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COVID-19 PRACTICE SURVIVAL GUIDE

- MONEY Protect your practice finances
- PRACTICE MANAGEMENT Keep your practice sanitary and safe
- LEGAL Shut down and closure advice
- CHRONIC CONDITIONS Caring for typical conditions during the crisis
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here’s no sugar-coating it: As a result of the COVID-19 pandemic, physician practices are about to experience one of the most challenging, uncertain and difficult periods. Not only are physicians putting themselves in harm’s way to follow their calling and treat their patients, but the businesses they run are going to have to make sweeping and drastic changes to preserve their revenue and protect their future.

It will not be easy, but challenges are not things that physicians shrink away from, and it’s not like times weren’t already challenging for practices, especially smaller and independent practices that make up the backbone of our primary care system. And, of course, Medical Economics is here to provide all the information you need to persevere in the face of this unprecedented situation.

As a result, Medical Economics scrapped our previous plans for our April 25 issue and devoted most of this edition to providing a guide for physicians to help their practices survive.

In our practice survival guide, you’ll find:

- Tips from physicians and other experts for dealing with this financial emergency;
- Strategies for unrolling a robust telehealth program to treat your patients during social distancing;
- Advice on practice cleanliness, bolstering staff morale, and dealing with new ways of managing practice workflow;
- Commentary from a health policy expert on how physicians can confront the challenges of treating patients with chronic conditions during these circumstances; and
- Legal advice on employment contracts and difficult decisions about shutting down your practice, if necessary.

The on-the-ground situation in regard to COVID-19 will likely be much different once this issue reaches you. While our content will hold up in the interim, we are also providing constant news and updates on the COVID-19 pandemic on our website, MedicalEconomics.com. To read all of it, please visit: MedicalEconomics.com/coronavirus.

As always, if you have feedback on our content, story ideas, or would like to contribute to Medical Economics, please reach out to our editors at medec@mjhlifesciences.com.
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MEDICAL ECONOMICS® (USPS 337-7206; Digital ISSN: 2150-7155) is published semimonthly (24 times a year) by MultiMedia Healthcare LLC, 2 Clarke Drive, Suite 100, Cranbury, NJ 08512. Subscription rates: one year $95, two years $180 in the United States & Possessions, $150 for one year in Canada and Mexico, all other countries $150 for one year. Single copies (prepaid only): $18 in US, $22 in Canada & Mexico, and $24 in all other countries. Include $6.50 for U.S. shipping and handling. Periodicals postage paid at Cranbury, NJ and additional mailing offices. Postmaster: Send address changes to Medical Economics®, PO Box 457, Cranbury, NJ 08512-0457. Printed in the USA.

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An epidemiologist discusses what physicians need to know about the novel coronavirus (COVID-19).

**Coronavirus:**

What doctors need to know

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**CORONAVIRUS 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 development
- Tips for physicians to extend the life of N95 respirators
- Mental health tips for doctors and other care providers
- How physicians can protect themselves from the virus
- Strategies for using telehealth to connect with your patients

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

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- Telemedicine: including best practices and plain language consent forms
- Links to infection disease prevention guidance
- Education and resources for healthcare providers on the front lines

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Thank you. For all that you are doing. You are our heroes, and we are here if you need us.
The pandemic caused by the novel coronavirus (COVID-19) is sending massive shocks through the healthcare system and the global economy—and physicians and their practices are sitting at the center of it. In an effort to inform our physician audience of the myriad ways the coronavirus pandemic is affecting the medical profession and the economics of running a practice under these circumstances, we’ve assembled this practice survival guide to help physicians navigate these uncertain times.

BY MEDICAL ECONOMICS STAFF

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For ongoing coverage of the COVID-19 pandemic, visit: MEDICALECONOMICS.COM/CORONAVIRUS
The outbreak of the Covid-19 virus is having a financial impact on private practices nationwide. Experts say that many practices are seeing a decline in patient volume as people try to avoid doctors’ offices unless they have no other choice, and that decline is expected to continue as the crisis broadens.

“This is especially true for primary care offices,” says Lisa Stevens Anderson, president of Equality Health’s Management Services Organization division, who oversees 1,200 primary care physicians. “They are the lowest paid on the physician spectrum and have the busiest offices. They are the ones during the initial phase that are the hardest hit as they try to adjust to the new normal and how to maneuver in this business environment.”

Currently there are so many unknowns that keeping a practice profitable is a daunting challenge. If the crisis lasts for months, as many expect, it could threaten the viability of practices that were already struggling as patient volume continues to decline.

Experts say practice leaders need to accept that their practice is most likely going to take a financial hit and start planning accordingly.

“This could have a major impact on each practice,” says Owen Dahl, MBA, FACHE, a medical practice management consultant. “Throw in an employee who gets the virus or has to stay home because of their kids, and it could become a major issue.”

“You have to really over-plan at this point. We could really be looking at many months of problems, and a lot of practices may not survive that. We can’t get into a situation as a nation where physicians are unable to keep the doors open.”

— JOSEPH VALENTI, MD, BOARD MEMBER, THE PHYSICIANS FOUNDATION

Dahl says to start running projections on what the practice finances would look like if revenue dropped 10, 20, 50 or even 80 percent. “Building pro formas on what the impact would be is critical,” he says. “Then then look at what patients you need to see and what you can do to generate rev-
enue in some fashion.” With the loosening of telehealth restrictions, some practices may be able to keep patient volume up while still getting reimbursed by Medicare and commercial payers.

“You have to really over-plan at this point,” says Joseph Valenti, MD, a board member of The Physicians Foundation. “We could really be looking at many months of problems, and a lot of practices may not survive that. We can’t get into a situation as a nation where physicians are unable to keep the doors open financially and are unable to take care of patients when they most need them.”

Expenses need a careful review after the projections are complete. “You may have to lay off employees or rotate staff to work alternating days,” says Dahl. “You don’t want to lose staff if you can help it, because you will need them to recover.”

If a practice doesn’t have a line of credit, Dahl says, now is a good time to apply for one. It could be the difference between practice survival or going out of business. “It’s for these kind of emergency situations,” says Dahl. The proforma projections will help determine where the money needs to be spent.

Valenti says an SBA loan is another option if a line of credit isn’t available, and that doctors should not be reluctant to reach out to vendors to renegotiate or ask for more repayment time. Because some vendors won’t send more products if payments are in arrears, Valenti says it’s important to explain the situation to see if they will grant an exception.

“The same thing goes with rent—you may need to ask for a lease abatement,” he adds. “You have to make your practice as trim and fit as possible. All you can do is ask, and the worst thing they can say is no.”

Don’t forget professional associations, says Anderson, who notes that many are providing resources and guidance to their members during the emergency. For example, the American Academy of Family Physicians (AAFP) recently called on Congress to establish a 24-month, interest-free loan program for small and independent practices that have been negatively impacted by the COVID-19 crisis. The AAFP has also called for provisions that would require Medicaid to reimburse at Medicare rates and has asked for a grant fund so that small practices could purchase telehealth equipment.

Doctors should also look at a worst-case scenario. If the practice had to close because too many employees are sick, or all the doctors are sick, it could trigger business interruption insurance coverage. So Dahl says to make sure to under-

The Centers for Medicare & Medicaid Services (CMS) has expanded its accelerated and advance payment program to ensure physicians have the resources needed to battle the COVID-19 coronavirus. According to a news release on the expansion, the accelerated and advance Medicare payments provide cash flow based on historical payments when there is disruption in claims submission or processing. They are typically offered in natural disasters.

CMS is expanding the program to Medicare providers across the country during the COVID-19 pandemic and payments can be requested by hospitals, doctors, durable medical equipment suppliers, and other Medicare Part A and Part B providers and suppliers, the release says.

“With our nation’s healthcare providers on the front lines in the fight against COVID-19, dollars and cents shouldn’t be adding to their worries,” CMS Administrator Seema Verma says in the release. “Unfortunately, the major disruptions to the healthcare system caused by COVID-19 are a significant financial burden on providers. Today’s action will ensure that they have the resources they need to maintain their all-important focus on patient care during the pandemic.”

To qualify for accelerated or advance payments, the physician must:

- Have billed Medicare for claims within 180 days immediately prior to the date of the signature on their request form
- Not be in bankruptcy
- Not be under active medical review or program integrity investigation
- Not have any outstanding delinquent Medicare overpayments

Medicare will begin accepting and processing requests immediately and CMS anticipates the payments will be issued within seven days of the physician’s request, the release says.

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Physician investing tips in a time of crisis

by John J. Grande, CFP, Traudy F. Grande, CFP, and John S. Grande, CFP Contributing authors

I have seen it all, or at least I thought I had.

But this current financial/health outlier-black swan event is one in which no one can give early predictions as to the impact on our world or domestic economies, or the very survival of our healthcare system. Our family’s and our own mortality are actually called into question. Out of nowhere, we are now faced with unprecedented challenges. And in many cases overwhelming fear of the unknown.

Advice for young and mid-career physicians

If you are in the accumulation phase of your career, nothing has changed. Unless this is the end of our financial systems as we have known them, and that is highly unlikely, the companies you have invested in and loved are now at fire-sale prices, provided you are going to hold them long-term. Just keep saving and investing as you have been.

Uncertainty is the last thing Wall Street wants to see. Uncertainty is the last thing any of us wants to see, especially when it comes to our health or financial security. We have, as a team at Grande Financial Services, witnessed more than three decades of ups and downs in the market, and just about every geo-political event imaginable.

But this downturn, as severe as it has been, is something that we have not seen before. It is disconcerting, to say the least, to watch your investment holdings lose up to 30% of their value in one week.

However—and yes there is a however—even though we have not seen exactly this particular rapid spiral into a bear market and possible recession, we know how things have turned out in the past, which has always been to come back and advance further. This time should be no different, since banks are strong and the government is giving its full accommodation to both the virus and the financial markets.

I have witnessed firsthand over the years that fear is the most dangerous emotion when it comes to investing. The feeling of watching your portfolio grow each year is pleasant, but does not match the intensity and pain of watching your investments lose value. Presuming that you had a good financial plan laid out, and your exposure to stocks was not more than the absolute minimum risk you had to assume to achieve your financial goals, just stay the course.

You must remember that your stock portfolio represents a long-term strategy, and not to sell because of fear. Selling after a large decline in the markets is turning a paper loss into a real loss.

Then comes the problem of getting back in before the markets turn upward, possibly as fast as they went down. This is the age of computer trading and things happen very fast, as we have just experienced. This particular downturn may well be the fastest and most severe to date. It gave few investors a chance to trim their holdings, since the markets went down considerably in just one week.

Advice for physicians ready for retirement or already retired

For those ready to retire or in retirement now, it may be a good time to divide your expenses between essential and discretionary. Essentials must be paid, e.g. food, mortgages, property taxes, utilities, car payments, etc.

The discretionary side would be anything not essential, such as eating out, gifts, travel, etc. When you calculate what the essential and discretionary costs are, you can divide each number by your investment net worth, find what the percentage is, and stick to a budget that does not exceed this percentage.

As your portfolio goes down or up, and if the percentage is higher than planned, you may want to cut back on your discretionary spending until the portfolio has recovered. This will preserve principal and the danger of creating a vicious cycle of depleting your savings when your withdrawal percentage keeps increasing as the portfolio value declines.

There are other strategies to consider as well. Some examples would be tax-harvesting losses by switching positions on the same day, thereby not missing a possible market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forwards. Also, repositioning portfolios that previously had too much increase to consider a move into market upturn, but locking in future loss carry-forward...
stand what is and isn’t covered and prepare accordingly.

TEAMWORK AND FOCUS
Boosting staff morale is also key to maintaining focus on patient care and getting everyone to work toward keeping the practice open.

“I think it’s important, so say to the staff: ‘Let’s get through today and not think about the future, but two to four weeks from now, let’s start to think about what the future holds,’” says Dahl. “What does it hold, how can we make sure we improve care and come out of this whole?”

“Recognize the stress the staff is under,” says Anderson. “Make regular, timely communications about efforts to maintain the office, take care of patients, and maintain financial viability. If employees don’t have information, they get scared.”

If staff cuts are being considered, Anderson says to explain the situation to the staff and see if they have any ideas. Instead of assuming no one wants their hours reduced, for example, someone may volunteer because of their current life circumstances. “If you can stay connected during this time you can increase and reinforce their loyalty,” she says.

Valenti says that the crisis might help reaffirm the important role of physicians in the healthcare system. “With the relaxation of some of the CMS rules, I think we are about to demonstrate why over-regulation is not a good thing,” he says. “We all need some regulation, but when it’s overdone, it hinders our ability to practice and we become less efficient. I think deregulating some of these things during the pandemic will prove we don’t really need them.”

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If the Coronavirus pandemic contains any silver lining for primary care doctors, it may be to speed the adoption of telemedicine and other alternatives to in-person patient visits.

While technology enabling doctors to provide some forms of care remotely has been available for decades, adoption has been slow due to privacy concerns, lack of adequate reimbursement, technology costs, and physician inertia.

But with patient visits dwindling as a result of the coronavirus pandemic, clinicians have been turning to e-mail, texting, and telemedicine to maintain contact with and provide care for patients. And that could be a positive development to emerge from the current crisis, says Ron Holder, MHA, FACMPE, chief operating officer of the Medical Group Management Association.

“This may be just the impetus needed to prepare for what’s going to be the future of healthcare anyway, Coronavirus crisis or not,” Holder says. And with fewer patients coming in, he adds, “this is your opportunity to try some of the things you may have been wanting to try but hadn’t had the time.”

The federal government is providing additional encouragement to use telemedicine, in the form of increased Medicare reimbursements and a loosening of HIPAA’s privacy, security and breach notification rules.

GETTING STARTED

So how should a practice get started with telemedicine? The first step, experts say, is to find a platform—the technology that enables secure, HIPAA-compliant video and audio communication with patients via computer, smartphone or other electronic device.

Platforms typically will provide a method for registering patients, a virtual queue/“waiting room” for patients, and a method of recording and archiving the encounter, explains Russell Libby, MD, a board member of The Physicians Foundation and president of the Virginia Pediatric Group, which has been offering telemedicine visits for a little over a year.

A Google search can yield a great deal of useful information on telehealth platforms and services, Libby says. In addition, The Physicians Foundation has joined forces with the AMA and several state medical societies to form the Telehealth Initiative, a repository of telehealth-related advice and resources for practices and individual physicians.

Ideally, a telehealth platform will integrate with the practice’s website, so that the process of connecting with a provider is seamless to patients, says Eric Haden, founder and president of the telehealth consulting firm Drexly Health Solutions LLC.

“You want to list your providers on the home page and have the patient be able to click on a provider’s name and be
entered into the [virtual] waiting room,”
Haden explains.

**FOCUS ON THE BASICS**
Haden advises practices offering tele-
health for the first time to focus on sim-
plicity and flexibility. That means using a
standalone platform, one that’s not nec-
essarily part of a fully integrated EHR sys-
tem but whose only function is enabling
remote communication with patients.
“The important thing is just to get some

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**Telemedicine coding: What you need to know**

*by Bill Dacey, CPC Contributing author*

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

On March 17, Medicare temporarily relaxed some of the geographic and security/privacy restrictions on Telehealth visits, including the office visit codes. This will allow patients to call your office, and as long as there is some type of combined audio/video communication between the provider and the patient, these ‘visits’ can be billed with the 99201-99215 series codes, adding the 95 modifier.

**Medicare options:**

1. **OFFICE CODES 99201-99215:** The new visit codes to the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
   - Any new visit codes 99201-99205 would likely need to be coded based on time given the limitations of the exam.
   - The established patient codes 99211-99215 could be billed by counseling time or by documenting the level of history and medical decision-making associated with a given code level.

2. **VIRTUAL CHECK-INS (E.G. TELEPHONE CALLS) THE G2012** - A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications devise to decide whether an office visit or other service is needed. This is provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
   - Valid for up to 7 days, cumulative time during the 7 days. For Medicare these are
     - **G2061** – for up to 7 days, cumulative time during the 7 days; 5-10 mins.
     - **G2062** – for up to 7 days, cumulative time during the 7 days; 11-20 mins.
     - **G2063** – for up to 7 days, cumulative time during the 7 days; 21 or more minutes.
     - **For commercial/payers and some Medicare Replacement plans:**
       - **99421** – 5-10 mins
       - **99422** – 11-20 mins.
       - **99423** – 21 or more minutes.

3. **THE E-VISITS** - Online digital E&M service, for an established patient, for up to 7 days, cumulative time during the 7 days.
   - For Medicare these are
     - **G2061** – for up to 7 days, cumulative time during the 7 days; 5-10 mins.
     - **G2062** – for up to 7 days, cumulative time during the 7 days; 11-20 mins.
     - **G2063** – for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

**For commercial/payers and some Medicare Replacement plans:**

- **99421** – 5-10 mins
- **99422** – 11-20 mins.
- **99423** – 21 or more minutes.

Those are the mainstream codes to consider here. Reimbursement varies with the office visit codes typically paying the most.

Although we cannot speak broadly for all payers, many have allowed, at least temporarily, the use of the office visit codes for Telehealth during the COVID-19 Emergency.

Some states, starting with Massachusetts, have mandated that commercial payers cover Telehealth during the crisis.

Go to the websites for United Healthcare, BCBS, Aetna, CIGNA, Humana and others for specific policy changes.

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

**Bill Dacey, MHA, MBA, CPC-I** is principal in The Dacey Group, Inc., a consulting firm dedicated to coding, documentation and compliance concerns for physicians.
Clinicians using it now, so you can continue seeing patients,” he says. “Start small, get used to it, then grow and fit it into your practice. I tell my clients, ‘Instead of buying the whole cow now, you just need the milk.’”

At the same time, it’s important that the platform have expansion capabilities so that the practice can add users and functionality in the future. “Some of the products out there only offer solutions for use by individual doctors,” he says. “It’s better to pick an individual solution from a vendor that offers practice-wide capabilities so you can easily integrate with them in the future if you decide to.”

One important caveat for practices using standalone platforms, Haden adds, is that they will need a way to download recordings of patient visits into their EHR so they can be added to the patient’s record.

Given the fluidity of the current situation, Haden advises against signing a long-term agreement with a vendor, but instead look for one that permits month-to-month contracts and/or offers free trials.

“Before investing in any telehealth service, investigate your options,” he says. He also cautions that, with the increased demand for telehealth services, practices can expect waits of a week or more to get set up with a platform. “Normally, it gets done in one to three days,” he says.

Some practices, Haden notes, have a telehealth platform in their current EHR system that they aren’t using. If so, he says, now is the time to try it out—unless the vendor charges exorbitant fees or requires a long-term contract for setting it up and using it.

**IMPACT ON STAFFING, WORKFLOW**

Extensive use of telemedicine services most likely will be accompanied by changes in a practice’s workflow and staff responsibilities, and possibly require some physical alterations. “People are going to have to assume different roles depending on each practice’s circumstances,” says MGMA’s Holder. He cites the example of a nurse who, finding she’s spending less time performing hands-on patient care, instead triages requests coming through the practice’s patient portal and deciding which provider they should be routed to.

In addition, Holder says, practices will need to ensure that every clinician has access to space where they can conduct telehealth visits in private, so as to comply with HIPAA privacy rules.

Once a practice has acquired telemedicine capabilities, the next step is informing patients. The most effective ways to do this, says Holder, is via e-mail and/or the practice’s website. Both methods should explain the service, include instructions for how to register for it as well as a link for accessing the virtual waiting room.

“In addition to telehealth, doctors can use e-mails and text messages for remote communication. In order to be HIPAA-compliant, however, e-mail correspondence must take place through a patient portal, while text messages require the use of a secure server that encrypts the messages. Some telehealth vendors will include these technologies in their platforms for an additional fee, Haden says.

Experts predict that practices adopting telehealth during the current crisis will soon see its advantages, starting with happier patients. “My clients have found that once their patients experience telehealth their satisfaction levels are through the roof, and they never want to go back to the old way of receiving care,” says Haden.

Libby notes that introducing telehealth is an opportunity to reduce care costs while improving outcomes. By making it easier for practices to check on and monitor patients with chronic conditions, telehealth can reduce emergency department visits—an outcome especially important to a practice in an ACO or paid under some form of universal capitation.

“This is opening the box, and doctors are seeing it’s a comfortable box to be in,” Libby says. “They can use it to benefit their patients, their practice, and their community.”

_“This is your opportunity to try some of the things you may have been wanting to try but hadn’t had the time.”_ — RON HOLDER, MHA, FACPME, CHIEF OPERATING OFFICER, MGMA
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Addressing staff and patient concerns

by KEITH REYNOLDS Associate Editor

As the COVID-19 virus sweeps the globe and uncertainty increases, physicians and practice leaders should turn their attention to the welfare of their staffs and their patients.

Gary Price, MD, a Connecticut plastic surgeon and president of The Physicians Foundation, says that in times of crisis such as this, it is important to start by re-examining the practice’s fundamental mission.

“We’re here to keep people healthy and happy in the end,” Price says. “So that’s an important thing to keep in mind as we make the rest of the decisions.”

KEEPING STAFF SAFE AND CALM

Price advises getting as much information as possible about the situation, so that physicians and practice managers can ask the proper questions, such as whether it is necessary to have patients who are not in dire need of care come into the office or facility.

Once information is gathered, experts say, communication with staff is crucial, not only so they know what is required of them but also to calm any fears they may have.

Jagdesh Khubchandani, Ph.D., a Ball State University health science professor, says practice leaders should remember that their staff is made up of human beings under a remarkable amount of stress and should adjust their interactions in the interest of maintaining staff morale.

“For physician leaders and practice leaders, they have to first know that everyone around them is scared, they go home, and they deal with the fear of their family, or the risk of infecting other family members,” he says. “So, I think as a leader in practice, physicians should hopefully be kind in their communication, watch their own words, and then realize that everyone else is dependent on them financially, socially, emotionally.”

Maintaining staff morale can be as simple as bringing in lunch or asking if they need anything for their homes. Acts of kindness such as these can have a big impact, experts say.

Khubchandani researches self-destructive tendencies in healthcare workers, such as excessive drinking, and says that a failure to address staff concerns can lead to more incidents of these behaviors.

“Generally healthcare professionals have one or two different types of stressing factors, but now there’s multiple factors,” he says.

A major part of maintaining staff morale and practice operations is urging em-
ployees to stay home if they are sick and providing cross training so that employees can fill in for one another when someone takes a day off.

Another important facet of staff safety is ensuring that everyone is trained on the importance of personal protective equipment (PPE) and proper hand hygiene, experts agree.

As a way to keep himself and his patients safe, Price says he has begun offering telehealth as an option. This takes the form of phone calls with patients seeking preoperative consultations that don’t need face-to-face time.

"The telemedicine option also gives a tremendous boost to ability to care for people. Even though it’s not a huge thing for my practice, I think for many practices, it will be," he says.

**KEEPING PATIENTS SAFE**

As the threat of infection becomes apparent across the country, physicians should be aware of how their patient flow can be putting people at risk and consider options to change check-in processes.

Dahl says that preparation for a possibly infected patient should begin when they call to schedule their appointment. "When a patient calls in, find out their symptoms indicate the virus, then ask the patient that when they get to the office, to call you and stay where they are," he says. Staff can then go out to the patient and walk them in with PPE.

If that’s not possible, patients exhibiting symptoms can be brought in a back entrance to the facility so as to avoid the waiting room, Dahl says. In addition, infected patients should be seen in rooms with negative air pressure, and the room should be cleaned thoroughly before and after the patient is treated, Dahl says.

It is better, he adds, if patients can move through the practice without congregating in the waiting room. If patients must be in the waiting room, ensure it is stocked with alcohol-based hand sanitizer and tissues and PPE that may be used to slow the spread of the virus. Also, follow guidelines on social distancing by keeping waiting patients at least six feet apart.

Khubchandani advises asking the facility’s cleaning staff to beef up sterilization efforts, and don’t be afraid to be insistent about it. "It’s not rude to educate your supervisors, subordinates and clients because that’s what we’re here to do now," he says. "Anyone who seems to be at risk, educate them."

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**Coding for coronavirus**

For Diagnosis coding consider the following codes:

- **Code B34.2 (coronavirus infection) in addition to manifestation**
- **Code B97.29 for COVID 19 Diagnosis**

Other codes to consider:

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible Exposure to COVID-19 ruled out</td>
<td>Z03.818</td>
</tr>
<tr>
<td>Exposure to person with confirmed COVID-19</td>
<td>Z20.828</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>J12.89</td>
</tr>
<tr>
<td>Acute bronchitis</td>
<td>J20.8</td>
</tr>
<tr>
<td>Respiratory infection NOS</td>
<td>J98.8</td>
</tr>
<tr>
<td>Acute respiratory distress syndrome (ARDS)</td>
<td>J80</td>
</tr>
</tbody>
</table>

Source: Bill Dacey, CPC

If a practice staff member contracts COVID-19 and is being treated in an outside facility, do not count that time as part of their paid time off, since it is a work-related incident, says Owen Dahl, MBA, FACHE, a medical practice management consultant.

Price says that to protect his staff he was able to quickly develop a mechanism to allow his patient coordinator to access the scheduling system so that staff member could work from home. Dahl recommends a similar workaround for billing departments, but in that case a secure virtual private network is essential.
As part of its efforts to slow the spread of the coronavirus, the Centers for Disease Control and Prevention (CDC) has developed recommendations for medical practices, aimed at reducing the chance of patients spreading the disease when they come to a medical office. They include steps practices should take before, during and after a patient visit.

Below is a summary of the CDC’s recommendations.

Before the patient arrives

- When scheduling appointments for routine care, such as an annual physical, instruct patients to call and reschedule their appointment if they develop symptoms of a respiratory infection (e.g., cough, sore throat, or fever) on the day they are scheduled to be seen.
- When a patient requests an appointment to be evaluated for a respiratory infection, use triage protocols to determine whether an in-person appointment is necessary or if the patient can be managed from home.
- If the patient must come to the office, instruct them to call in advance to inform triage personnel that they have respiratory infection symptoms.
- The practice should require the patient to take appropriate preventive measures, such as wearing a facemask upon entry and during the visit.

During the visit

- Post signs and posters at the entrance and elsewhere with instructions about hand and respiratory hygiene and cough etiquette.
- Instructions should include how to use tissues to cover the nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to wash hands.
- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub with 60-95% alcohol, tissues, and no-touch receptacles for disposal at entrances, patient check-in stations, and in waiting rooms.
- Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between office staff and potentially infectious patients.
- Prioritize triaging of patients with symptoms of Covid-19 or other respiratory infections.
- Ensure that triage personnel have an adequate supply of facemasks and tissues for patients with symptoms of respiratory infection. Provide these to patients with symptoms of respiratory infection when they check in.
- Ask all patients at check-in about the presence of respiratory infection symptoms and their history of travel to areas experiencing transmission of Covid-19 or contact with possible Covid-19 patients.
- Isolate patients suspected of having Covid-19 or other respiratory illness in an exam room with the door closed.
- If an exam room is not available, don’t allow the patient to wait among other patients seeking care. Instead, identify a separate, well-ventilated area that allows waiting patients to be separated by six or more feet, and with easy access to respiratory hygiene supplies.
- Another option is to allow patients to wait in a personal vehicle or outside the facility and contact them by mobile phone when it’s their turn to be seen.
- Incorporate questions about new onset of respiratory symptoms into assessments of all patients. Monitor and evaluate all new fevers and respiratory illnesses among patients. Place any patient with unexplained fever or respiratory symptoms on appropriate transmission-based precautions and evaluate.

Additional considerations during periods of community transmission:

- Cancel group healthcare activities, such as group therapy sessions.
- Postpone elective procedures, surgeries, and non-urgent outpatient visits.
How will other needed care be provided during the pandemic?

As our healthcare system and others around the world gear up to deal with the largest public health crisis of the past 100 years, an important question to consider is: How will other needed healthcare delivery occur during the pandemic?

This needed healthcare includes elective surgeries that may still be important to help an individual function or manage other healthcare conditions; primary care services like chronic disease management that patients must get to avoid having their conditions worsen or cause other health problems; and preventive care that may help reduce the possibility of getting Covid-19 or mitigate its severity once contracted.

Given the healthcare system’s current inability to properly address the pandemic, it is fair to wonder how much other important healthcare will be neglected during the outbreak, and what additional negative impact this will have on the health status of Americans.

Already, my family and I have received e-mails from our providers telling us that their offices are closing to all but emergency care, for periods that may last a while. We have been told by several that we may be able to conduct telehealth visits with them for certain issues. It is difficult to understand how telehealth can be used quickly or in a high-quality manner for services like orthopedics, cardiology, or dermatology; or any care that requires lab work, imaging, procedures, or an actual physical examination.

Regarding virtual care, the reality is we are simply nowhere close to having the technology or expertise to do it right, regardless of payment being available. In addition, some healthcare professionals still have to be involved in telehealth provision, so in a sys-
tem with no capacity, it is hard to imagine telehealth making much short-term difference.

There is no doubt that our health system must gear up first and foremost for the crisis at hand. The need to keep people at home and away from public spaces is a short-term imperative to blunting COVID-19’s spread. But over the

There are no easy solutions to these problems. Nations have spent years underinvesting in primary care systems almost everywhere—Italy, the United Kingdom, and the United States, to name a few. Here in the U.S. we have encouraged an expensive, fragmented, and mostly hospital-based system of specialty care.

Blood sugars and high blood pressure that cannot be monitored or controlled properly; unperformed surgical procedures that would enhance patients’ ability to care for themselves or others; mental health issues that will impact people’s ability to think and behave proactively with respect to staying healthy, and being able to work and earn a paycheck—left neglected, these realities will amplify how Covid-19 affects local populations and leave many more Americans in worse health once this pandemic is over.

And because hospitals are having to care for the sickest COVID-19 patients, it is difficult to get other needed forms of care out to the places where many live and work. Many hospitals have to focus almost solely on COVID-19 patients, both because of the highly communicable aspects of the illness and their lack of capacity to do anything else while dealing with patient demand from the illness.

How soon they are able to get back to business as usual once the current crisis ends is an open question. It may not be easy for them.

Even when we have enough COVID-19 tests available, we will have difficulty getting the tests out to individual patients, in part because there are many communities without enough care providers, and because many medical practices are closing for extended periods of time.

What is left of the primary care system in the U.S. will need to step up to handle a good chunk of this other needed care delivery once the current crisis eases. Bringing physicians and nurses out of retirement in local communities to work in primary care offices and urgent care centers is one needed step.

Moving whatever basic primary care we can to the virtual space, whether via phone or computer, is a second step. Making some primary and urgent care offices in local communities remain open 24 hours a day, with certain hours allocated for specific types of care delivery, and staffed accordingly, is a third step. Redesigning workflows in these offices to improve care efficiency is a fourth step. Providing added financial support to these offices, in the form of enhanced reimbursement, underlies it all. These steps may require many months to be implemented. Still, when the time is right, we have to try.

The COVID-19 pandemic is like nothing we have seen in our lifetimes. We must do everything possible to lessen its potential destructiveness. That includes making sure we do not forget about the other important care patients require to stay healthy and function.

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**HEMODYNAMIC DRIVERS**
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Physician practices are struggling with how to handle physician and mid-level employment contracts in light of the COVID-19 pandemic. Although a practice may not be required to close, many have cancelled elective visits and procedures. This has greatly impacted patient volume and revenue and may require them to close eventually. Even in practices that continue to offer some patient services, cutbacks are imminent.

Physician and mid-level employment agreements generally do not apply to extreme situations such as COVID-19. Most contracts are terminable either without cause (which typically requires 30-90 days prior notice) or for cause. Employment contracts invariably require both the employer and employee to agree to any amendment. As a result, an employer risks potential liability if it unilaterally reduces a provider’s pay or hours.

While there are common law doctrines that arguably provide a basis for a practice not to fulfill its obligations under an employment agreement, the applicability of those doctrines to a situation such as the COVID-19 pandemic is uncertain. As a result, practices are faced with the need to negotiate with salaried employees for reduced hours and/or compensation in order to remain in operation during this pandemic. Many practices have successfully negotiated such agreements since some staff want to be home and others are willing to take less pay or work fewer hours to preserve their benefits and their jobs.

But remember that any such modifications to employment contracts should be in writing to be enforceable and to avoid liability because the practice failed to follow the terms of the contract. Practice owners and managers should refamiliarize themselves with paid time off or other policies the practice has in place. They should also be sure to offer similar deals to all contacted practitioners to avoid any claims of illegal discrimination.

Practices with employees who are unable or unwilling to cut back hours or accept modifications to their contracts may have no choice but to provide notice of termination as soon as possible. E.g., if this pandemic continues, but the notice period in a provider’s employment agreement for termination without cause is 60 days, the practice will at least get relief from its obligations to compensate the provider after 60 days, but before the pandemic ends.
While termination of a valued employee under these circumstances is unfortunate, it may be unavoidable. Paying an employee during the notice period may also be a challenge for the many practices that may be struggling to survive in the coming months.

The following steps should be followed by practices as closures and layoffs become necessary:

1. Review your practice contracts and policies so you are familiar with scheduling and compensation obligations. Review which employees have contracts and how those contracts might differ.

2. Consider whether to close the practice and if this will be temporary or permanent. If you continue operating, can you lay off employees or cut hours, and what will be required to do that? Establish a timeline for when these decisions will need to be made. This is critical if you need to terminate employees without cause and continue to pay them during the notice period.

3. Work with your employees to determine their flexibility. You may be surprised to find, for example, that some are willing to give up compensation as long as they have benefits. Others may take lower pay or fewer hours to help the practice survive.

4. Many states will provide special unemployment options for workers who have been laid off or had their hours reduced due to the pandemic. Make sure you and your employees understand the support available in your state. Even an employee who suffers a reduction in hours may be eligible for a partial benefit.

5. Check the resources available to your practice. Many banks are making it easier to draw on lines of credit or borrow funds. The SBA is helping small businesses in many states. For example, Ohio recently sent certification to the SBA seeking an economic injury declaration related to the coronavirus. This will make funds more readily available to small businesses, and we expect to see other states follow suit.

6. Practices should look at all possible avenues to survive the weeks and months ahead. Consider the increased flexibility for telemedicine options that have been put in place during the COVID-19 emergency to see how they may benefit your patient volume and bottom line. Consider home visits, or limited services that will allow patients to feel secure in the practice’s office.

7. Check your insurance policies to see what coverage you may have to cover business interruption and similar claims.

8. Determine if there are expenses that can be reduced or eliminated. For example, if your practice maintains a defined benefit pension plan, consider freezing the accrual of benefits or changing the plan’s benefit formula to reduce future contributions.

The current situation is fluid and available guidance is changing rapidly. Check with counsel and stay on top of what your state and the federal government may be doing to assist medical practices and other small businesses to survive.

Ericka L. Adler, JD, has practiced regulatory and transactional healthcare law for more than 20 years. She represents physicians and other healthcare providers across the country in their day-to-day legal needs, including contract negotiations, sale transactions, and complex joint ventures. She also works with providers on compliance issues such as Stark Law, Anti-Kickback Statute, and HIPAA.
The mental toll: How treating the pandemic affects physicians

by KEITH REYNOLDS and LOGAN LUTTON

Frontline medical workers dealing with the COVID-19 coronavirus are experiencing psychological burden, according to a new study.

The study, published in JAMA Network Open in March, looked at responses on a battery of mental health measurements from 1,257 healthcare workers in 34 Chinese hospitals with fever clinics or wards for patients suffering from the virus from Jan. 29 to Feb. 3. Of the respondents, 64.7 percent are between the ages of 26 and 40, 76.7 percent are women, 60.8 percent are nurses and 39.2 percent were physicians. An additional 60.5 percent worked at hospitals in Wuhan, the region where the outbreak began, and 41.5 percent are frontline healthcare workers.

A large portion of respondents reported suffering from various psychological burden. This includes:
- Depression 50.4 percent
- Anxiety 44.6 percent
- Insomnia 34 percent

The psychological burden most often reported by respondents was distress, at 71.5 percent.

Nurses, women, frontline healthcare workers, and those working in Wuhan reported more severe measurement of mental health symptoms than other groups included in the study. Being a woman with an intermediate professional title was associated with severe symptoms of depression, anxiety, and distress, the study found.

It is worth noting though, that the majority of respondents being women may have skewed this result.

The study also showed that working on the front line of the pandemic was an independent risk factor across all cohorts.

The results of the study may bring insights into the effects the pandemic can have on healthcare providers the world over.

A study of U.S. physicians produced last week showed that 96 percent of physician respondents said they were some level of concerned about the virus having an impact on themselves or their patients directly.

Details of the mental toll and U.S. physician attitudes are still murky though as the Chinese survey was conducted before recent declines in positive tests for the virus and the U.S. survey was performed before the pandemic had fully taken hold of the country.

"Special interventions to promote mental well-being in health care workers exposed to COVID-19 need to be immediately implemented, with women, nurses, and frontline workers requiring particular attention," the report says.

Mental health tips for physicians

Here are some ways for physicians and other providers to cope during this difficult time.

Manage your stress

- You and many of your health worker colleagues are likely stressed; in fact, it is quite normal to be feeling this way in the current situation.
- Stress and the feelings associated with it are by no means a reflection that you cannot do your job or that you are weak.
- Managing your stress and psychosocial wellbeing during this time is as important as managing your physical health.

Take care of basic needs

Employ helpful coping strategies:
- Ensure rest and respite during work or between shifts
- Eat sufficient and healthy food,
- Engage in physical activity,
- Stay in contact with family and friends.

Make help accessible

If you are a team leader or manager in a health facility, facilitate access to, and ensure staff are aware of where they can access mental health and psychosocial support services.

Managers and team leaders are also facing similar stressors as their staff, and potentially additional pressure in the level of responsibility of their role.

It is important that the above provisions and strategies are in place for both workers and managers, and that managers are able to role-model self-care strategies to mitigate stress.

Source: World Health Organization
Finding mobile health apps that work for doctors and patients

by JEFFREY BENDIX Senior Editor

Mobile health (mHealth) apps are exploding in number and popularity, a development that presents new challenges for physicians: How do they determine which among the thousands of health-related apps on the market will help their patients? And how do they receive and process data from these apps in a form they can use?

To help answer those questions, Medical Economics spoke recently with Tom Malick, senior product manager at Rightpoint, a digital consulting firm whose services include app design, marketing and development. Malick has worked with mHealth app developers to help increase adoption of their apps, and many of the insights developed from that experience also apply to doctors and patients.

A transcript of the conversation, edited for brevity and clarity, follows.

Q: Medical Economics: With all the mHealth apps available today, how does a doctor know, or go about deciding, which ones are going to be effective and help patients achieve their health goals?

TM: That’s a great question. I’d bifurcate the conversation about how to choose an app into two parts. One is the more technical part, things like privacy safeguards, regulatory safety standards, interoperability. The FDA is actually doing some work right now in certifying those base level things, but you definitely need to check those boxes.

The more challenging part is determining what the app is supposed to do, and does it work for my patients? You can have apps that simply educate the patient, you can have apps that track biometrics and encourage actions based on those biometrics, they could titrate medications, they could assist with medication adherence, they could be related to a physical monitoring device.

So there could be lots of things the doctors may want. But I think the thing people are really concerned about today is that we have something like 10,000 baby boomers hitting 65 every day for the next 15 years. And many of them have two or more chronic conditions. And I think PCPs are struggling with how to manage that.

To help frame that, look at pharma. In many cases when pharma releases a drug the FDA just looks for it to be better than the placebo it was tested against, and that it doesn’t harm the patient. I think doctors should use that type of thinking when they look at an app. Because what we’ve found is that the Hawthorne effect is very powerful. And the Hawthorne effect is that the act of measuring something means you’ll change your behavior. When you start to measure your steps daily you’ll start to walk more just because you realize you’re measuring it.

That has a huge amount of relevance for clinicians. Just keeping people focused on their health in some way and to track it is really important. But here’s where the most difficult part comes in. How will the doctors leverage that data? In a scenario where a doctor has recommended multiple apps to a patient, currently they [the doctor] would need separate login information for each of those apps to access that patient’s data. Clearly that’s untenable for doctors, most of whom are struggling just to find the time to review information in the patient’s EHR before the patient visits.

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The other thing that is absolutely critical: Think about if you’re a patient with diabetes, and you’ve gone through six months of logging data, always diligently monitoring your blood glucose readings. And you get to your doctor’s office only to find out they didn’t even look at it. It’s pretty demoralizing. And you can’t expect the patient to continue monitoring after that.

So I think there basically needs to be a handshake agreement between the doctor and the patient, in terms of setting expectations as to how the app will be used, and what data the doctor will look at. The timeliness of their readings becomes very essential in getting people to use that app.

Q: ME: So how does a doc get around that? Is it just by limiting the number of apps they recommend to an individual patient, so they don’t get flooded by data?

TM: I think docs would love to be able to navigate this world. But the truth is, they’re somewhat held hostage by their computer systems.

Here’s an example. In the current EHR environment everyone says we’ve got everything electronic and it’s wonderful, but the vast majority of the data sitting in the EHRs is just faxed data that’s been scanned and entered into it, not structured in any way. And you may have faxes from 10 different providers of all your medical history that’s almost indecipherable by your primary care provider. And in that vein, they certainly don’t have time to actually structure all that data.

For an app to be effective it has to integrate into the EHR and be consumable by the doctor in a way that doesn’t add to their administrative burden.

Q: ME: Do such apps actually exist?

TM: I think a lot of people certainly want those apps to exist. I think a good example is Livongo, which has done a great job in terms of meeting the patient where they’re at, which is really important from a user experience perspective, but also understanding that they can’t just drop an app on a doctor and expect it to work if it’s not interconnected in the medical ecosystem.

Apps that live on islands die on islands, so apps that kind of go it alone, it’s going to be really difficult to get doctors to use them.

The other thing we should address is the reimbursement aspect. Doctors don’t generally recommend procedures and things that aren’t reimbursable. Livongo is an example [of an app] that’s now reimbursable on some Medicare Advantage plans. So those apps that integrate with the rest of the ecosystem are the apps that will really shine in the future.

The real gold standard is where you have enough medical research, you’ve met all the privacy and security standards, and you’ve gotten to the point where Medicare is going to reimburse for your app. I think it’s the ultimate litmus test for whether a doctor should recommend an app.

I think another consideration for whether doctors should recommend an app is its usability. Will the user love it? Some apps that are out there now, like Facebook and Twitter, are designed where people absolutely love and want to open them all the time. Don’t we want that in medicine, where someone who has diabetes can’t wait to open their diabetes app? For people with chronic conditions, the hardest thing for them sometimes is to confront that condition. And opening an app every day reminds them of that [condition].

So that app needs to be designed in such a way that it’s inherently motivating. And I think when a lot of folks go to build an app they do it backwards. They try to back it into the existing system whether it be pharmaceuticals or remote monitoring or payment. And the apps that have really blazed a trail have said, ‘We’ll worry about that later. What we want to do first is to make sure that people love it and want to use it and stick with it.’ That motivating part is so important to the success of the app.
important step you could do. To me, the American healthcare system has a weakness. Our data chain is only as strong as its weakest link. And by allowing providers to fax unencrypted information indiscriminately from provider to provider has not pushed us enough to creating structured data. And this means there hasn't been a demand side for app data getting into the EHR. Because there hasn't been a push for getting rid of that weakest link in the chain.

So policywise, in many ways the Europeans are ahead of us. In terms of technology, the overburdensome regulatory environment that they live in makes it more difficult to create apps and all sorts of technology in general, whereas in the U.S. we've been able to really blaze a trail. So maybe we could learn a little from each other.

Q: ME: Are there any particular types of patients we know are really being helped by health apps?

TM: It's quite a mixed bag. It looks like some apps do virtually nothing, while others certainly help patients control their blood sugar, reduce their blood pressure and things of that nature. Often the apps that really do well struggle to make money. And some of those have gone away. That itself would be a great study, to find out how many apps that showed efficacy are important step you could do. To me, the American healthcare system has a weakness. Our data chain is only as strong as its weakest link. And by allowing providers to fax unencrypted information indiscriminately from provider to provider has not pushed us enough to creating structured data. And this means there hasn't been a demand side for app data getting into the EHR. Because there hasn't been a push for getting rid of that weakest link in the chain.

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8 tips for avoiding employee handbook crises

by CAROL GIBBONS, RN, BSN, NHA Contributing author

Can your employee handbook get you in trouble? Many healthcare businesses have an employee handbook, or employee policy handout, but fail to update them on a regular basis. There have been a large number of changes to employment law over the past couple of years that have forced me to review these documents more closely.

The handbook should be a general overview of your expectations while working in your business. Sometimes you can get too specific in your guidelines for disciplinary action, which can tie your hands in situations when an immediate action would have been better for your business. Your handbook is an evolving document and should be reviewed every year after the Supreme Court has ruled on all pending cases and released all their rulings at the end of June. It is not intended to be a comprehensive list of rules, but rather guidelines about how you expect employees to conduct themselves in your business. Here are some items you should be sure to include:

1 SOCIAL MEDIA
Do you have a social media policy? If you have one, does it prohibit employees from posting negative comments about your business?

You might be surprised to learn that you cannot prohibit employees from accessing their personal email accounts on company equipment.

2 AT-WILL EMPLOYMENT
If your state has an at-will employment law, you should also have a statement that the handbook cannot be considered a contract and that you have the right to make changes in an employee’s status whenever you feel necessary.

The National Labor Relations Board (NLRB) has been critical of these statements in 2016, stating that at-will statements may limit the employee’s right to engage in activity to challenge their at-will status. In other words, the employee might want to negotiate a contract that gave them better benefits or wages. So your statement should include that only the head of the company or organization can negotiate a change in an employee’s at-will status.

The word permanent needs to be removed from your handbook. An example might be a statement that after probation the employee would become a permanent full time. That can be construed as generating a contract, so don’t use it in your handbook.

3 DISCIPLINARY PROCEDURES
Do you have a huge list of things employees might do that would result in disciplinary action?

You might want to review that process and delete the list. You might instead have a statement about honesty, ethics, respect and the attributes you expect from them rather than a long list of items they can’t do. Trust me, there have been legal cases won because the termination infraction was not covered by the list in the handbook. You should also have a statement that holds employees to a standard that they should refrain from physical contact, threatening behavior, or violence.

4 DISCIPLINARY ACTION
Do you have a policy about your process and how you will track absences?

Review this policy carefully. Less is nearly always better than extensive. Do you have so much detail in the policy, that in practice you never comply with all of the rules? That could cause a problem if an employee wants to fight a termination and takes your handbook to an attorney. You should always have a statement that your disciplinary process, while liberal in nature, could result in immediate termi-
nation depending on the seriousness of the infraction.

Foul language is always grounds for termination, right? Here is an example: An employee discussion gets heated and loud in a room with a closed door and not witnessed by other employees, and the employee is cursing and making disparaging statements about the supervisor. You would think that this is a reason to terminate, but it appears the employee can use foul language and make disparaging statements about the employer and supervisor as long as they are not within hearing of other employees.

That is exactly what happened in the case Banner Health System dba Banner Estrella Medical Center and James A. Navarro. The NLRB ruled that the employee’s behavior in using foul language was not threatening, and an employee should be able to have a discussion about workplace issues. So be careful about your documentation when an altercation occurs. If you felt threatened by the employee’s behavior, make sure that is included in your disciplinary document.

5 HARASSMENT

Do you have a policy that says harassment should be reported to the manager or supervisor? Just keep in mind that the manager/supervisor could be the person harassing the employee. You might want the employee to have the option of reporting to any manager. They need a way to report that does not affect their job in any way, so the reporting might be to a manager of a different department, or a supervisor in a different area.

The handbook should make clear that you will not tolerate harassment, and if any employee experiences or observes harassment it should be reported immediately. The last thing you need is for a terminated employee to complain about unreported harassment and then enlist another employee to confirm their statement. Since your handbook should require that both employees must report harassment immediately, it would be more difficult for an employee to win a legal case if it was not reported until after the employee was disciplined.

6 BENEFITS

Have you reviewed your benefits to make sure they comply with federal and state laws? After the U.S. Supreme Court ruled that same sex marriages are legal in all states, many employers did not look at the wording of their benefits contracts. Several cases were brought against employers for having an insurance policy that did not cover same sex spouses.

If you do not have enough employees to be impacted by the Family Medical Leave Act, leave it out of your handbook and state you are not required to offer FMLA benefits. If you do have to comply with the FMLA, make sure your employees are told who to contact and that they must fill out the proper forms in order to be eligible.

Look at items like bereavement leave and make sure you have taken into consideration same sex spouses.

7 VACATION, SICK LEAVE, PERSONAL TIME OFF (PTO)

Does your handbook explain specifically how these will be calculated? Whether you choose vacation and sick leave in your business or PTO, you need to document how they will be calculated and when the employee will be eligible for these benefits.

The handbook should also state whether any benefits can be carried over at the end of the year, or if employees must use or lose benefit time. If your policy allows some leave time to be carried into the next year, then that should be specified in the handbook. It should also address whether leave time survives termination of the employee.

The handbook should not spell out the specific insurance coverage for healthcare. It should only specify that you offer health insurance and a 401K plan if you offer that. The handbook should tell the employee when they are eligible for benefits and have a statement that the benefits could change at any time.

Each year you should give the employees a separate benefit document that covers the specific information about insurance coverage and scheduled vacation days. That way you can modify as needed without requiring employees to read and sign the entire handbook again.

8 COMPENSATION

Does your handbook prevent employees from discussing their pay with other employees? The NLRB has ruled that companies cannot ban employees from telling other employees how much they are being paid. These rulings are generally aimed at large companies with many employees, but your handbook must be consistent with the current law in your state as well as the latest rulings from the NLRB. The motivation behind this ruling is that when employees have a complaint against management, they need the right to collect data to support their grievance. As a business owner, you should review the handbook yearly, at a minimum, and consult your company attorney to review any changes to make sure you have adequately protected your company from employee lawsuits. Do not just go on the internet and get a do-it-yourself handbook. Your handbook should be common sense guidance to your employees about your specific business, and these handbooks that are available online are not written to match your individual business.

Carol Gibbons, RN, BSN, NHA, is a healthcare business consultant.
How to fix the primary care crisis

A recent article by Victoria Knight of Kaiser Health News chronicled the declining interest in primary care (i.e., general internal medicine, family medicine and pediatrics) by medical school graduates.

Of 8,116 primary care post graduate training positions, only 42 percent were filled by graduates of U.S. medical schools. Osteopathic graduates (DOs) and foreign medical school graduates (FMGs) made up most of the remainder.

There is nothing negative about DOs and FMGs being primary care physicians (PCPs); the question is why don’t more U.S medical school graduates enter primary care? This issue is critical because the American Association of Medical Colleges (AAMC) projects that there will be a shortage of 21,100 to 55,200 PCPs by 2032.

Knight suggests a few reasons for the declining interest:

- Specialists typically earn twice as much as PCPs (although the median PCP income of $223,000 is not trivial.)
- Many medical schools overtly or covertly encourage graduates to pursue specialties.
- PCPs must spend an inordinate amount of time completing the electronic health record (EHR) and other insurer-required paperwork.
- 76 percent of medical students graduate with debt. According to the AAMC, the median debt in 2018 was $200,000.

Missing the point

Knight’s article was well researched, written and thoughtful, but like so many, she missed the most important point. Medical students are smart. They look around and realize that for less money, they get more responsibility and longer hours. And they have to earn that money by seeing far too many patients per day—24-30 patients, with an average visit of only 15 minutes—less when actual face time is considered.

With less time, students realize that they will not be able to practice comprehensive medicine as they are trained and desire to do. They realize that complicated issues that can’t be solved in a just a few minutes will need to be passed on to a specialist, substantially raising total healthcare costs. They also realize that they will not have the time to develop a close, trusting relationship with their patients and hence lose the potential for trust and true healing.

With the added burdens placed on them by insurers that further dilute time with patients, the end result is a simple decision—choose another career path even if primary care would otherwise be their preference.

PCPs need to see more and more patients per day to cover their costs and maintain their incomes. Frankly, it is a non-sustainable business model.”

Underestimating the value of primary care

There is an insidious misunderstanding of primary care. Most people, including all too many physicians and medical school faculty, think of primary care as treating only the “simple stuff.” That explains in part why they are prone to tell aspiring medical students that they are “too good for primary care.”

In fact, the well-trained and experienced PCP can handle most of the complex chronic illnesses that currently beset the American population—diabetes, heart failure, obesity, hypertension, etc. These are the diseases that consume 75-85 percent of all healthcare dollars. They are also adept at addressing most of the mental health problems, including anxiety, which accompanies or drives a large percentage of medical visits. Of course, they
“There is an insidious misunderstanding of primary care. Most people, including all too many physicians and medical school faculty, think of primary care as treating only the ‘simple stuff.’ That explains in part why they are prone to tell aspiring medical students that they are ‘too good for primary care.’”

know when it is appropriate to refer a patient for more specialized care.
Why is it necessary to see so many patients per day? Insurers reimburse PCPs at low rates and do not appreciate the value of involved history taking, thorough examinations and the time spent learning and thinking. Insurers have also burdened the PCP with innumerable new requirements that add to the burden of ‘feeding’ the EHR and that further take time away from patients. Billing and coding have driven up office costs dramatically.
The result is that PCPs need to see more and more patients per day to cover their costs and maintain their incomes. Frankly, it is a non-sustain-able business model. The result is that many PCPs are retiring early, others are selling their practices and working for the local hospital, while others are just keeping their heads down and getting burned out; over 50 percent have some objective evidence of burnout today, which negatively impacts not only doctors but their patients.
For those patients whose PCP follows the 24 -30 patients per day model, the result is less comprehensive care, more referrals to specialists, inadequate coordination of care, more tests, more ER visits and far less satisfaction.

Fixing the crisis
There are a number of possible approaches to solve this crisis in primary care. One is for a physician to reduce his or her practice size from the usual 2,500-3,000 patients to 400-800 patients, depending on the demographics of the patient population (practices with more seniors can see fewer total patients). The physician or nurse practitioner offers same-day and next-day appointments that are as long as necessary, plus prompt access by email and cell phone. Patients receive a comprehensive annual evaluation along with special attention to wellness and prevention.
Several different models use similar fundamentals:
Direct primary care (DPC), an approach that is usually the least expensive but entails seeing more patients
Membership-based
Retainer-based
Concierge medicine (which is more expensive but physicians have fewer patients in their practice)
In most of these mod-
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Thank you for everything you’re doing to keep patients healthy, informed, and safe during this unprecedented crisis. It is your work, and in many instances your sacrifices, that are keeping our families and loved ones safe. And there are no words to adequately express our gratitude to all of you.