicole Washington, D.O., M.P.H., a psychiatrist based in Tulsa, Oklahoma, advises probing a little more deeply into the patient’s situation. “Telling a patient to exercise is fine. But what if [patients] don’t have sidewalks or a safe place to walk? We just can’t give cookie cutter advice.
CHRONIC CONDITIONS / SOCIAL DETERMINANTS

when people aren’t living cookie cutter lives,” she says. “We may all be in the same storm, but we’re in very different boats.”

Washington recommends asking patients struggling with adherence what is stopping them from implementing a healthy behavior or treatment. “Sometimes we don’t ask those questions. We just label people as being nonadherent,” she says.

Chirag Patel, MD, medical director of population health at Wellstar, recommends asking intentional questions, such as “Are you having trouble getting food to eat? Are you afraid of being evicted? Is there mold in your house?” If patients provide answers that indicate difficulty with one of these key SDOH, the physician can offer a resource list or try to connect the patient with a care navigator, social worker or related staff person.

COVID-19 reveals societal gaps in care

by Jordan Rosenfeld

The COVID-19 pandemic has changed the way people around the world live and work, including how they access health care. COVID-19 is also having a huge impact on social determinants of health (SDOH), those conditions of work, society, environment, race and more that affect our health, experts say.

“COVID-19 is shining the light on where the gaps and weaknesses in society are,” says Erin Jospe, M.D., an internist and chief medical officer of Kyruus, a provider data management platform in Boston. She points out the significant difficulties some patients face in accessing and paying for food, medications and health care, problems exacerbated by COVID-19. “We must recognize that some of our patients may be feeling (vulnerable) in really acute and potentially tragic ways during COVID-19,” Jospe says.

As a safety precaution during this time, most states have residents sheltering in place. This is a privilege not afforded to everyone, including essential workers, who may already be dealing with a greater number of SDOH than people who are able to stay at home, says Jeffrey F. Hines, M.D., medical director of diversity, inclusion and health equity for Wellstar Health System in Atlanta.

“Many of these people have to take public transportation to their jobs. Then, when they return home, they may be in spaces where it’s difficult to socially distance when multigenerations are living in the same home,” Hines says.

COVID-19 is revealing economic inequalities that are forcing some people to choose between health and financial stability, says Nicole Washington, D.O., M.P.H., a psychiatrist based in Tulsa, Oklahoma. “When everyone is saying ‘stay home’ but your employer is saying ‘we’re open,’ and you have to choose between possibly getting this virus and being able to pay your bills, it makes it very difficult,” she says.

The “economic dislocation” of COVID-19 will have a big impact on nutrition, from both possible disruptions in the food supply chain and unemployed people’s inability to afford food, says Alexandra Schweitzer, M.P.P., a senior fellow at the Mossavar-Rahmani Center for Business and Government at Harvard Kennedy School in Cambridge, Massachusetts.

In addition, Jospe points out the widening digital divide that affects those who can’t access the internet or Wi-Fi services or don’t have a computer to get online for, say, education and health care. “The inequality between who has certain necessities, like data plans and broadband and high speed internet, have suddenly become (more glaring),” Jospe says.

An inability to connect online has the potential to increase social isolation and degrade mental health. “There’s evidence that social isolation and loneliness affect health,” Schweitzer says.

Physicians can help patients by being proactive and reaching out, says Jospe, who suggests asking patients if they are have trouble with refilling or paying for prescriptions or accessing internet services.

“There’s a lot of fear and uncertainty right now,” she says. “I can say that many of those outreach phone calls that physicians’ offices are making right now are really being warmly met. People feel cared for.”
Partner with community resources

It’s important to begin the process of assessing for SDOH, but Schweitzer cautions against doing it alone: “Physicians probably shouldn’t try to do it all themselves,” she says. “Often one of the best ways to get some help is to provide a community health worker, a nonclinical person who comes from the community and speaks the right language, to establish a rapport and some trust [with patients].”

Helping a person who struggles with an SDOH such as food insecurity isn’t as simple as providing a link to a local food bank, she says. It might require assisting them with filling out the application for Supplemental Nutrition Assistance Program benefits. It might take providing nutritional education and even support with obtaining basic kitchen supplies so patients can cook for themselves.

“A lot of the difficulty with adopting healthy behaviors is that people have to struggle to wind their way through the system and figure out all the bureaucracy in the middle of what are probably fairly hectic lives,” Schweitzer says.

Patel says he believes in strong partnerships and advocacy at a local level: “This includes community organizations, corporate, philanthropic and policy partners that want to make a difference in this space.” He suggests partnering with local faith and spiritual groups, which often have “significant influence” on healthy behaviors and practices of their members.

For physicians who don’t yet have a lot of connections, Schweitzer recommends referral platforms like Healthify that help physicians find sources for SDOH needs.

Empower patients with knowledge

Though it is important for physicians to become better educated in SDOH and health equity practices, Patel stresses that it’s equally important to improve patients’ health care literacy. “I think one of the areas we need to explore more in our country is helping patients know what questions to ask when they go to see the doctor,” he says.

As an example, he cites the high incidence of fibroids in African American women. Many doctors recommend an intervention such as a uterine fibroid embolization or partial hysterectomy, but those treatments can impair the ability to become pregnant. Many young African American women opt for these treatments in their childbearing years because they don’t know about alternatives or what questions to ask. “That’s not an equitable outcome compared to other ethnicities,” Patel says. “We have to give the tools of education and information to our patients so they know what to ask.”

There are numerous ways physicians can think about and screen for SDOH, but what matters is that they begin somewhere, Jospe says: “We need to think about our familiarity with the resources we can bring the best way to highlight them and offer them to our patients, so that when there is stigma about needing to ask for help, that can be taken away.”

“We just can’t give cookie cutter advice when people aren’t living cookie cutter lives.”

—Nicole Washington, D.O., MPH, a psychiatrist based in Tulsa, Oklahoma
Chronic diseases are a recent part of human history. In the past people only went to healers, physicians or hospitals when they became sick. Generally these were due to infections, injuries or other maladies. Even cancer was very rare in the past as described by Mukherjee (“The Emperor of All Maladies,” 2010). The concept of chronic diseases emerged in the 1970s with high blood pressure (hypertension) being the first. Type 1 diabetes (a complete lack of insulin) became understood in the early 20th century, but the far more common Type 2 diabetes (due to excess carbohydrates and insulin resistance) emerged with the epidemic of overweight and obesity. High cholesterol became recognized as a disease in the 1980s. Auto-immune diseases were known in the past but exploded in frequency in the 1970s and a new medical specialty developed — rheumatology.

Chronic diseases are often referred to as Western diseases due to being more affluent and industrialized. But affluence and industry do not lead to disease, the lifestyle that commonly goes along with them does. We have learned that all these diseases are reversible through lifestyle change. That is what Restore Health is all about. By guiding people through the necessary lifestyle changes, people are able to get off most medications and erase chronic diseases from their active medical history. There are six elements to a healthy lifestyle:

- **Nutrition** is the most important and is estimated as an 80% factor in causing most chronic diseases,
- **Physical activity**, both movement and strength,
- **Stress management,**
- **Healthy restorative Sleep,**
- **Social connections** (important and usually not a problem for most in the Coachella Valley), and
- **Having meaning and purpose to life** (the spiritual dimension).

The Restore Health approach will be to explore and seek to optimize each of these elements for a healthy lifestyle.

Chronic diseases number in the hundreds and can be grouped into categories.

### 1 BONES, JOINTS, STRENGTH AND BALANCE

Our modern lifestyles may give us greater longevity but our healthy years (health span) is in decline. Our muscles and our skeleton ages and causes many reversible problems. At Restore Health we use the BioDensity and Power Plate technologies to naturally restore strong bones reversing osteopenia and osteoporosis. The result is healthy normal bone. Drugs do not do that. After getting a body composition and balance test, our expert training will add muscle strength and restore balance, turning back your physical clock many years.

### 2 DISEASES OF CARBOHYDRATE OVERLOAD

Our modern American diet and culture is loaded with sugar and refined carbohydrates that have made the majority of Americans overweight with an elevated blood sugar leading to dementia and many other problems. Forty percent of Americans are obese with excess body fat as stored energy. Restore Health uses a healthy human diet of Superfoods that has healthy fats, protein and low carbohydrate resulting in the reversal of overweight, obesity, prediabetes, Type 2 diabetes, high cholesterol, fatty liver and metabolic syndrome. Exercise and stress reduction help this process.

### 3 DISEASES OF INFLAMMATION AND AN UNHEALTHY GUT MICROBIOME

Inflammatory proteins and fats in common foods cause us to have systemic inflammation and an unhealthy gut microbiome (dysbiosis). Common gastrointestinal problems result from this including acid reflux, irritable bowel syndrome and inflammatory bowel disease. Our stomach acid is good for us and the drugs to reduce stomach acid harm us in the long run. The entire spectrum of auto-immune diseases originate in the gut as a result of dysbiosis and small intestinal bacteria overgrowth. The RH diet and lifestyle reverses all these problems.
OPINION / CHRONIC CONDITIONS

4 DISEASES OF STRESS
Life today is stressful for most everyone. Achieving a life controlling stress is an important skill that can be learned. This leads to equanimity during the day and natural restorative sleep at night. Hypertension (high blood pressure) can be reversed along with many common mental health problems such as anxiety and depression. At RH we use mind and body solutions for stress reduction and optimal mental health.

5 CHRONIC FATIGUE AND FIBROMYALGIA
These common health problems respond to optimizing nutrition and lifestyle. With chronic fatigue improving immune function is vital when a chronic virus in at the core of the problem.

6 COGNITIVE DECLINE
Dale Bredesen (“The End of Alzheimer’s”) and Daniel Amen (“Memory Rescue”) have shown that cognitive decline can not only be avoided but even reversed! The three most common factors are blood sugar levels, inflammation and toxins. At RH we use the Bredesen protocol to preserve cognitive function and reverse cognitive decline if caught in stage 1 or 2 dementia.

7 CANCER REMISSION
While cancer occurs for many different reasons once it exists it is a metabolic disease. It must be fed and nurtured to cause disease and death. Much has been learned about maximizing your changes for cancer remission. At RH we will guide you in a cancer remission diet and lifestyle to improve your changes for remission and a full recovery.

8 ANTI-AGING
Much has been learned about the biology of aging. We are designed to age and die. The modern diet and lifestyle often accelerates aging and death. At RH we will guide you to have the longest healthspan possible. We will also provide the latest knowledge about how to extend your biologic life through medications and supplements that delay the processes leading to aging and death.

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Arnel Sator, MS, BS, PTA has an extensive background focused in physical health, kinesiology and exercise physiology and is a former U.S. Olympic athlete.

80%
OF CHRONIC DISEASES IS ESTIMATED TO BE CAUSED BY NUTRITION

Restore Health is an office devoted exclusively to promoting health rather than treating diseases with drugs and procedures. The goal is for you to discontinue as many of your medications as possible and to erase chronic diseases from your medical problem list. All practices are based on the latest science information. Whenever possible real foods are used over supplements. All six elements of a healthy lifestyle are addressed in every person. Health Insurance is about covering you for disease treatment so it will not be used for coverage of these services.

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Digitize admin tasks to reduce staff burdens

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

Physicians enter the medical profession because they want to take care of patients, not focus on administrative tasks. Yet these tasks continue to dominate their time and attention, leading to frustration and burnout. Administrative tasks also overwhelm staff, fueling job dissatisfaction and turnover.

“If you find yourself saying, ‘There’s got to be a better way,’ then it’s time to take action,” says Rob Wiley, head of marketing and product strategy at Formstack, a workflow and process automation vendor in Fishers, Indiana. The COVID-19 pandemic has made it increasingly necessary for practices to shift certain time-consuming administrative tasks from a manual to a digital workflow, and to use digital methods for services that have been done in person in the past.

Beyond COVID-19, this shift can also help practices meet patient demands in an era of health care consumerism, says Michael Morgan, CEO of Updox, a customer relationship management vendor in Dublin, Ohio. “Patients expect to be treated like customers,” he says. “You can’t use old processes — phone calls, paper and voicemail.”

Consider digitizing these three tasks:

**Patient check-in**

Having patients check themselves in can boost staff efficiency while simultaneously decreasing patient wait times, says Craig Cooper, product manager at AdvancedMD, a cloud-based software provider in South Jordan, Utah. Using practice-owned tablets or kiosks that connect directly to a secure check-in app, patients validate demographic and insurance information and more, all without interacting with front office staff.

When using the check-in app, patients also can review outstanding balances and pay the amount owed, reducing the time staff members spend following up with unpaid invoices, Cooper says.

In December 2017, Thomas Miller, M.D., a family physician in Arlington, Texas, started having patients use a self check-in process. “I have experienced a significant...
return on investment,” Miller says. “It streamlines check-in and frees my staff for other tasks.”

Anything physicians can do to use less paper is beneficial, Wiley says. Paper forms have many drawbacks: Patients aren’t usually able to complete them in advance and don’t arrive early enough to complete them prior to their appointment; patient handwriting may be illegible; and front office staff must spend time scanning the forms into the electronic health records system (EHR).

“Using mobile-friendly forms allows patients to provide their information from any device at any time before their appointment, which increases efficiency for patients and providers alike,” Wiley says. These HIPAA-compliant forms can then be automatically uploaded to the patient’s record, giving providers immediate access to the information that’s critical for accurate diagnosis and successful treatment.

### Tips for success
- **Make self check-in a personal experience.** Ensure that a staff member is always available to greet patients upon their arrival, direct them to the tablet or kiosk, and assist them if questions arise, Cooper says.
- **Choose a user-friendly application.** Look for apps that provide simple navigation with clear instructions on how to proceed from one step to another, Cooper says.
- **Prepare for faster check-ins.** If your practice has more than one tablet or kiosk, multiple patients can check in at the same time, thus increasing patient flow on the front end. Practices may need to consider hiring additional medical assistants or providers, positions that are often funded by reducing front-end full-time staff, Cooper says.

### Patient-provider communication

Long gone are the days when patients were willing to wait on hold or play phone tag to schedule an appointment, hear about a lab result or request a prescription refill. In addition to communicating with patients via a secure portal, another method has quickly emerged as the new normal: texting.

“Physicians need to accept that texting is here to stay and that it is the preferred method of communication by every generation,” says Kathy Ford, president and chief product officer at Rhinogram, a telehealth communications company in Chattanooga, Tennessee.

Texting not only improves patient satisfaction, it also reduces the administrative burden on physicians and staff. “Physicians love not being tethered to a desk in order to respond to patients,” Ford says. Staff members can text multiple patients almost simultaneously while seeing a 50% reduction in phone calls, according to Rhinogram data. The best part? Staff training is minimal, and staff are often able to respond to messages within 10 minutes. Contrast this with voicemails. It typically takes staff at least 24 hours or more to respond to voice messages, she says.

Practices also may be able to use HIPAA-compliant texting to facilitate and bill for chronic care management. Other potential services include asynchronous remote evaluations, virtual check-ins, and online digital evaluation and management services, depending on the payer, says Ford. These types of visits can be particularly helpful during the current COVID-19 outbreak because they eliminate the need for patients to come into the office, she adds.

When coordinating care with other providers, practices spend a considerable amount of time sending and receiving paper faxes — a task that can be digitized to improve efficiency, says Morgan. Online faxes are automatically downloaded into a HIPAA-compliant platform where they can be routed to the appropriate individuals (e.g., a medical assistant who receives all faxes related to durable medical equipment and then contacts patients regarding insurance coverage). Staff also can send faxes with a click of a mouse.

“Before we went digital, we had
TECHNOLOGY / DIGITIZING TASKS

“I have experienced a significant return on investment (using self check-in). It streamlines check-in and frees my staff for other tasks.”
—Thomas Miller, M.D., family physician, Arlington, Texas

Tips for success:

- Educate patients. Alert patients waiting on hold on the phone that they can text the practice instead, Ford says. Put up signs in the waiting area informing patients of the option to participate in secure texting. Also provide this information on the practice’s website and Facebook page, she adds.

- Obtain patient consent. Per an exclusion in the Telephone Consumer Protection Act, practices don’t need to obtain patient consent for texting about appointment reminders or clinical information, but they do need it for everything else, even to wish patients happy birthday, Ford says. Still, best practice is to let patients choose what types of text messages (if any) they prefer to receive. Be sure to inform them that any information they send isn’t protected until their provider receives it. This means it isn’t protected during transmission from their phone to their carrier and from their carrier to their provider, she adds.

- Use HIPAA-compliant texting. Physicians shouldn’t text directly from their private cell phone because it’s not secure, and messages ultimately reside on that phone, not in the patient’s record, Ford says.

- Develop protocols for texting. For example, determine whether the practice will permit staff to text all lab results or only negative ones, Ford says. Some practices, for example, permit texting positive lab results because they can also set up an in-person appointment or coordinate a prescription during the same conversation.

- Ensure HIPAA-compliant texting can automatically route text messages to the appropriate individuals, Ford says. Being able to route messages to specific physicians during a specific timeframe (e.g., 48 hours post-surgery, when complications could develop) is also beneficial, she adds.

To schedule one staff member, usually a medical assistant, away from their normal duties so they could concentrate on faxes, “says Stan Adamek, D.O., co-owner and physician at Bridgeport Family Medicine in Tigard, Oregon. “We were at the point of deciding to hire another employee just to help with all of the faxes, medical records and pharmacy requests.” The return on investment has been significant, Adamek says. “Our staff can work more efficiently, and we are saving money from not having to buy pallets of printer paper,” he says. “We’ve also reduced the cost of shredding services, not to mention being able to reduce our impact on the environment.”
Physician documentation

Physician documentation is one of the biggest administrative burdens, requiring 16 minutes on average per patient encounter, according to a recent study published in the New England Journal of Medicine Journal Watch. Yet this documentation drives care coordination, medical coding, reimbursement, quality metrics and more. Speech recognition software (which costs an average of $1,200 per physician annually) can help reduce documentation time by as much as two hours a day for most physicians, says Peter Durlach, senior vice president of health care strategy and new business development at Nuance Communications, a health care software company in Burlington, Massachusetts. It can also generate higher reimbursement. “Physicians using speech recognition tend to describe more of what’s going on with the patient,” he says. “This means they capture patient acuity more accurately to drive more accurate payment.”

Tips for success:

- Weigh all options. Some physicians may prefer to hire an onsite or virtual scribe to alleviate documentation burdens, while others prefer solutions that provide a more technology-centric experience, such as ambient clinical intelligence (ACI), says Durlach. With ACI, physicians and patients talk and artificial intelligence technology converts their dialogue into a clinically accurate note populated in the EHR, he says.

- Be prepared to validate. Today’s speech recognition products are highly accurate, regardless of accent and specialty. However, physicians must always take a few seconds to review the text before signing off on it, Durlach says.

- Consider workflow. When using speech recognition, it’s often most efficient to dictate during the patient’s appointment, Durlach says. Physicians who do this prevent documentation from backing up until the end of the day. They also benefit from patients being able to listen and make corrections, he adds.

Questions to consider

When performing a cost-benefit analysis of going digital with administrative tasks, experts say physicians should consider these six questions:

1. Will this change or improve patient satisfaction?
2. Will this change or reduce physician burnout?
3. What “hard costs” (e.g. paper, toner, scanners) can the practice reduce or eliminate?
4. What other operating costs (e.g., transcription or scribes) can the practice reduce or eliminate?
5. Will this change increase efficiency? If so, how can physicians and staff use their time more productively? Can physicians shorten their workdays? Can they see more patients and increase revenue while working the same number of hours? Can they see the same number of patients but spend more time with those patients?
6. Will a digital workflow help the practice maintain regulatory compliance and avoid HIPAA-related penalties?
Jeremy Gabrysch, M.D.,
Austin, Texas

When the COVID-19 crisis hit, telehealth was forced to the forefront when many primary care physicians closed their doors to in-patient visits due to safety concerns. As both patients and doctors became more comfortable with the technology and level of care provided, it looks more and more like telehealth will play a much bigger role in the future.

Medical Economics® spoke with Jeremy Gabrysch, M.D., an emergency medicine physician and CEO of Boston-based Remedy, to discuss this and other changes in health care.

(Editor’s note: The transcript has been edited for brevity and clarity.)

Medical Economics® (ME): Because of the COVID-19 crisis, telehealth has made huge inroads into medicine. Is this good for both providers and patients?

Jeremy Gabrysch: The explosion of telehealth that we have seen during this pandemic is such a boon for patients. It really helps ensure a continuity of care at a time when you know patients are scared. They’re seeing what’s happening on the news. They’re hearing stories. They are afraid of going to a waiting room where they might be sitting next to someone else who’s sick. So, you know, this puts a pressure on the doctor-patient relationship. But telehealth relieves that pressure; it
allows patients to stay connected with their doctors.

We’re told that 25% to 30% of care that we have traditionally given in a clinic could potentially be given virtually, and I would say our experience with Remedy is that we have a virtual-first approach. We’ve seen that we’re able to resolve about seven out of 10 cases virtually, and it really kind of opens your mind to the prospect that there’s probably a huge opportunity for telehealth here, much bigger than we even realized.

The other thing that we’re seeing right now is that people are delaying care because of fears around the pandemic. A Kaiser Family Foundation study found that half the public reported that either they or their loved one had delayed care. And I think we’d all agree, that’s not good. One out of 10 of those said there was actually a deterioration because of a delay in care. So, when you bring telehealth in as an option, you restore that connection to the doctor. Patients are able to get a consult; they’re able to either allay their fears about the condition or find out if they truly need to get in-person care. These kinds of things have proved vital during the pandemic.

ME: Do you think the level of telehealth will continue after the crisis passes, or do you expect it to decline?

Gabrysch: I think that is a great question. I mean, it is certainly at an incredible level right now in terms of the adoption that we’re seeing. When you look at last year, for example, McKinsey did a study in which they asked people about their interest level in engaging their doctor by telehealth, and only 11% said that they were interested in that venue versus in person. Now, you look at that same question today — “Are you interested in using telehealth to connect with your doctor?” — and 76% of people say that they’re interested. That’s a huge jump. And that is definitely being affected by what we’re seeing with the pandemic.

You also look at the numbers of cases. For example, we’re a very virtual-focused company and do a lot of telehealth. And even with that in mind, our numbers were up: We’re seeing a 1,000% increase in the number of telehealth video visits that we’re doing relative to this time last year, so the spike right now is huge. And so then, you ask, “Well, what’s going to happen when this crisis subsides or passes?” It’s definitely going to decline some from where it is right now. There is going to be a tendency to sort of go back to the old way of doing things. Providers are going to be maybe more eager to see patients back in the clinic; patients might even gravitate toward that a little bit. But I don’t think that we’re going to go back to where we were. And I would say that we really should resist going back at all, because this is a huge opportunity that this has presented. We have moved virtual care forward, and we know that we can provide a more connected experience, better outcomes and just a more virtual-first approach to medicine.

Think about the way you bank, for example. You probably engage with your bank mostly through your smartphone or your computer, and occasionally you go into the branch. We’re not saying that all in-person care is going to go to virtual, but if you look at the banking analogy, you see that a lot of what you can do can be done remotely and then occasionally with those visits to the brick-and-mortar branch. And I would submit that this is an opportunity to move medicine more into that paradigm, where we’re doing a lot of the care virtually and occasionally bringing patients in for in-person visits, when that makes sense.

ME: From your experience, what are some best practices to apply during a virtual visit with a patient?

Gabrysch: Well, you definitely want to make sure that the patient has a phenomenal experience, right? So you want to use that as your starting point. Certainly, telehealth is convenient, but you want to make sure that connectivity issues are resolved and that there’s a very seamless experience of the patient getting into the video with the doctor and that they aren’t just staring at a wall or something, but they’re talking to a real person as quickly as possible. And then follow standard tips like looking into the camera and being engaged with the patient.

I also recommend that providers use a second screen. Often we need to interact with the patient’s medical record, such as looking at their medications or their previous visit, so I’ll have a screen open to the side where I can have that medical record open. You want to tell
ME: In the past, telehealth wasn’t widely embraced because many payers wouldn’t reimburse it at the same level as an office visit, if at all. Do you think the success of telehealth during COVID-19 has permanently changed the reimbursement outlook for the better?

Gabrysch: I certainly hope so. This is a question that I get a lot. And before COVID-19 hit, I think there was a question about whether or not payers were going to pay for virtual care, and I think that has largely been answered. Payers are saying that they’re going to pay for it, and so it’s not so much a question of if they will pay for it. But then the next question is this idea of parity, you know: Will payments be equal to what payments for in-office care will be? And I think that’s an open question. I do think in order for these gains in virtual care to sustain and for us to really capitalize on this, we’ve got to solve this issue. Value-based contracting is one way in which to solve it. If you’re paying for sort of the total package of care that’s being delivered, then the providers are definitely incentivized to provide more care virtually, to provide these virtual touchpoints with patients that will probably improve outcomes. Within a value-based construct, they actually have a way to get reimbursed for it. In a fee-for-service structure, we definitely have to think about how we can incentivize this behavior and how we can reimburse providers so that they actually are incentivized to drive this type of care as we move forward, and not just go backward and lose all our momentum.

ME: Do you think the attitude of doctors toward telehealth has changed for the better during COVID-19?

Gabrysch: I think it definitely has for some but not all. I think that many of the younger generation of doctors grew up with smartphones; they’re very comfortable with technology and interacting with patients virtually. I think that varies as you get into some of the different generations of providers. I will say that I have often, just in my practice and with family and friends, interacted with patients over FaceTime or texted with them, and typically it’s a friend or family member reaching out. But these are ways that I’ve stayed connected with folks and been able to help them over the years and am comfortable with it. I do talk to doctors who are rather reluctantly embracing telehealth right now during the pandemic. They realize that this is something they have to do to stay connected to their patients or maintain a revenue stream, given these circumstances, but they’re eager to get back to the old way of doing things. They’re eager to get back into the clinic and more of the in-person care. I would say that we should be careful about swinging too far back to the status quo, because there are these younger patient groups who want this kind of virtual care. Actually, people across all generations have found that this is very convenient and that they still feel very connected to their doctor even when they connect by video. So again, we don’t want to lose this opportunity.

ME: Smaller rural practices often struggle with technology because of cost and complexity. What can be done to make sure they aren’t left behind with telehealth and some of these other advances?

Gabrysch: Well, one of the big issues here in rural areas is internet connectivity. Fortunately, state and larger organizations are working to improve broadband access and cellphone coverage in many of these areas, because that really is imperative if you’re going to be able to deliver care in this way. But I will tell you that in the states...
that we serve with Remedy, we see lots of patients in the rural areas who might be a decent drive from a brick-and-mortar facility, but they’re able to get connected to care using virtual care. As we look at rural practices, patients may be fairly spread out, and it may be more difficult for them to get in. Maybe they have transportation issues, so this is a huge opportunity to really transform care for those areas, as well.

Again, some of it comes back to the reimbursement issue. These are smaller practices in these rural areas that are relying on fee-for-service income, a lot of times from office visits. We can improve connectivity; we can talk about more connected care and all these things. But at the end of the day, we have to figure out a way to reimburse these providers for that type of care in order to incentivize it and make sure that it does indeed take off.

ME: How will the standards of care change in medicine post pandemic? What do you think will look different? What’s going to change once the COVID-19 crisis has passed?

Gabrysch: Well, I think there needs to be an openness in the medical community about what a new standard of care that is heavily focused on virtual and leveraging virtual could look like. I’ll give you a couple of examples. So, the other day, I had a friend who was experiencing some heart palpitations. And she, through using her Apple Watch, was able to obtain a digital electrocardiogram, which was then submitted to cardiologists, virtually, who took a look at it, chatted with her and then ordered some additional tests. All of that typically would have taken place in an emergency room or urgent care clinic or the cardiologist’s office. But because of technology, because of this wearable device and access to virtual care, we’re able to envision a new standard of care.

Another example, and this is another specialty care example: I talked to a patient who had a foot injury and, using high-quality photos of their foot and video and a consultation with an orthopedic surgeon over virtual care, an X-ray was ordered, a small nondisplaced fracture was found in the foot, and the specialist recommended a walking boot for several weeks. Again, all that care took place virtually. Typically we would say, “Well, the standard of care there should require an in-person visit.” And I would challenge that. I would say that we should really rethink, in light of our access to technology, what the standard of care looks like with these new connected devices with virtual meetings. Patients have a lot of monitors, on their bodies and in their homes, that provide us a lot of information, and we can actually deliver a very high quality of medicine virtually, whereas we might not have been able to do that before.

Our medical system is heavily invested in the brick-and-mortar model that got us to where we are today. We have to be careful not to be too saddled by that, because if we are, we’re going to be very reluctant to embrace these changes, and we’re going to be more inclined to go back to the way we used to do things. We’re too narrowly focused on that brick-and-mortar model and that old way of doing things, and virtual care can solve so many of the things that people typically have come into the office for. There is an opportunity for us to really change the way we deliver care, the way that we pay for care and, actually, the cost of care. We waste a ton of money in this country, providing in-person office visits and care that doesn’t actually make us healthier and doesn’t make us live longer. Of the $3.5 trillion that we spend, there’s a huge chunk of it. That’s just waste. And if we really are open to adopting this more virtual approach, we will save so much money, and we will provide a better experience and get better outcomes for patients.»

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Medical practices across the country are reopening. But are they doing it safely? Although physicians are eager to return to normal, it's vital that they have robust protocols and procedures ready to ensure patients and staff are safe. *Medical Economics* sat down with Karin Torpey Bashaw, vice president of patient safety and risk management with The Doctors Company, to discuss how physicians can prepare to reopen and manage their risk in this new normal of health care after COVID-19.

The following interview was edited for length and clarity.

**Medical Economics® What criteria should physicians be using to make reopening decisions?**

**Bashaw:** I think it's really important for them to have a framework to use. So when we think about opening a practice, I would recommend four things. The first thing is for them to look at their operations pre-COVID-19, because that's what the staff is used to. That's what the patients are used to. They also need to take a look at what's happening from a federal perspective and from a state perspective. Local, it's all about local public health, but the physicians should be getting their direction from the local public health authority; that's where they're going to get the most information that's relevant to their practice. Then it's really important for them to be checking, every single day, those websites with that information... — so, having a framework, getting the information together and then making sure that the staff are up-to-date and know what's going on. The staff and the patients, especially, are very, very frightened. Physicians are telling us that the patients are not coming in; hundreds of patients are not coming to their appointments. So, they're fearful. Getting communication out, making sure that the patients know that you're following the CDC (Centers for Disease Control and Prevention) guidelines, is going to be really, really important. And the criteria for opening really come from that local public health authority.

**ME:** Let's talk about staff training. What kinds of training should be conducted or refreshed?

**Bashaw:** In general, you want to train staff regarding infection control principles. And the nice thing is, you can go right to the CDC website and pull it down at the staff training page. You cannot educate staff enough, because the rules have all changed. So before you even reopen your office, provide standard training regarding infection control and use of PPE (personal protective equipment) donning and doffing. If you are on the primary care medicine side, you're probably used to wearing gloves, but you're not used to wearing a mask. If you have a procedure or you're doing wound care or something that has to be done in the office, you're going to want to gown up, and you need to put that on correctly. For example, most practices are not used to using an N95 mask.

Communication cannot be stressed enough.
Your staff members are afraid. They have been through a lot.

I highly recommend a leadership evidence-based practice: the daily huddle. So, at the beginning of your day, every day, you’re going to check the CDC website, you’re going to talk about the plan for the day, you’re going to look at the patient list and see who’s there and what their issue is. And you can explain what your process is; make sure that everyone on the team knows what the plans for the day are for the patients. And then do check-ins during the day. The staff will do many things that they have never done. Tackling COVID-19 is about standardization. It’s about standardizing your practices, so you can improve them and then tweak them every single day.

So, a huddle at the beginning of the day is going to be key, but you also need a debriefing at the end of the day. What went well? What didn’t go well?

I have a story, if you want me to share it. We had a practice call. The practice had done extensive work: They had their protocols in place; everybody was trained; they had their PPE. They did all their work offline with regard to educating the patients. The patients didn’t come into the waiting room. They didn’t allow family or staff to come in the patient rooms. In this instance, the provider went to give a deep injection and pulled the mask down to have a conversation with the patient and then left it down partway while giving the injection. And the family of this elderly person went ballistic, because that is not the standard of care. There are so many things that are changing, and one little slip is a break in the standard of care, which can be very, very problematic. Despite the extensive work that happened with this practice, one little slip—it can cause immense problems.

So, standardization, education briefings, debrief at the end of the day so you learn from your mistakes and figure out what you can do differently tomorrow. That’s going to be really important for keeping up staff morale and making sure that they’re energized and feel cared for and that they have a voice about what’s happening in the practice.

I have a story, if you want me to share it. We had a practice call because we asked the patient to come in. “You can do that via your website or the patient portal, however you want to do it. But I can’t overemphasize the need to document all your attempts to communicate with your patients. And if you do communicate, you need to put that information in the chart, so it shows your due diligence by reaching out and communicating and making sure that the patients understand the implications.

**ME: Is there anything else that you think is important for physicians to consider as they reopen their practice?**

**Bashaw:** Physicians go into medicine because they want to practice good medicine. No physician goes in with the intent to harm. And so I think I would be remiss if I didn't use this opportunity for those that aren't physicians. You know, right now, our physicians and nurses are heroes, and they are putting their lives on the line to help their patients because they care about their patients. I can't say it enough: I think we need to support providers and offer them protections. These are crisis times, and practices are doing the best they can. Malpractice is about not meeting the standard of care, which is the standard of care is changing daily. But when you're trying to do the best that you can in a complex and ever-changing environment, I think we owe it to our providers to take a stand and provide them with some protection. I don't need to tell the physicians out there that going through a malpractice case is incredibly stressful.
How practices can negotiate with a competing hospital

Over the past 20 years, hospitals have entered many markets previously serviced exclusively by private practice physician groups, either by hiring individual physicians or acquiring entire practices. These developments have changed many health care markets, often to the detriment of physicians. For independent physician groups, this means three things:

1. Hospitals are now their major competitors.
2. Referrals may dry up as hospitals that employ large numbers of primary care physicians steer referrals in-house.
3. Access to hospitals and other key facilities essential to running their practice may be cut off as retaliation for competing effectively.

This does not mean that hospitals and physicians are locked in mortal combat from which only one will emerge. In many instances, it can be beneficial for independent physician groups and hospitals to work together.

The hospital perspective

Unless a hospital has its sights set on monopolizing physician markets, it may not make economic sense for it to enter a variety of medical specialty markets or even expand its position in specialties in which it has only limited offerings. Expansion requires a hospital to directly employ physicians, which increases costs, and the hospital may not be able to realize sufficient integrative efficiencies to offset these costs. Hospitals can hire physicians from existing practices, but that can trigger lawsuits, create ill will and result in higher salaries than recruiting physicians from outside the community. At the same time, recruiting from outside the community can be riskier than hiring known and established local physicians.

Physicians with established practices typically have long-standing relationships with their patients and the community, and they have established referral networks and skills that a hospital may have significant difficulty replicating. This is exactly what the hospital hopes to build.

Find common ground

Overall, hospitals and physicians each have qualities the other wants, which is the bedrock of any potential joint venture or collaboration. Federal and state antitrust laws, however, limit the types of arrangements hospitals and physicians can draft. The antitrust laws, for example, make agreements between competitors that unreasonably harm competition and consumers unlawful. Although agreements between firms that do not compete against one another can raise antitrust issues, these types of agreements are subject to less scrutiny than those between preexisting competitors. This means that the best time for a practice to enter into a joint venture with a hospital is before the hospital enters the physician’s area of specialty.

Making a joint venture

Even if the hospital and private practice can come to terms on a joint venture, they need to do so in a way that does not prompt government intervention. Agreements between existing competitors are subject to certain limitations. For example, agreements to fix prices, allocate markets and customers, or boycott rivals can violate antitrust laws.

However, competing hospitals and physicians can embark on a broad range of collaborative endeavors. Joint ventures in which hospitals and physicians share risk can create significant efficiencies, benefit consumers, bring new services into a community, and prevent redundant and wasteful capital expenditures. Further, certain joint ventures may bring a new medical service into the community, which benefits consumers.

Even a joint venture with a legitimate objective can raise antitrust issues. The government will look for two key concerns:

- Will the joint venture have market power?
- Does the framework contain anticompetitive agreements?

A significant market power problem can make a joint venture untenable under antitrust laws, but this might be easily remedied by structuring the agreement differently. An ancillary anticompetitive provision might have an alternative that does not raise antitrust problems. Taking steps to avoid anticompetitive outcomes goes a long way with the government.

George M. Sanders, J.D., is an antitrust attorney who has represented physician practices in antitrust matters across the country. Send your legal questions to medec@mjhlifesciences.com.
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