BUILD WEALTH
How to create, nurture and protect your financial future

Practice Management
Turn smiles into cash: How happy patients drive revenue growth

Technology
Biden’s tech guru talks health IT

Careers
Concierge: a practice model worth investing in

Legal
How to keep hackers from ruining your business
DON’T BE OUT OF THE LOOP ON OUT-OF-POCKET COST

LET PATIENTS KNOW THE AVERAGE OUT-OF-POCKET COST MAY BE LESS THAN THEY THINK

SHINGRIX (ZOSTER VACCINE RECOMBINANT, ADJUVANTED)

LESS THAN* $5

*Average out-of-pocket cost for commercially insured patients.1

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

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

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

• Solicited local adverse reactions in subjects aged 50 years and older were pain (78.0%), redness (38.1%), and swelling (25.9%)

• 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

• In a postmarketing observational study, an increased risk of Guillain-Barré syndrome was observed during the 42 days following vaccination with SHINGRIX

• Review immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX

In fact, when it comes to healthcare, coverage and cost are often big concerns for patients. However, for most commercial plans, the out-of-pocket cost to patients is usually minimal.
When it comes to healthcare, coverage and cost are often big concerns for patients. But as you’ll see, cost doesn’t need to be an obstacle to receiving quality care. In fact, for most commercial plans, the out-of-pocket cost to patients is usually minimal.

Nationally, payers covering 96% of commercial medical benefit enrollees cover SHINGRIX2,1

96%

90% of privately insured patients pay no or limited out-of-pocket cost with the average cost being less than $5 per dose1

The Affordable Care Act (ACA) requires all Health Insurance Marketplace plans and most other private health insurance plans to cover all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines, including SHINGRIX, with no cost sharing (deductibles, copayments or coinsurance) if administered in-network.3

90%

Individual access may vary by geography and plan benefit design.

What you need to know:
Coverage, coding, cost to patient, reimbursement amount for product, and administration fee will vary by payer, plan, patient, professional setting, or services rendered and are subject to change without notice. Cost to patients may vary. Coverage and reimbursement decisions are made by individual payers following receipt of claims from providers. Providers must follow payer documentation and billing requirements.

1SOURCE: Managed Markets Insight & Technology, LLC, Database as of June 2021. “Coverage” is formulary access without restrictions, which means reimbursement from a health plan with no accompanying step edits or prior authorizations. Veterans Affairs (VA) and Indian Health Service (IHS) lives have been omitted when calculating the percentage of lives for this geography.

Important Safety Information (cont’d)

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


You are encouraged to report vaccine adverse events to the US Department of Health and Human Services. Visit www.vaers.hhs.gov to file a report, or call 1-800-822-7967.

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

To see additional information about cost and coverage go to CoverageSHINGRIX.com

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SGXJRNA210005 April 2021
Produced in USA.
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

2.1 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.

2.2 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.

5.2 Guillain-Barré Syndrome (GBS)

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

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

Overall, 17,041 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 17,331 (59.8%) subjects were aged 70 years and older. Both studies were conducted in North America, Latin America, Europe, Asia, and Australia. In the overall population, the majority of subjects were white (74.3%), followed by Asian (18.3%), black (1.4%), and other racial/ethnic groups (6.0%); 58% were female.

Solicited Adverse Events

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

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

Table 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

<table>
<thead>
<tr>
<th></th>
<th>Aged 50-59 Years</th>
<th>Aged 60-69 Years</th>
<th>Aged ≥70 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SHINGRIX %</td>
<td>Placebo %</td>
<td>SHINGRIX %</td>
</tr>
<tr>
<td>Pain</td>
<td>88.4</td>
<td>14.4</td>
<td>82.8</td>
</tr>
<tr>
<td>Pain, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>10.3</td>
<td>0.5</td>
<td>6.9</td>
</tr>
<tr>
<td>Redness</td>
<td>38.7</td>
<td>1.2</td>
<td>38.4</td>
</tr>
<tr>
<td>Redness, &gt;100 mm</td>
<td>2.8</td>
<td>0.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Swelling</td>
<td>30.5</td>
<td>0.8</td>
<td>26.5</td>
</tr>
<tr>
<td>Swelling, &gt;100 mm</td>
<td>1.1</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Myalgia, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8.9</td>
<td>0.9</td>
<td>5.3</td>
</tr>
<tr>
<td>Fatigue</td>
<td>57.0</td>
<td>19.8</td>
<td>45.7</td>
</tr>
<tr>
<td>Fatigue, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8.5</td>
<td>1.8</td>
<td>5.0</td>
</tr>
<tr>
<td>Headache</td>
<td>50.6</td>
<td>21.8</td>
<td>39.6</td>
</tr>
<tr>
<td>Headache, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6.0</td>
<td>1.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Shivering</td>
<td>35.8</td>
<td>7.4</td>
<td>30.3</td>
</tr>
<tr>
<td>Shivering, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6.8</td>
<td>0.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Fever</td>
<td>27.8</td>
<td>3.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Fever, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.4</td>
<td>0.2</td>
<td>0.5</td>
</tr>
<tr>
<td>GI&lt;sup&gt;b&lt;/sup&gt;</td>
<td>24.3</td>
<td>10.7</td>
<td>16.7</td>
</tr>
<tr>
<td>GI, Grade 3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.1</td>
<td>0.7</td>
<td>0.9</td>
</tr>
</tbody>
</table>

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

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

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

Placebo was a saline solution.

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

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

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.

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

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

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

There were no differences in the proportions of subjects reporting any or Grade 3 solicited local reactions between Dose 1 and Dose 2. Headache and shivering were reported more frequently by subjects after Dose 2 (28.2% and 21.4%, respectively) compared with Dose 1 (24.4% and 13.8%, respectively). Grade 3 solicited general adverse events (headache, shivering, myalgia, and fatigue) were reported more frequently by subjects after Dose 2 (2.3%, 3.1%, 3.6%, and (continued on next page)
Two doses (0.5 mL each) administered intramuscularly according to an 0- and 2-month or 0- and 6-month dosing schedule were collected using standardized diary cards for 7 days following administration of SHINGRIX. Solicited general adverse events 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%).

### Serious Adverse Events (SAEs)

In the 2 studies, SAEs were reported at similar rates in subjects who received SHINGRIX (2.3%) and placebo (2.1%) from the first administered dose up to 30 days post last vaccination. SAEs were reported for 10.1% of subjects who received SHINGRIX and for 10.1% 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 (0.2%) 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 0.8% of subjects who received SHINGRIX and for 0.9% of subjects who received placebo. Causes of death among subjects were consistent with those generally reported in adult and elderly populations.

### Potential Immune-Mediated Diseases

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

### Dosing Schedule

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

### 6.2 Postmarketing Experience

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

#### General Disorders and Administration Site Conditions

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

#### Immune System Disorders

Hypersensitivity reactions, including angioedema, rash, and urticaria.

#### Nervous System Disorders

Guillain-Barré syndrome.

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

The association between vaccination with SHINGRIX and GBS was evaluated among Medicare beneficiaries aged 65 years or older. Using Medicare claims data, from October 2017 through February 2020, vaccinations with SHINGRIX among beneficiaries were identified through National Drug Codes, and potential cases of hospitalization for GBS among recipients of SHINGRIX were identified through International Classification of Diseases codes. The risk of GBS following vaccination with SHINGRIX was assessed in self-controlled case series analyses using a risk window of 1 to 42 days post-vaccination and a control window of 43 to 183 days post-vaccination. The primary analysis (claims-based, all doses) found an increased risk of GBS during the 42 days following vaccination with SHINGRIX, with an estimated 3 excess cases of GBS per million doses administered to adults aged 65 years or older. In secondary analyses, an increased risk of GBS was observed during the 42 days following the first dose of SHINGRIX, with an estimated 6 excess cases of GBS per million doses administered to adults aged 65 years or older, and no increased risk of GBS was observed following the second dose of SHINGRIX. These analyses of GBS diagnoses in claims data were supported by analyses of GBS cases confirmed by medical record review. While the results of this observational study suggest a causal association of GBS with SHINGRIX, available evidence is insufficient to establish a causal relationship.

### 7. Drug Interactions

#### 7.1 Concomitant Vaccine Administration

For concomitant administration of SHINGRIX with inactivated influenza vaccine [see Clinical Studies (14.9) 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 a 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 eG 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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Produced in USA.
BUILD WEALTH — your way

How can physicians build the future of their dreams? In a high-pressure, high-stress profession such as medicine, day-to-day challenges of running a practice and treating patients can sometimes lead to tunnel vision. Many physicians can be years into their career — which also started later than most high-skill professionals — before realizing they need to think about their financial future and make a plan.

Our cover story in this issue is about this important topic: building wealth and setting up a secure future for you and your family, no matter what stage of your career you are in. Frankly, physicians of different ages have different financial priorities and challenges. Young physicians, for example, want to get a nice nest egg started, but also need to deal with potentially hundreds of thousands worth of student loans from medical school. Physicians closer to retirement, perhaps, are thinking about how they want to spend their money to enjoy the fruits of their labor and how to pass on as much as they can to the next generation. For our story, we focused on these different stages, and asked experts for their best advice on how to navigate the various challenges.

We have some other great wealth building content in this issue, including some trendy ways that many are losing wealth — and how to avoid that fate. We have coverage of the cryptocurrency craze, and what physician investors need to watch out for if they want to dip their toe into this complex investing space. Also, we take a close look at the trend of day trading which, thanks to some easy-to-use apps, has taken off in popularity among amateur investors. And as always, our investing columnist Dave S. Gilreath, CFP, takes a look at what’s going on in the stock market, and uses his expertise to parse where things may be headed.

Here are some other stories we’re excited about.

Did you know there’s a direct correlation between happy patients and your practice’s bottom line? This is intuitive, but a physician breaks down how this works and how to make it pay off for you.

We sat down with President Biden’s health IT guru, Micky Tripathi, to discuss what physicians can expect when it comes to EHRs, interoperability and the years to come.

Many physicians are looking to jump into concierge medicine. But starting a new practice is not the only answer. You can also purchase a practice from a retiring doctor. Two physicians explain how they made that work.

Let us know what you think of how we’re doing. Send us an email at medec@mjhlifesciences.com. Enjoy the issue!

Mike Hennessy Sr.
Chairman and Founder
of MJH Life Sciences

CHAIRMAN’S LETTER
Physician’s Financial News®

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COVID-19 COVERAGE CENTRAL

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

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- 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.

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Sticker shock
Consumer and producer prices surge; Fed forecasts interest rate hikes

By Keith A. Reynolds
Associate Editor

Consumer prices rose at the highest rate since 2008. Producer prices rose at highest rate on record. The benchmark inflation rate is higher than the Federal Reserve expected.

Welcome to the post-COVID-19 economy.

While federal bankers call the inflation transitory, and consumer price hikes are being attributed to supply bottlenecks as the world economy lurches out of the pandemic, the economic picture looks very different than it has for years.

In June, the Bureau of Labor Statistics said the Consumer Price Index had seen the largest 12-month rise since the period ending in August 2008. Producer prices surged by 6.6%, the highest rate on record.

According to a Fed news release, the index grew 0.6% in May after rising 0.8% in April. In the past 12 months the all-items index saw a 5% increase before seasonal adjustments; the largest increase since the period ending August 2008.

About one-third of the seasonally adjusted all items increase was tied to index for used cars and trucks, which rose 7.3% in May. The food index increased 0.4% in May, while the energy index was unchanged as a decline in the gas index offset increases in the electricity and

Investing in the post-COVID stock market

By Dave S. Gilreath, CFP

Remember how the stock market plummeted in March 2020 at the onset of the pandemic and then turned sharply upward to become a resuscitated, robust bull market?

This apparent disconnection with the COVID-19-crippled economy gave many investors a backward feeling, much like when the bull market that began in March 2009 belied the most severe recession since the Great Depression.

If you’re expecting a surging market to result from today’s recovering economy, prepare to have that backward feeling again. Sure, the economy is recovering apace, but to a considerable extent, gains from this recovery are already priced in because the market is forward looking: Expectations of economic growth push up stock valuations in advance but often not so much when this growth actually occurs.

Some stocks will register gains from economic recovery for months to come but not to the magnitude expected by investors who are overly zealous believers in the so-called recovery trade.

Over the past 10 years, starting with the economy’s slow climb out of the Great Recession, returns of the Dow Jones Industrial Average (DJIA) have been several percentage points above its 23-year average of 8.92%. The index’s 50-year average is 10.9%, and for the past decade, it has delivered about three percentage points above that. That’s huge.

The next decade could easily be two to three points below the 50-year average, but still decent,
Physician compensation remained flat during COVID-19 pandemic

Although the health care industry was financially slammed by the COVID-19 pandemic, physician compensation remained mostly static.

According to a news release from the Medical Group Management Association (MGMA), the 2021 MGMA “Provider Compensation and Production” report looked at data from 185,000 providers across more than 6,700 organizations and found that some specialties saw slight decreases or increases but that, overall, compensation remained the same.

Specifically, primary care physicians saw a modest increase of 2.6% between 2019 and 2020, as the government swooped in to support practices through the Paycheck Protection Program and the Provider Relief Fund and as patient volumes eventually rebounded. Advanced practice providers also saw a slight increase of 1.25% in compensation during the same time frame, according to the release.

The report also noted a 1.91% reduction in the median total compensation for specialists physicians between 2019-2020, a 0.89% decrease for surgical specialists and a 1.26% decrease for nonsurgical specialists.

“MGMA’s modest compensation findings belie the turmoil of 2020,” says Halee Fischer-Wright, M.D., president and CEO of MGMA, in the release. “Our numbers tell a story of a year of unprecedented challenges that could have potentially led to a serious decline in compensation across every category we track. Practices acted quickly to leverage government programs to cover staff costs and expenses during the early part of 2020. They adapted to new delivery models such as telemedicine and were able to quickly ramp up when patient volumes returned later in the year. It is a testament to the resiliency of physician groups that (weathered) the challenges of a year that tested us all in so many ways.”

BY KEITH A. REYNOLDS
ASSOCIATE EDITOR

June’s Fed news came at a time when the economy is awakening after its COVID-19 slumber, with consumer prices reaching a 12-year high and inflation on the rise. Fed officials expected inflation to reach 3.4% this year, higher than the Fed’s typical target of 2%.

“Inflation has increased notably in recent months,” reads the opening statement from Wednesday’s FOMC meeting. “The 12-month change in [consumer] prices reached 3.6% in April and will likely remain elevated in coming months before moderating. Part of the increase reflects the very low readings from early in the pandemic falling out of the calculation as well as the pass-through of past increases in oil prices to consumer energy prices.

“Beyond these effects, we are also seeing upward pressure on prices from the rebound in spending as the economy continues to reopen, particularly as supply bottlenecks have limited how quickly production in some sectors can respond in the near term. These bottleneck effects have been larger than anticipated, and FOMC participants have revised up their projections for inflation notably for this year.”

Despite the higher projections, Fed officials are confident the effects are being caused by “transitory supply effects” and they expect inflation to follow to 2.1% in 2022 and 2.3% in 2023.

“The Federal Reserve is committed to using its full range of tools to support the U.S. economy in this challenging time, thereby promoting its maximum employment and price stability goals,” a news release stated.

June’s Fed news came at a time when the economy is awakening after its COVID-19 slumber, with consumer prices reaching a 12-year high and inflation on the rise. Fed officials expected inflation to reach 3.4% this year, higher than the Fed’s typical target of 2%.

“Inflation has increased notably in recent months,” reads the opening statement from Wednesday’s FOMC meeting. “The 12-month change in [consumer] prices reached 3.6% in April and will likely remain elevated in coming months before moderating. Part of the increase reflects the very low readings from early in the pandemic falling out of the calculation as well as the pass-through of past increases in oil prices to consumer energy prices.

“Beyond these effects, we are also seeing upward pressure on prices from the rebound in spending as the economy continues to reopen, particularly as supply bottlenecks have limited how quickly production in some sectors can respond in the near term. These bottleneck effects have been larger than anticipated, and FOMC participants have revised up their projections for inflation notably for this year.”

Despite the higher projections, Fed officials are confident the effects are being caused by “transitory supply effects” and they expect inflation to follow to 2.1% in 2022 and 2.3% in 2023.

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With a small dip, the index for medical care was one of the few major component indexes to decline in May, while the index for all items less food and energy rose 0.7% in May. Indexes that rose included household furnishings, new vehicles, airline fares, and apparel, according to the release.

The medical care index only rose 0.6% over the past 12 months, the smallest increase since the period ending in March 1941, the release says.

The index for all items less food and energy saw a 3.8% rise over the past 12 months. Vehicle indexes saw a stark rise over the same period, with a 29.7% increase for used cars and trucks, a 16.9% increase for motor vehicle insurance, and a 3.3% increase for new vehicles, the release says.

The index for car and truck rentals saw more than doubled over the past 12 months, with a 199.8% increase, according to the release.

Meanwhile, the Federal Reserve announced in June that interest rates would likely rise by 2023, sooner than previously anticipated.

Fed Chairman Jerome Powell discussed the coming interest rate hikes at a news conference following the Federal Open Markets Committee (FOMC) meeting, during which Fed bankers signaled potentially two interest rate hikes before the end of 2023. Powell cautioned against reading too much into the projections, but the DOW Jones Industrial Average closed more than 260 points down following the announcement.

ADVICE YOU CAN INVEST IN

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Physician compensation remained flat during COVID-19 pandemic

Although the health care industry was financially slammed by the COVID-19 pandemic, physician compensation remained mostly static.

According to a news release from the Medical Group Management Association (MGMA), the 2021 MGMA “Provider Compensation and Production” report looked at data from 185,000 providers across more than 6,700 organizations and found that some specialties saw slight decreases or increases but that, overall, compensation remained the same.

Specifically, primary care physicians saw a modest increase of 2.6% between 2019 and 2020, as the government swooped in to support practices through the Paycheck Protection Program and the Provider Relief Fund and as patient volumes eventually rebounded. Advanced practice providers also saw a slight increase of 1.25% in compensation during the same time frame, according to the release.

The report also noted a 1.91% reduction in the median total compensation for specialist physicians between 2019-2020, a 0.89% decrease for surgical specialists and a 1.26% decrease for nonsurgical specialists.

“MGMA’s modest compensation findings belie the turmoil of 2020,” says Halee Fischer-Wright, M.D., president and CEO of MGMA, in the release. “Our numbers tell a story of a year of unprecedented challenges that could have potentially led to a serious decline in compensation across every category we track. Practices acted quickly to leverage government programs to cover staff costs and expenses during the early part of 2020. They adapted to new delivery models such as telemedicine and were able to quickly ramp up when patient volumes returned later in the year. It is a testament to the resiliency of physician groups that (weathered) the challenges of a year that tested us all in so many ways.”

BY KEITH A. REYNOLDS
ASSOCIATE EDITOR

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compared with the many leaner market periods that figure into it. For domestic equities over the next decade, the analysis firm Strategas is projecting an average annual return of 7%.

As many investors experience that backward feeling in the coming months, the market will continue its now-nascent evolution from a remarkably abnormal period. This started with a sometimes-interrupted 11-year bull market, gave way to the black swan event of the pandemic (a sudden trough and then ethereal ascent) and then took on the current personality of extremely high volatility. The economy can’t grow briskly, nor can a bull sprint, indefinitely — and the market may be reflecting that now.

Over the next one to three years, the market will become more normal; that is, it will deliver returns more characteristic of historical averages. This return to normalcy won’t be sluggish, just a slower leg of what I see as the DJIA’s journey to 50,000 by the year 2027.

The approaching slower period will likely be characterized by lower performance by growth stocks (especially big tech growth) and improving performance from older, established companies with a long history of stable performance and reliable dividends, known as dividend aristocrats. Names of these companies can be found in various exchange-traded funds (ETFs) based on this concept, including NOBL.

Many of these stocks are currently exhibiting value stock characteristics. Although many growth companies are young firms that reinvest profits in their enterprises, mature companies like the aristocrats use real profits to pay dividends to get and keep investors.

There’s evidence that the growth/value seesaw is already starting to tip the other way. Over the past two years, growth stocks have trounced the large, venerable dividend aristocrats.

“This is not to say that some growth stocks won’t do well over the next few years, but if the current trend continues, it will be increasingly difficult to pick winners in this category. Meanwhile, many investors’ penchant for opportunistically buying growth companies that are all potential and no earnings will likely fall out of fashion, much to the benefit of companies that consistently post positive earnings numbers.

However, it’s important not to paint all tech companies with a growth brush. Many established, large tech companies with real earnings in fields like semiconductors will likely remain viable. Amid the current semiconductor shortage (which curiously stemmed from anticipating less demand during the pandemic rather than what turned out to be more), companies like Nvidia and others in the ETF SMH are trying to crank out chips as fast as Frito-Lay to meet near-ubiquitous demand for products including digital toasters, phones, autonomous cars, you know it.

Yet the performance of many tech companies in the growth category is ebbing, and this will probably continue, causing money to flow elsewhere. Eventually, much of this money will probably find its way to mature
The ins and outs of day trading stocks: Should physicians take part?

By Todd Shroyack
Managing Editor

Buying and selling a stock in the same day is a high-risk — potentially high-reward — strategy for those with the time to do the research and monitor the market.

William Ross started day trading in 2018 after a few years of success buying and selling stocks using more traditional strategies. Early on, he lost a few thousand dollars day trading, as he oriented himself to the challenges of the daily ebbs and flows of stock prices. But now, he makes enough money that he used his profits for the down payment on an investment property and to boost his lower-risk investments.

“Day trading is high risk,” says Ross, a corporate consultant and director of Better Business Consulting Co. “You have to be risk tolerant to play it. I like to take the profits from high-risk investments and move them into something low risk.”

Day trading by definition is buying and selling a stock in the same day. Day traders look to capitalize on small moves in the market and then quickly cash out. But it involves research, time investment and some amount of luck to avoid losing money.

“We’re basically in the greatest bull market of all time, going on 12 years now,” says Jim Schultz, Ph.D., host of “From Theory to Practice” on tastytrade financial network. “Everybody just feels like, ‘If I buy something on Thursday and then sell it by the close on Friday, I make money,’ (and) then repeat on Friday and Monday. That’s just a really dangerous game to play when you think you can predict short-term market movements like that consistently — because the market is very, very random.”

Day trading is so volatile that some don’t even consider it a form of investing. “Some of the companies we trade are honestly worthless,” says Jesse Acosta, founder of The Day Trader Chatroom. “They’re not companies I would ever considering putting money into long term. Day trading for me is just a way to generate income that I can then grab and put in actual investments.”

Getting started
The minimum amount required by law to establish a day trading account is $25,000, and experts say more than that is needed because if the account value dips below $25,000 during the trading day, the owner will be locked out of the account.

But before opening an account, Acosta says it’s vital to research day trading. Start with a Google search and take in the various YouTube videos and blogs dedicated to day trading to learn the terminology, where to find stock data and how to make trades. “Typically speaking, I always tell everyone (that) you want to spend at least a year learning different strategies because there are many, many different strategies to day trade.

“We’re basically in the greatest bull market of all time, going on 12 years now.”

Managing risks
Knowing when to cut losses is a key part of day trading but also a difficult skill to master. Most traders use what’s known as a stop-loss order to help manage their risk. The order automatically sells the stock when it hits a certain price. For example, Acosta recently had a $115,000 position with Tesla stock, but the movement of the market went against him. The stop-loss order limited his loss to $200.

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Companies such as the dividend aristocrats.

This scenario suggests a barbell asset-allocation strategy of sorts. On one end of the bar, investors could hold substantial amounts of long-term dividend payers — dividend aristocrats and real estate investment trusts (REITs) — with dividends comprising one-third to one-half of expected returns. Then, on the other end of the bar, investors could allocate a smaller portion to growth stocks. These stocks might include a judicious selection of growth tech companies likely to do well from their role in the digital revolution. But investors should probably avoid huge growth tech companies that shot up and stayed strong through the pandemic and then faded — for example, Netflix, Amazon and Tesla — and smaller companies likely to struggle to maintain their lock-down-period growth. Many of these have stretched or negative price-earnings ratio, e.g., Zoom and Peloton.

This lesser allocation to growth stocks would ideally include shares of companies from various sectors that are becoming performance outliers. I say “are becoming” because once they’ve become established performers, prices may be too high. Stocks in this category tend to have good fundamentals — rising sales and earnings growth and low debt — and, perhaps most important, rapidly rising acquisition by institutions, as indicated by an increasing percentage of institutional ownership relative to individual ownership. These data can be found on your brokerage’s website.

Setting up this lopsided barbell allocation shouldn’t require a lot of heavy lifting, but it will require a little research and planning. Yet there’s time for this because, although the transition to normalcy has already started, it will be gradual.

So when you get that backward feeling, consider what the market conditions causing it might portend for the durability of your present equity portfolio.

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

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“I have a stop-loss that I will sell out of the trade if it reaches that level, and I have my price targets for my sells to make my profit,” says Acosta. “I have all of that established before I enter my trade. As long as I stick to that, I don’t see day trading as too risky. The risk comes in where people are not able to — because of a lack of discipline — stop out, so they end up holding the bag, as they say.”

Ross says with the right stop-loss strategy, a day trader can have eight losing trades and two winners and come out ahead because the losers might drop 5% while the winners might increase 25% to 50%. “Cut your losers very quickly, and let the winners ride longer,” says Ross.

Acosta says it is vital to always enter active trades with a plan in mind. “It’s like regular investing — you have to have an investment plan.”

Each investor who goes into day trading needs to define what success looks like to them. Some people make their living day trading, and a few make more than $1 million a year doing it. Many, however, lose money.

“The biggest tip is to know the market, know what’s going on and know all the trading terminology,” says Ross. “Just like you read a medical chart, you need to be able to read all the financial reports, stock charts and different technical indicators and have a good hold on what you are doing.”

Acosta and Ross both use their day trading proceeds to provide funding for their more conservative investments. Others dabble in it enough to make money for an extra vacation.

“All those types of goals can be achieved as long as the person is able to get proper day trading education and learn that it’s very important to manage their risk,” says Acosta.

Day trading also requires a time commitment, and not all physicians have time to spare to do the research required to increase their odds of success. Ross typically makes three to 10 trades per week and invests five to 15 hours to do so. Acosta will make one or two trades per day, based on research done the night before. He sets up his trades in the morning and is usually done by 11 a.m., checking later in the afternoon to see if any stocks look promising for the next day’s trading.

Physicians, with their intimate knowledge of health care, may be drawn specifically to health care stocks because they feel they have an advantage over investors who aren’t physicians. Although this may provide some advantage in regular investing, it may not translate to day trading, for which traders are studying trend charts — not what the company’s newest drug does. Ross says doctors may benefit from their understanding of pharmaceutical FDA clinical trial reports, which can shorten the education process of dealing with pharma stocks.

“Translating that industry knowledge into understanding how the market is going to react to news, to earnings calls and to profit results is not a one-for-one thing,” says Schultz. “In fact, it’s not even close to a one-for-one thing. It’s a ‘one to question mark’ thing.”

He adds that physicians would be better off using their industry knowledge on longer-term investments in health care companies. “Oftentimes, what you’re trying to accomplish needs a little bit more time to come to fruition. If you handcuff yourself, feeling like you have to be right directionally in that moment, it is extremely difficult and I would say potentially impossible to do. Given the market randomness, there’s going to be so many times when, if you had just given your hypothesis a little bit more time to play out, you would have been successful.”

The quick-money potential of day trading means a lot of people are out there promoting “can’t fail” strategies, but buyer beware. “Don’t believe all the hype,” says Acosta. “Do your own research, and find yourself a good program that you can understand and that you can dedicate your time to and get educated. Most people fail at day trading and blow up their trading accounts because they don’t get educated. You’re going to be trading against the best of the best and against computer algorithms, so you have to get educated to gain a little edge.”

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Medical Economics.com
Going the extra mile to make patients feel welcome

by Ethan Lazarus, M.D., FOMA

Many people are anxious when it comes to visiting their health care provider. Results from one study found that many patients avoid going to the doctor because they feel uncomfortable seeking medical care or fear a serious illness. As providers, we need to recognize these issues and create a welcoming environment for all patients to ensure they don’t postpone care or avoid it entirely.

This can be especially important when working with overweight or obese patients. We must practice compassionate care and create an office that’s inclusive for patients of all shapes and sizes. From providing chairs that are designed for patients at higher weights to having blood pressure cuffs that fit properly cuffs, patients must feel welcome while in your care. They will be more open about their health issues and you will be better able to engage in genuine conversations that are rooted in trust.

Practice with compassion

The concept of compassionate care is not new to the medical community. We’ve always been committed to sharing our clinical expertise and delivering health messages with an empathetic tone. However, not every provider has a supportive bedside manner, and this can adversely affect patients with obesity.

One mistake physicians make when treating patients suffering from obesity is instructing them to lose weight, but not providing guidance to help along the way. Just telling a patient to “lose weight” is as unhelpful as suggesting to a patient with depression “think happy thoughts.” Instead, providers should collaborate with patients to develop a comprehensive obesity treatment that includes intensive lifestyle intervention, structured nutritional assistance, physical activity prescription, and medical management.

Create a patient-friendly environment

From the moment a patient enters your office, they should feel welcome. The front desk staff should be courteous and knowledgeable when addressing patients with obesity and other health conditions. Most importantly, patients should feel encouraged before, during, and after their appointments.

Here are some ways to ensure your office is inviting:

- Weigh patients in a private setting on a scale that can accommodate higher BMI patients.
- Offer furniture that allows patients of all sizes to sit comfortably.
- Use equipment and supplies (e.g., blood pressure cuffs, exam tables, gowns, etc.) designed for larger patients.

Leverage today’s technology

In addition to the solutions mentioned above, there are also technological tools that can enhance your patient’s experience. A body composition scale breaks down a patient’s BMI into fat and fat-free weight, skeletal muscle, and visceral fat. The scale offers insights that go beyond just the body weight and helps providers hone-in on factors that affect weight loss. Another way to motivate patients is with a take-home report that charts their weight-loss progress and health improvements. Lastly, consider supporting patients outside of the office with a HIPAA-compliant portal for virtual or phone appointments.

Making patients feel secure and cared for is what we strive for every day. By being aware of how we speak with patients and how we welcome them into our office environment, we can help people feel more comfortable turning to us with their health concerns. And this, in turn, enables us to provide them with the care they need and deserve.

Ethan Lazarus, M.D., FOMA, has practiced full-time obesity medicine since 2004, and has served on the board of the Obesity Medicine Association since 2013. He is also a delegate in the American Medical Association.
The link between financial success and patient satisfaction

by Michael Blackman, M.D. Contributing Author

When considering the “health” of a medical practice, much of the focus is on financial indicators: missing collections at the time of service, recurring denials, poor claims management and aging patient balances. However, another area needs attention but is often overlooked: patient satisfaction.

The patient experience is a critical factor in the success of any health care practice — and its importance is increasing with the rise of health care consumerism. Individuals today commonly approach health care as they would any other consumer service. If a patient doesn’t find the overall experience satisfying, they will exercise their freedom to find another practice that better suits their needs and offers a more engaging, productive experience.

Happy, healthy patients result in financially stable practices

Studies also show a direct correlation between patient experience and profitability. For example, positive patient experience is associated with increased profitability, and a negative patient experience is even more strongly associated with decreased profitability. Furthermore, patients’ quality perceptions have accounted for a 17% to 27% variation in key financial metrics, and negative word-of-mouth about a hospital or health system could result in revenue losses up to $400,000 over one patient’s lifetime.

These studies demonstrate the link between patient satisfaction and clinical outcomes, which is why patient satisfaction has become an important and more frequently used measurement to help access health care quality. Since passage of the Patient Protection and Affordable Care Act in 2010, the Centers for Medicare & Medicaid Services has also tied Medicare reimbursements to patient satisfaction scores, making these metrics even more of a priority.

COVID-19’s impact on patient satisfaction

Although the shift to value-based care and the consumerization of health care has been happening for years, the COVID-19 pandemic put the spotlight on patient experience as individuals reevaluated the ways in which they have consumed and received health care and, overall, how their preferred providers have reacted to the COVID-19 crisis.

In Accenture’s COVID-19 Consumer Health Experience Survey 2020, 25% of patients who believe their provider is handling COVID-19 poorly say they will not seek further care from the practice — or will wait at least a year until doing so. More concerning, perhaps, is that 64% of patients say they will likely switch providers if their expectations are not met.

How providers respond to these changing demands and expectations will make or break their financial recovery and future success.

Building blocks for creating a positive patient experience

The stakes are high for providers to deliver an exemplary patient experience. If your practice is
not already doing so, it’s time to put a stronger emphasis on the patient’s satisfaction.

What follows are five strategies that can help your practice deliver a positive patient experience and set the foundation for improved financial performance.

**Make a good first impression**

A patient’s first interaction often takes place before they even enter the practice. A patient could have seen and read an online review or received a recommendation from a friend as they were searching for quality health care. Considering you never get a second chance to make a first impression, ensure that your presence, both digitally and physically, is a credible one. Routinely monitor the online review sites where you have a presence and, when possible, set a consistent cadence of responding to both negative and positive reviews to help your patients feel heard. Leverage social media and your website to share important health information to demonstrate your role as a trusted resource in your community.

**Encourage greater patient engagement**

Encourage patients to play a more active role in their health and overall care experience. Place emphasis on collaboration by considering the patient’s input and involvement to determine the best course of treatment or care. Instead of simply sending an appointment reminder for a yearly checkup, leverage e-newsletters to educate your patient population on common topics, such as allergies, wellness exams, flu season or even more localized health-related news. Drive greater patient engagement through the use of patient messaging solutions, which offer the ability for providers to “check in” with patients about their progress or health status.

**Improve access to care**

During the pandemic, patients and providers alike relied on virtual care services to not only continue care during periods of quarantines and shutdowns, but also to keep all individuals safe from exposure to the virus. Now that patients are accustomed to telehealth and appreciate its convenience, consider the possibilities for patients who may have previously faced transportation issues or other social factors that have impeded their access to care. Barring inequities with broadband access in some parts of the country and specific communities, consider educational outreach — that when clinically appropriate, all you need is a smartphone with video capabilities for more existing patients to adopt virtual care options. These same strategies could be applied to attract new patients.

**Add omnichannel conveniences**

Virtual visits aren’t the only conveniences today’s patients expect from their providers. Offering an online portal for scheduling appointments, accessing health records, viewing test results and paying bills gives patients more flexibility to manage their care when and where they want. Today’s patients no longer wish to rely solely on phone calls, voice mails and in-person visits to communicate with their providers. Rather, more than half of patients prefer to communicate via text, portal or email with their provider. Despite specific preferences, the Medical Group Management Association’s “Digital Payment Progress Report” found that 77% of providers still send paper bills, even though 52% of patients prefer electronic billing.

**Improve practice workflow**

Leverage innovative technology to transform your practice and make internal processes more efficient. Clinical time should be focused on patients and clinical issues, so the more intuitive the user interface is for providers, the better. Your health information technology vendor’s user experience and software design principles should be guided by user-informed personal research and data analysis. Clinicians and other office personnel should be able to efficiently complete necessary tasks while maintaining optimal patient engagement, including moving from a desktop computer to a tablet or other mobile device to better enable those workflows. In-person communication from the provider can also help set expectations so the patient does not feel ignored during the visit and has an improved experience as a result. If your practice’s technology stack is slowing down staff, it’s time to consider what changes are needed. Quality technology should play a role in helping reduce provider burnout while streamlining repetitive administrative work and supporting improved health outcomes.

By following these five strategies, your practice can improve patient satisfaction scores, which impact reimbursement related to a variety of value-based programs, and strengthen your practice’s overall financial health. If patient satisfaction is not already one of your 2021 goals, make it a priority and seek to provide the best possible care to optimize outcomes and improve key financial metrics that support long-term success.

Michael Blackman, M.D., is chief medical officer at Greenway Health. He brings an extensive background in health information technology and product management along with his knowledge of outpatient and inpatient care. He was an early leader in the development of electronic prescribing for controlled substances and believes health care is a team sport that requires the talents of all contributors working together to succeed. Prior to joining Greenway, he was medical director for population health at Allscripts and, previously, he served as chief medical officer for McKesson’s Enterprise Information Systems division.
Improving your bottom line:
Address these 4 areas first

ome of the biggest changes and challenges physicians have faced over the past year have been financial in nature. Most practices entered 2021 operating within razor-thin margins and needing an overhaul of revenue cycle management (RCM) strategies to ensure accurate and complete capture of all reimbursement opportunities.

Physician practices have the ability to make key moves to ensure their revenue cycle runs like a well-oiled machine. While change is never easy, it’s not too late to improve billing efforts and maximize reimbursements.

Admittedly, it’s impossible to fix everything at once. But what practices can do right now is address four areas that will have the biggest impact on the bottom line and ensure they’re staying ahead of the curve amid shifting billing and payment dynamics.

**Eligibility checks**
The more practices can do on the front end, before a patient sees a physician, the less likely they will encounter problems on the back end. Eligibility checks — reaching out to the billing clearinghouse, checking on deductions and coverage, and so forth — are probably the most important step. But rechecking eligibility is just as important as the initial check (e.g., to ensure a payer will cover X visits over a six-month interval). This is especially true in 2021, when job losses and health plans can change as quickly as an individual’s COVID or vaccine status. If a patient doesn’t get reauthorized, the doctor is doing their visit for free, and will have to write it off later.

**Price transparency**
Patient-responsible balances were on the rise before the pandemic. And as expected, the number of self-pay patient patients grew as unemployment rose in 2020, but that didn’t mean that patients were prepared to pay out-of-pocket health care costs. In one pre-pandemic study, as many as 68% of consumers said they weren’t prepared to pay surprise medical bills of $500 or less.

In addition to checking and rechecking eligibility, practices need to be up front about the costs of their services and offer plenty of opportunities for pre-payment and financing health procedures.

**Denial trends**
Coverage fluctuated so frequently in 2020 that many common errors were missed. But as a Medical Group Management Association (MGMA) correspondent pointed out in a recent op-ed, “Most practices find that 80% of their denials are a result of 20% of the problems.” In 2021, providers should pay closer attention to trends such as telehealth claims from a Medicare Advantage plan taking longer to get paid. Analytics platforms, which comb through claims data and identify codes and procedures associated with common denials, can help.

**Write-offs and old debt**
Considering we’re in the midst of a health crisis with economic repercussions, collecting unpaid balances and addressing debt will only become more difficult the longer we wait. Practices need to follow up on unpaid claims sooner rather than later and work out plans with patients that are fair and manageable.

Keep in mind that additional training may be necessary to ensure administrative and billing teams are up to speed. Physician practices may consider connecting with a third-party RCM vendor partner to address issues such as common billing errors, if they’re struggling to meet KPI goals.

While many of changes and challenges in RCM may be hard to adjust to and accept, the more work practices put in now, the greater the financial rewards will be in the third and fourth quarters of 2021.

Todd Davis is the director of revenue cycle management at InSync Healthcare Solutions. Send your practice management questions to medec@mjhlifesciences.com.
New innovations in e-commerce: What physicians need to know about Alibaba.com

The growth of digital technology has impacted primary care physicians, other healthcare providers, and practice administrators. The COVID-19 pandemic dramatically accelerated this digital trend as physicians had to adjust “overnight” to keep their offices running and avoid any slowdowns in delivering care to their patients.

According to a recent study by Alibaba.com, 93% of U.S. companies are now doing some portion of their B2B business online, and 43% are using e-commerce to source the products they need to run their business.

This has impacted the industry in many positive ways, but it also comes with some pain points and challenges. Medical Economics sat down with Sylvia Bao, Global Marketing Specialist at Alibaba.com, to discuss how physicians can take advantage of the growth in digital trade to enhance how they source products within the US and internationally.

**How has technology changed the way businesses, including medical practices, source products?**

That’s a great question. One of the things we have definitely seen during the pandemic is a surge in e-commerce and acceleration in digital transactions. Amid the pandemic business-to-business (B2B) sourcing and selling via our online marketplace actually grew by 14 percentage points from 21% to 35% between the end of 2019 to September 2020. We think the top reasons U.S. companies’ source online is to find and introduce new products faster, reach international markets, have greater supplier options and customers, increase profit margins and, of course, drive revenue growth.

**Can you tell me what Alibaba.com offers buyers? What can they expect when they sign in?**

Businesses large and small come to our platform to source finished goods, parts and inputs to manufacture products or to resell because they can look up suppliers anywhere in the world, communicate with them directly, issue a request for quotations, draft product specs and contracts, arrange for inspections, customs clearance and shipping and source securely from around the world.

To reduce the risks associated with global trade, buyers who purchase on the Alibaba.com platform can use the proprietary escrow service, Alibaba.com Trade Assurance. Through Trade Assurance, if anything goes wrong such as issues with quality or shipping delays, Alibaba.com will assist in reaching a satisfactory outcome, including getting your money back.

And now with the need to digitize due to the pandemic, we saw the number of active buyers from the United States on Alibaba.com nearly doubled and overall transactions by U.S. businesses on Alibaba.com actually increased more than 150% in the past year.

**What does Alibaba.com offer physicians and their practices in terms of sellers and products available? How robust are the offerings?**

On Alibaba.com, suppliers with the “Verified” logo are factories that have been verified by independent third parties. Buyers can see their comprehensive strengths such as corporate qualification, product qualification, and corporate capabilities when searching, checking product details/company profile.

In order to meet the needs of professional buyers in the industry, independent third parties also verified the industry-specific qualifications/services of these suppliers.

To make it even easier, Alibaba.com recently launched an Elite Partner Event that is accessible year-round. This vetted group of global suppliers features innovative, new technologies and products in a variety of categories to help enhance your competitive edge.

**What common pain points do business have when sourcing products, and what does Alibaba do to help solve them?**

The biggest challenges buyers often face when sourcing online surround the risks and uncertainty built into doing business globally, such as finding trusted suppliers, optimizing shipping efficiencies and reducing the risk of global trade. Our team is working really hard to make that sourcing process less stressful. We are constantly optimizing our shipping efficiencies. We offer shipping services that are transparent, reliable and cost effective.

**Administrative hassles are one of the major challenges facing medical practices. How does procuring products in this type of platform cut down on issues?**

To answer that question, I want to shine some light on our payment features innovative, new technologies and products in a variety of categories to help enhance your competitive edge.

**Get more information:**

Hover your smartphone camera app over the QR code to watch the complete interview with Sylvia Bao of Alibaba.com.

Sign up for a free Alibaba.com account!
E/M coding: Can you bill multiple same-day visits?

Q: Can a physician ever bill more than one office evaluation and management (E/M) code for a patient in the same day?

A: In some cases, a provider may perform more than one office or outpatient E/M service for a patient on the same day. New patient E/M codes 99202-99205 and established patient E/M codes 99211-99215 don’t state “per day” in their descriptors, but payer rules may prevent you from reporting more than one E/M code for a single patient on the same date of service.

For instance, Medicare will “not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day,” according to the Medicare Claims Processing Manual, chapter 12, section 30.6.7.B.

There is, however, an exception to Medicare’s rule about reporting multiple office and outpatient E/M services on the same date. If the provider documents that the visits were for unrelated problems and that the services could not be provided during the same encounter, then Medicare allows you to report separate E/M codes for the same date. The example the Medicare manual provides is a patient presenting for blood pressure medication evaluation and then returning five hours later for evaluation of leg pain following an accident.

To support reporting the services separately, experts advise maintaining distinct documentation for each service. You also will need to check payer preference for which modifier to append to the additional E/M code, such as modifier 25 (significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) or modifier 59 (distinct procedural service).

If a provider sees the patient twice on the same day for related problems and the payer doesn’t allow you to report those services separately, then you should combine the work performed for the two visits and select a single E/M service code that best describes the combined service. For example, if a patient comes in with elevated blood pressure, the physician may give the patient medication and then have her come back later that day to see how she is doing. In this case, because the visits are for the same complaint, you should combine the work performed for the two visits into a single E/M code.

“To support reporting the services separately, experts advise maintaining distinct documentation for each service.”

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis. Send your billing and coding questions to medec@mylifesciences.com.
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Cyberliability coverage: What physicians need to know

by Rachael Zimlich, B.S.N., RN Contributing Author

Virtually every medical practice relies on technology for some aspect of care, from electronic medical records to billing. The move to bring health care online was meant to make medical care more efficient, but it also made the industry more vulnerable to cyberattacks.

According to a report from the Herjavec Group and Cybersecurity Ventures, ransomware attacks on health care organizations quadrupled between 2017 and 2020, and more than 93% of health care organizations had some kind of data breach over the last few years. Email is a big weak spot when it comes to cybersecurity risks, and email phishing scams exploded during the COVID-19 pandemic, according to the cybersecurity firm KnowBe4. The problem is only expected to get worse, with some experts predicting that cyberattacks will increase fivefold between 2020 and 2021.

These increasing threats have led to the evolution of cyberliability coverage. Like malpractice insurance for cyberattacks, these policies can help offer protection if your practice’s data is breached or taken for ransom. Keep reading to learn what these policies cover, what they cost and why the need for cyberliability insurance is increasing.

Why health care?

Personal health information is protected by federal Health Insurance Portability and Accountability Act of 1996 and, while one might think this increases the privacy of this information, it also increases the risk health care practices face if this information is stolen.

Janel Loud-Mahany, senior vice president of underwriting and policyholder services at Copic, says health care is a prime target for cyberattacks because of the wealth of valuable patient information organizations store, such as birthdates, Social Security numbers and billing information. Copic is a medical liability insurance carrier that specializes in coverage for health care providers and organizations.

“We are seeing increased sophistication of cybercriminals, a growing base of connected devices, increased use of telehealth and human error all contributing to cybersecurity risks that are being exploited,” she says.

A growing risk

Matt Sherman, senior vice president of reinsurance programs at Tokio Marine HCC-Cyber & Professional Lines Group, says cyberliability insurance began as a matter of privacy protection but has really evolved over the years. Privacy violations from patient records that were exposed by employee error were the main cause of loss, he explains, but now extortion through hacking is the bigger risk.

“What’s changed in the last couple of years is the proliferation of threat actors,” Sherman says. “Hacking is not new, but the business of extorting people for private information is skyrocketing in the last 36 to 48 months, and health care is at the epicenter of that issue.”

This is partly because many health care providers do not have the proper network and system protections needed against malware that infects and locks their systems containing personal patient information. The Health Insurance Portability and Accountability Act and other regulatory frameworks require notification in the event there is exposure of that information. To make matters
worse, he says, advanced ransomware and the complexity of health care technology mean that many organizations are behind when it comes to protecting themselves against these threats.

“The systems that small offices are using are not up to the same level as finance and commercial businesses,” Sherman says, adding that the migration to electronic medical records has only made the problem worse.

The COVID-19 pandemic also increased the risk of cybercrime because health care providers had to scramble to transmit information and provide care in new ways, Sherman says. The rush to provide the same care without delay during lockdowns meant that many were doing their work in new ways without much security or preparation, he explains. There was also a rise in scams and hacking of personal devices used for health care work.

Lee Kim, director of privacy and security at Healthcare Information and Management Systems Society North America, agrees that the COVID-19 pandemic has increased problems with cybersecurity, mostly due to the larger perimeter health care organizations created through increased remote work and telehealth.

“Previously, most IT assets and personnel were located within the walls of the hospital,” Kim says. “Now, though, many personnel are working beyond the hospital walls, such as from their homes. Thus, we’re vulnerable since we’re dealing with a lot of fluidity.”

Disruption of IT operations and clinical information systems, destruction of data and patient safety risks — especially in regard to the functioning of medical equipment or devices — are the major concerns when it comes to cyberliability risks in health care. Even worse, breaches can occur undetected for long periods, she adds.

There are many forms of cyberattacks that can impact any business, but particularly the health care industry.

**Phishing** is often used to refer to text message, phone or email scams that appear to be from a legitimate source. This could be an email to a patient from an outside source posing as a valid health care organization asking for sensitive information.

**Ransomware**, on the other hand, is used to describe malware, or a type of program that can infiltrate technology system to steal or damage files. When ransomware is used to target critical technology — like the operation of medical devices — health care organizations are usually willing to do whatever it takes to restore their operations.

“Many are unaware that their health care organizations are experiencing security incidents,” Kim says. “Being willfully blind will not make the problem any less. Situational awareness and robust defenses are keys to maintaining the fortress.”

Employee negligence is a leading cause of cyberlosses, Loud-Mahany adds, with cybercriminals tricking workers into providing login or credit card information. General awareness and concern about cyberattacks is increasing across the health care industry regardless of hospital or practice size.

**WHAT’S COVERED?**

Different insurers also provide varying levels of insurance. In many cases, a low limit of coverage may be included as a standard part of a professional liability plan. The dollar amount of coverage may vary, and limits can be increased through add-ons to those policies. The cost to increase coverage is usually based on practice size, using the number of physicians or revenue amounts as a unit of measurement.

Cyberliability insurance plans are often embedded into medical professional liability insurance policies and can include coverage for:

- unauthorized access to IT systems;
- defense costs/fines associated with a data breach;
- data breach response costs;
- damage to network assets and interruption expenses;
- cyberextortion/cyberterrorism;
- fines and penalties levied by the Payment Card Industry Data Security Standards Council; and
- loss of revenue directly resulting from an adverse media report and/or notification to customers of a security or privacy breach.

While many of the damages that can occur in a cyberattack are covered by these policies, no policy is all-inclusive, Loud-Mahany says. Every policy has exclusions, and it’s important to read the entire policy to understand specific coverage restrictions. Examples of acts that might be excluded from...
cyberliability plans are intentional crimes and employee sabotage, she explains.

Most cyberliability plans cover a mixture of first- and third-party coverage components, Sherman says. For breach notification, health care organizations may need to hire a lawyer, a breach coach, or even a public relations team. Smaller practices might think this doesn’t cost enough or that their practice isn’t large enough for the insurance cost to be worthwhile, but the entire process is time-consuming and costly.

Sherman says his organization manages more than 2,000 breach events each year and most of those are in the health care industry. Smaller practices might think they have less risk than larger organizations, but he says they are actually the most vulnerable because they are using generic email accounts like Gmail or they lack protection software.

“This leaves health care practices exposed, and the first time you realize this shouldn’t be an actual breach,” Sherman says. Practices then have to figure out how to restore their operations and get back to business as soon as possible.

In cases of extortion, hackers can gain access to an entire system, forcing doctors to lose access to their entire network, Sherman says. You may have to pay a ransom or figure out other ways to restore the system and even look into forensics to recover files.

Even phishing scams have become more sophisticated, Sherman says. Scammers don’t rely on pleas for cash from some overseas stranded royal anymore. Instead, hackers can mimic an organization’s aesthetic and email address to pose as a vendor or provider.

“We all get spam. These hackers are sending out tens of thousands of spoofed emails at a time in hopes that a few make money,” Sherman says. “Add to that the fact that doctors are vulnerable and inclined to make ransom payments.”

Public perception is a big part of this vulnerability, too, Sherman explains. Privacy is a big concern in health care, and patients who feel as though their privacy has been compromised may be hesitant to continue working with an organization.

One big question when it comes to cyberliability insurance is coverage of bodily harm. This could
happen when medical operations are hacked and medical devices are affected. Coverage for a device that malfunctions or doesn’t work because of a cybercrime and results in bodily harm to a patient varies by policy, Sherman says. Insurers debate where cyberliability insurance ends and medical malpractice coverage begins.

“Bodily injury is a very gray area,” Sherman says. “We don’t intend to cover anything a medical professional policy would already cover. That’s the evolution of it.”

Other nuances of coverage depend on the policy, too. Sherman says some policies are starting to exclude things like major cyberevents that cause dependent business interruptions. For example, if a state’s power grid were hacked, shutting down power in large areas, a cyberliability policy may exclude problems related to that larger systemic event — even though these disruptions could cost billions in losses.

**What’s the cost?**

Costs are a huge factor in cybersecurity and liability plans. While these policies may seem like a big investment on top of other security measures, Loud-Mahany says a 2020 report by IBM/Ponemon Institute revealed that health care has the highest industry cost for data breaches containing personally identifiable customer information. She says analysis of these breaches shows that stolen patient records can cost health care providers about $429 per patient — roughly triple the loss from stolen data in other industries.

“Like other types of insurance, people should look at the resources available to them that help prevent issues from occurring and tools that support efforts to identify and address risks proactively,” Loud-Mahany says. “One of the biggest impacts a cyberissue can have is reputational damage. Good coverage will hopefully mitigate the effects a cyberissue has on your business and a big part of this is having a support team ready to help walk you through the necessary actions that should be taken.”

As the risk and frequency of cybercrimes against health care organizations increase, Loud-Mahany says premium costs are increasing as well.

“In order to increase limits, we’re seeing increased control requirements to prevent and limit the possibility of cyberattacks,” she says.

Many cyberliability policies are sold through other insurance companies as part of a larger medical liability plan, Sherman says. Limits are usually set relatively low, at about $50,000 to $100,000 worth of coverage. The insurance company may then offer additional coverage for an extra fee as a benefit to existing customers, he says. For this reason, health care organizations usually get more bang for the buck when cyberliability coverage is combined with malpractice insurance. But is it enough?

The average security breach may cost a practice between $15,000 and $20,000 to resolve, according to Sherman. In that case, $50,000 to $100,000 in coverage would be enough. An extortion event, on the other hand, can cost hundreds of thousands of dollars. For this reason, some practices may elect to increase their protection — even up to $1 million.

A million-dollar policy used to cost about $1,000 for the year, but increased loss activity in the last few years has driven costs up. Now, Sherman says, a million-dollar policy will cost a smaller practice or hospital about $2,000 per year in annual premiums. A solo physician can expect to pay about $1,000 per year in cyberliability premiums, he says, while larger hospitals can pay up to $10,000 per year.

**Reducing the risks**

A key aspect of cyberliability management is education. Just as health insurers are increasingly interested in preventive health care, professional liability insurers who offer cyberliability insurance have an interest in making sure clients have the necessary safeguards in place.

“So many doctors are trained in a very specific profession and don’t know the real danger about how it might affect their practice,” Sherman says. “There is very basic cyberhygiene that all professionals should be practicing.”

Loud-Mahany says Copic offers several tips to help clients prevent ransomware and other security breaches:

- Use two-factor authentication for a secure application access.
- Implement online data backups.
- Deploy spam filtering and email configuration.
- Install next-generation anti-virus software that provides behavior-based protection.
- Offer employees anti-phishing training.

In the end, insurance is just a piece of what should be a larger risk mitigation strategy, Sherman says. Practices should also be using protections like two-factor authentication and cloud-based backup software on a regular basis. Tokio Marine HCC offers its clients resources on risk management strategies. Sherman says education focuses on spelling out what could happen, what it could cost a practice, what to do if a practice has been hacked, questions to ask breach consultants and how to change passwords.

“Educating the client base will make a policy more profitable than increasing insurance premiums,” he says.
COVID-19 vaccines and medical liability: What physicians need to know

As of early May, about 152 million Americans had received at least one dose of a COVID-19 vaccine and approximately 115 million people were fully vaccinated, according to the Centers for Disease Control and Prevention (CDC).

As the long lines of patients seeking a lifesaving vaccine begin to shorten, the physicians, nurses, pharmacists, medical technicians and other health care professionals who have been working tirelessly to administer all those shots in the arm are bracing for a new threat: liability lawsuits.

Most of the risk of medical malpractice litigation related to COVID-19 vaccines comes from the possibility that staff did not follow their own best practices, and this risk can be greatly reduced by meticulous adherence to procedures.

Here are a few things your medical practice needs to know and prepare for as the public health campaign to quickly administer COVID-19 vaccines spurs a wave of litigation.

**Who is covered by the PREP Act?**

The Public Readiness and Emergency Preparedness (PREP) Act provides immunity from legal liability for covered persons who work on the development, testing, manufacturing and distribution of the vaccine (e.g., wholesalers, retailers, repackers, and common and contract carriers), plus those who are authorized to administer or dispense the vaccine.

As part of the public health push to get more people vaccinated quickly, several amendments to the PREP Act have expanded the list of professionals qualified to administer the vaccine. In addition to physicians, physicians’ assistants, nurses and emergency medical technicians, the list now includes dentists, podiatrists, veterinarians, midwives, health care students trained on vaccine injections, recently retired professionals and others.

**Testing the PREP Act’s immunity**

There is much confusion and uncertainty about whether normal medical malpractice insurance covers litigation related to the COVID-19 vaccines.

If a professional is authorized to administer vaccines, they would be a “qualified person” under the PREP Act’s immunity, so it may be a moot point; however, if a lawsuit is filed against a vaccine administrator, they would still need a defense attorney to file the necessary motions to dismiss while invoking the PREP Act. This costs money. It is anticipated that these types of lawsuits would fall under medical malpractice and/or ordinary negligence, depending on the wording of the complaint. In any event, it would be prudent for a practitioner to have this discussion with their insurance carrier to be sure coverage exists in the event that a lawsuit is filed against them.

Despite the PREP Act’s broad immunity coverage, plaintiffs’ attorneys have already been filing complaints in many jurisdictions to test the waters for possible wins that could set precedent in other venues.

There will also likely be litigation around the one exception to the PREP Act in which liability immunity gets suspended: death or serious physical injury caused by “willful misconduct.” To overcome the willful misconduct hurdle, a plaintiff must show that the vaccine administrator acted intentionally to achieve a wrongful purpose, knowingly without legal or factual justification, and in disregard of a known or obvious risk that is so great as to make it highly probable that the harm will outweigh the benefit — all of which results in serious physical injury or death. Serious injuries include those that are life threatening, permanently impair a body function, permanently damage a body structure or require medical intervention to avoid such permanency.

Even if there are some isolated cases in which serious injury or death can be conclusively tied directly to the administration of a COVID-19 vaccine, those individuals may be eligible to receive compensation through the Countermeasures Injury Compensation Program.
LEGALLY SPEAKING / LEGAL

COVID-19 vaccines and medical liability: What physicians need to know

James R. Embrey Jr., J.D., is a partner with Hall Booth Smith, P.C. Send your legal questions to medec@mjhlifesciences.com.

Follow the CDC’s vaccine toolkit
Medical practices must be able to demonstrate that they have fully trained their staff and adopted protocols to carefully follow the CDC’s COVID-19 Vaccine Storage and Handling Toolkit. Those guidelines were developed in collaboration with vaccine manufacturers, scientific studies and public health officials and are revised or updated periodically.

Each practice should write and adopt standard operating procedures for vaccine storage and handling and document the dates of staff training for each person who will be involved in their vaccine program.

Stay current on evolving CDC guidelines
It’s also important to look for and adopt updated guidelines from the CDC when they are issued.

The early toolkits didn’t address the importance of maintenance and temperature validation checks to vaccine storage units, for example, but that issue is addressed in the 65-page toolkit released in March.

A faulty seal on the door of a cold storage unit could compromise the potency of the vaccine, and dormitory-style combination refrigerator/freezer units are specifically banned. Practices must only use purpose-built or pharmaceutical-grade units.

Document everything
As always, the best defense is a good offense. Encourage all staff to have meticulous record-keeping practices and proactively look for opportunities to spot check or conduct double verification of important data or documents.

Something as simple as sloppy handwriting could be problematic in front of a jury. A carelessly scribbled number nine might look like a seven on first glance, for example. If there is ever any doubt, pause, double check and verify.

Preserve records
Should a patient complaint, threat of a lawsuit or litigation occur, ensure that all staff follow protocols for preserving patient charts, check-in and release logs, handwritten notes, notes about verbal conversations, voicemails, emails and other records that will be discoverable. Never alter a record or perform an unscheduled records purge.

Engage legal counsel early
Every physician practice should be working proactively with an attorney who is experienced in medical malpractice and liability litigation defense to plan and prepare for possible COVID-19 vaccine litigation.

That preparation should include a comprehensive review of current policies, procedures, staff training, documentation practices and other areas of potential exposure. Having a solid plan in place improves the defensibility of any claim that could arise and allows health care professionals to deal with possible litigation in a more confident way.

“Most of the risk of medical malpractice litigation related to COVID-19 vaccines comes from the possibility that staff did not follow their own best practices.”

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• CDC recommends that all adults 19 years of age and older who have not previously been vaccinated with Tdap receive a dose of Tdap¹

• However, only 31.7% of eligible adults in this age group are vaccinated with Tdap as of 2017²

  – By comparison, the rate for adult influenza vaccination for the 2016-2017 season was 45.4%²

  – As of 2017, pneumococcal vaccination coverage in adults 65 years of age and older was 69.0%²

¹ For vaccine age indications and coadministration information, please visit www.cdc.gov.

² Learn more at tdapgap.com/vaccine

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Tdap= Tetanus, diphtheria, and acellular pertussis

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Learn more at tdapgap.com/vaccine
Building wealth:
How to create, nurture and protect your financial future

by Jeffrey Bendix Senior Editor

When it comes to winding down a medical career, Robert Eidus, M.D., knows he’s in an enviable position.

After spending most of his career in New Jersey, Eidus, 72, and his wife moved to California in 2018 to be closer to family. Now he works a four-day, 30-hour week as a family physician for John Muir Health in Walnut Creek, California, leaving him ample time to spend with their granddaughters who live nearby.

But as important as his work schedule, in Eidus’ view, is having saved enough that he and his wife will be able to live comfortably regardless of how much longer he chooses to work. “I’m in a position where I’m working because I want to work, not because I have to,” he says.

In some ways it should be easy for most physicians to attain Eidus’ level of financial security by the time they’re contemplating retirement. Most of them earn far more than the average American, making it theoretically possible to save enough for retirement while still enjoying a comfortable lifestyle during their working years.

At the same time, doctors face some unique challenges when it comes to savings. For one thing, they start earning incomes later than most other professionals. They also begin their careers owing a lot of money. A 2019 Association of American Medical Colleges study found that 73% of medical students graduated with debt, the median amount of which was $200,000 for medical school alone.

These factors may help explain the results of a 2015 Fidelity Investments survey, which found that nearly half of doctors were saving just 9% of their income, well below the range most financial advisers recommend. The survey also revealed that 48% of doctors weren’t contributing the maximum to a workplace savings plan.

The issue of retirement preparation has taken...
on new urgency in recent years, experts say, as surging rates of burnout have more doctors thinking about leaving practice earlier than they once anticipated. According to a recent joint survey by Laurel Road, a brand of KeyBank, and The White Coat Investor, an online community that helps medical professionals better manage and invest their money, nearly 63% of practicing physicians plan to retire between the ages of 50 and 64 compared with about 20% who anticipate working to age 65 or beyond.

“It’s important for physicians, especially those just starting out, to recognize that they’ll want to have options earlier in their careers than they might think because so many of them become unhappy with what they’re doing,” says Steven Podnos, M.D., MBA, a certified financial planner (CFP) and principal of WealthCare LLC in Cocoa Beach, Florida, which specializes in working with health care professionals. “And the only solution is to attain financial independence as early as they can.”

Financial advisers and retirement experts say that to achieve that goal, doctors need to:

- Start saving as early as possible.
- Save as much as possible.
- Take maximum advantage of financial tools that allow savings to grow tax free, such as individual retirement accounts (IRAs) and employer-sponsored plans such as 401k and 403b plans.

Following these rules takes discipline, but it’s worthwhile in the long run, according to Eidus. “Among my friends, the happiest ones live relatively modest lives,” he says. “It gives them the financial security that allows them to do other things and practice the way they want to. Spending over your needs only creates pressure, and then you start to resent your work.”

Although doctors need to save for retirement throughout their career, it may take different forms depending on whether they’re in their early years of practice, midcareer or close to retirement.

**Just starting out: Pay yourself first**

Financial advisers say the early years of practice are, in many ways, the most important when it comes to saving for retirement for two reasons. First, the longer that money sits in a retirement account, the more time it has to grow. Second, saving right from the start instills the habit of not spending everything they earn. This is especially important for young doctors who, after years of delayed gratification during education and training, suddenly find themselves with a lot of disposable income.

“When doctors sign on to their first job, for some it’s like they won the lottery, and they quickly get accustomed to living like that,” says Dan Danford, MBA, CFP, principal of Family Investment Center in St. Joseph, Missouri. “The key is to get them started saving and investing right away. They generally find they still have plenty of discretionary income and can do all the stuff they want to. It’s just that they’re doing it with money after they’ve started saving and investing.”

Says Podnos: “We always tell our clients, ‘Pay yourself first.’ That means the first things that should come out of their paycheck should be retirement plan contributions, debt payoffs and any after-tax savings plans they may have.”

Financial planners vary on how much they advise their younger doctor clients to save, but the general consensus is between 20% and 30%. “Typically we encourage clients to save at least 25% of their income in whatever vehicle they have access to,” says Kayse Kress, CFP, a principal with Physician Wealth Services. That’s higher than the industry standard of 10% to 15%, she says, “but physicians typically are getting a late start on savings compared to their peers, so they need to save at a higher rate.”

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Paying off student loans: Strategies vary
Advisers say that student loans are also an important consideration in retirement savings because many clients want to repay them as quickly as possible, even if it means minimizing or delaying long-term savings — a strategy advisers largely endorse.

That’s the approach that Danielle Carter, M.D., 36, has taken since starting practice in 2014. A family physician at Ascension St. Vincent’s Riverside in Jacksonville, Florida, Carter paid off her $150,000 student debt in five years. She readily acknowledges that she benefitted from being part of a dual-income household since graduating from medical school in 2010. Even so, repaying the loans required her and her spouse to develop and stick to a budget.

“We started with all the things we knew we had to pay for, like the mortgage and car payments and insurance premiums. Then we included all the things we could get rid of if we had to, and we stuck to that until my loans were paid off,” she says.

Carter says she and her husband still benefit from adhering to their budget. “That’s how we’ve been able to get to a place where we have more disposable income and money for savings and investments,” she says, adding that half her income goes to the latter.

“You finally have a nice job with real income, and you want to reward yourself with a nice vacation or a new car,” she adds. “You just have to make sure you have the financial space for it and it doesn’t turn into lifestyle inflation, where you’re spending beyond your means.”

But not every financial adviser thinks loan repayment needs be a young doctor’s first priority. Danford, for one, recommends treating it like a home mortgage — starting out by paying just interest plus a little of the principal.

“When docs come out of school, their debt seems insurmountable, and I understand ... the feeling of wanting to pay it off,” he says. “But 15 years from now, it won’t seem like such a big mountain due to inflation and because they’ll be earning so much more. They can always ramp up the debt payments later on.”

Investing in 401(k)s and IRAs
The two most common savings vehicles are employer-sponsored 401(k) or 403(b) plans and IRAs. Under a 401(k) or 403(b) plan, employees direct a set amount from each paycheck into their individual account, up to $19,500 annually. The funds are invested, usually by an employer money manager, and they grow tax free until the employee begins withdrawing them. (Funds withdrawn before age 59 1/2 incur a 10% penalty).

The advantages of these plans are threefold, experts say. First, as noted above, the funds in them grow tax free. Second, they are funded with pretax dollars, so by contributing to them, doctors can sometimes move into a lower tax bracket. Finally, many plans include an employer match up to a certain percentage of the employee’s contribution. Most financial planners recommend that, at a minimum, doctors fund their retirement account up to the amount of their employer match.

“If you’re getting what’s essentially free money from your employer, at the very least, you want to take full advantage of that,” says Lawrence Keller, CFP, founder and principal of Physician Financial Services in Melville, New York.

Kress notes that 401(k) participation doesn’t require working for someone else. Contractors and the self-employed can have individual 401(k) plans. “It’s something we advise a lot of our clients who are working as 1099 [contract] employees to do because it’s easy and inexpensive to set up and gives them that deferral option,” she says.

IRAs offer benefits similar to a 401(k), in that money in an IRA account grows tax free until it is withdrawn. But unlike a 401(k), it’s up to the individual, rather than an employer, to set up an IRA and decide how to invest the money in it, and there is no employer match.

The IRA contribution limit for 2021 is $6,000 ($7,000 for individuals 50 and older), but whether and how much of the contribution is tax deductible depends on the...
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person’s income and if they participate in an employer-sponsored retirement plan.

Along with traditional IRAs, savers have the option of a Roth IRA, in which deposits are not tax deductible but withdrawals are not taxed at retirement. That makes Roth IRAs particularly attractive for young physicians, says Danford, because they are probably in a lower tax bracket early on than they will be when they start withdrawing money from the account. “The younger you are, the better a Roth looks,” he says.

Roths also come with some restrictions. They have the same annual contribution limits as regular IRAs. In addition, only single people earning less than $125,000 or couples earning less than $198,000 annually are eligible to make the maximum contribution. There is, however, a way around the Roth income limits, known as a backdoor Roth IRA. (See sidebar, “The backdoor Roth IRA.”)

What about HSAs?

Another pretax savings method that advisers recommend for some clients is to fund a health savings account (HSA). As with an IRA or 401(k), HSA contributions are pretax and grow tax deferred while they are in the account. Contribution limits for 2021 are $3,600 for an individual and $7,200 for a family.

Funds withdrawn from HSAs at any age to pay for medical expenses are not taxed, and after age 65, the money in them can be used for any purpose (although withdrawals are taxed if not used for medical expenses). For these reasons Keller calls HSAs “stealth IRAs.”

The major limitation of an HSA is that because they are intended to accompany high-deductible health plans (HDHPs), they are available only to people whose employers offer HDHPs and who don’t use another type of health insurance.

Saving after the early years

By the time doctors have gotten established in their career, they’ve usually reached their peak earning

The backdoor Roth IRA

When it comes to building retirement wealth, financial planners say that few tools are more effective than the Roth individual retirement account (IRA). Like a traditional IRA, money in a Roth account grows tax free. The difference is that Roths are funded with after-tax dollars, but the money in them is not taxed at withdrawal — the opposite of a traditional IRA. That makes Roths an attractive option for physicians just starting out because they are likely to be in a higher tax bracket when they retire than when they make deposits to a Roth account and because the money in the account has longer to grow.

“The younger you are, the longer you have until retirement, so even with paying taxes at retirement, you’ll likely end up in a better financial position,” says Lawrence Keller, a certified financial planner and founder and principal of Physician Financial Services.

Roths, however, do come with income eligibility limits: Only single people making less than $125,000 and couples earning less than $198,000 per year are allowed to make the maximum $6,000 contribution, which limits a Roth’s usefulness even for most young doctors.

Fortunately, there is a workaround to the income eligibility rules — the “backdoor Roth IRA”:

1 Make an after-tax deposit of up to $6,000 (or $7,000 if you’re over 50 year old) to a traditional IRA account
2 Open a second IRA account.
3 Move the funds deposited in the first account into the second account. (Having them at the same financial institution makes the process easier but is not required.)
4 Sign and file IRS Form 8606.

The backdoor Roth does have one significant catch, however, known as the pro rata rule. It essentially allows the government to include the value of all the individual’s pretax-funded IRAs — including traditional, simplified employee pension (known as SEP) and savings incentive match plan for employees (or, SIMPLE) IRAs — when taxing a Roth conversion, thereby eliminating most of its benefits.

The best way to avoid the pro rata rule’s effects, says Keller, is by moving funds in other IRAs into an employer-sponsored 401(k) or 403(b) account. Self-employed people can use an individual 401(k) account to do this.

“The IRS doesn’t count 401(k)s and 403(b)s under the pro rata rule, so as long as you have one of those, you can get the full benefit of a backdoor Roth conversion,” he says.
years — which means they can increase their retirement savings without having to sacrifice as much of their current lifestyle as when they were younger.

“That’s the period when we want people to be maxing out their retirement plan,” says Kress. “By that time they should have paid off any high-interest debt and made a good start on their student loans,” she says.

In addition, doctors who’ve built up substantial savings in tax-deferred IRA and 401(k) accounts need to begin thinking about how they’ll pay taxes on that money when they start withdrawing it. For that reason, “this is the point when it makes sense to bulk up contributions to non-nonretirement savings accounts,” she says.

Podnos also recommends that doctors establish after-tax investment accounts — even early in their careers, if possible. “For younger docs, we suggest they invest in large, diversified, low-cost stock funds and just keep adding to that. They’ll turn around in 20 years and see they did great.”

**How much will you need?**

As physicians approach the age at which they start thinking about retirement, the question inevitably arises of whether they’ve saved enough to retire and how long their retirement savings will last. The answer to the first question is fairly straightforward, according to Podnos. “Look at how much it costs you to live the way you want to live.”

For the second question, he says the consensus among financial advisers is that, in most cases, retirees can safely withdraw about 4% from their savings annually. “At that rate, it’s almost certain you can go at least 30 years, even under the worst scenarios, without running out of money,” Podnos says.

If an investment portfolio provides better-than-expected returns during the early years of retirement, he adds, the 4% annual withdrawal rate might be increased. “We come up with rough numbers based on what people want to spend and when they plan to stop earning an income, but then we make adjustments when they’re in the distribution years,” he explains.

For his part, Eidus says he has reached a point of financial security by contributing regularly to the savings plans available throughout his career, including both traditional and Roth IRAs and a 401(k). In addition, he received stock options while working for a publicly traded company.

Just as important as taking advantage of these opportunities, he says, has been living within his means. “During my career, I’ve noticed that the happiest doctors are the ones that live modest lives,” he says.

Since moving to California, Eidus and his wife have been working with a fee-only financial adviser to develop a plan for a post-retirement lifestyle that includes traveling, making charitable donations, taking classes and leaving money to their children and grandchildren.

“They use computer-driven formulas based on that information and our life expectancies to determine the plan’s likelihood of success,” he says. “What’s nice is they can change the algorithms in the formulas depending on how long I decide to keep working. It lets us know if we have to modify our goals.”

Eidus says having a solid retirement plan in place frees him from the stress he sees among some colleagues whose financial situations force them to work longer than they’d planned to. “When people ask me how long I plan to keep working, my response is, ‘as long as I keep looking forward to Mondays,’” he says. “When I start looking forward to Fridays, I’ll know it’s time to do something else.”

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Source: Laurel Road & White Coat Investor

Approximately what percentage of your gross income do you save each year for retirement?
5 things to consider when making a financial plan

Physicians spend their lives caring for others, but they also need to take care of themselves, including their financial well-being. From the moment doctors earn an M.D. to the day they hang up their white coat for good, they face unique financial hurdles and dilemmas.

What follows are five key components that every medical professional should consider when putting together their financial plan.

### Student loan debt
Medical school students will accumulate an average of $192,000 in student loan debt by the time they graduate. In comparison, the average student loan debt per student in the United States is $37,172.

Carrying five times the student loan debt as the average college graduate, medical professionals are starting their careers with a monumental financial burden. That’s why for most health care workers, paying down student loan debt is a top priority for the first five, 10, 15-plus years of their career.

If you’re still working to pay down debt, continue to make this a priority as you work with your financial adviser. Student loan debt that is not paid down strategically can wreak havoc on your credit score, savings goals, home buying dreams and retirement planning.

### A robust estate plan
Your career is demanding, but you still need to make time to prepare a plan to protect your future legacy. From determining what will happen to your private practice after your passing to ensuring your spouse and children are well taken care of, a robust and well-defined estate plan is critical for health care professionals.

### Disability insurance
For many medical professionals, establishing their own practice is a big goal. But pouring your resources and time into a private practice can leave you with little left in the way of savings, making disability insurance crucial for medical professionals.

For young doctors — and health care workers as well — their high-earning years are still ahead of them. Should they lose the ability to work now, they’re facing an uphill battle with debt to pay down and a loss of income. Disability insurance can help doctors, surgeons and other health care professionals protect themselves financially from this worst-case scenario.

### Malpractice insurance
According to the American Medical Association, 1 in 3 physicians has faced a medical liability lawsuit in their career. That number jumps to nearly half for physicians 55 years and older.

You’re working in a high-stakes field, meaning a less-than-desirable outcome could incite legal action by a disgruntled patient or their family.

The good news is, around 68% of claims are dropped, dismissed or withdrawn. However, medical professionals will still pay an average of about $30,000 in defense costs. Having malpractice insurance can help reduce or eliminate this financial burden.

### A good financial adviser
You know better than anyone that your financials are unique and that your needs can differ greatly from those of friends and family who work outside the health care industry. As a result, your financial plan deserves the dedication of a financial adviser who specifically works with and knows how to help medical professionals.

The right adviser is able to accommodate your busy (and often erratic) schedule, address your student loan debt, assess your risk coverage options and help prepare a legacy for your family. Additionally, you may want to work with someone who can help you establish a practice and transfer it to new ownership when you’re ready to retire.

Finding a well-suited financial adviser can be one of the most impactful decisions you make regarding your financial plan.

As a health care professional, it’s important to know you have a thorough financial plan that addresses all of your financial concerns. Pay special attention to these five components to help make the planning process productive and comprehensive.

Julianne F. Andrews, MBA, CFP, AIF, is a principal and co-founder of Atlanta Financial Associates. Send your personal finance questions to medec@mjlifesciences.com.

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Decoding cryptocurrency: A physician investor’s guide

The digital assets offer opportunity and risk

by Keith A. Reynolds Associate Editor

Bitcoin, Dogecoin, Litecoin: These may sound like collectibles from a video game, but savvy investors have turned these cryptocurrencies into an attractive vehicle for those with an appetite for risk.

In the 12 years since Bitcoin was introduced, these digital currencies have been used for things as varied as buying illicit drugs on the internet to massively overpaying for pizza. Now that companies like Tesla, Inc. and Square, Inc. have amassed hordes of the assets, what started as a project from an anonymous person or group has become the hottest trend in investing.

Although it may seem like a ticket to quick riches, experts warn investors that the young market can be volatile and that some of the actors in the space may have malicious intent.

What is cryptocurrency?

These assets are essentially a type of decentralized digital money meant to be used over the internet and built on a technology known as blockchain, which is basically an open-source ledger that can easily be read by anyone, according to cryptocurrency trading platform Coinbase. This blockchain is maintained by large server farms called mines that compute millions of math equations to verify transactions in a race against other mines. The first mine to complete the calculations and update the ledger are rewarded with more of the currency, which has made mining an attractive prospect for those with excess computing power available.

Proponents say this decentralized foundation and the open nature of the ledger make cryptocurrency transactions more secure than traditional online payments. The prospect of being able to spend the asset for goods and services adds another layer to its appeal that normal investments can’t compete with.

But many argue that in the race to verify transactions, miners are having an outsized impact on the environment. Bill Gates, the co-founder of Microsoft, told The New York Times earlier this year that Bitcoin uses more electricity verifying each transaction than any other method, a severe liability at a time when the public and governments are trying to get serious about combating climate change.

What to know before you invest

Zak Killermann, assistant publisher for global financial at Finder, says that first-time cryptocurrency investors should keep in mind this is still a young market undergoing regulatory changes and developments in countries around the world.

Indeed, as The Washington Post reported in March, President Joe Biden’s administration is studying gaps in oversight connected to the fledgling market, citing the wild swings in value Bitcoin saw in the opening months of 2021.

Even though established assets such as stocks have been highly regulated with different classes of stocks for different parties and established criteria and qualifications for brokers, Killermann says the cryptocurrency market is wide open at the moment.

According to Killermann, impending government regulation isn’t something to be feared because it could smooth out some of the wrinkles in cryptocurrency investing.

“I think that in a country like the U.S., it will absolutely help the market if we have more regulations so that banks can get involved,” he says. “It makes it easier to add cryptocurrencies to existing financial systems. And it makes it more clear for regular investors to add cryptocurrencies to the portfolios through existing brokers.”

Killermann recommends first-time investors do their homework and learn as much about the currency they’re looking to invest in before buying into it. He says his website, Finder.com, publishes unbiased explanations of the concepts, players and what coins are
available as well as analysis of where they think the market is going. But he says it’s unwise to trust any one source of information when it comes to the fledgling market.

“The market not yet at a place where I feel comfortable pointing to one individual’s advice and saying, this person or this website or this source of information will always be correct,” he says. “So I’d always recommend at least checking two or three places before feeling comfortable with the research that you’ve done.”

**Best practices**

Julianne Andrews, MBA, CFP, AIF, senior wealth advisor and senior director at Mercer Advisors Inc., in Atlanta, says that especially after the COVID-19 pandemic prompted some people to eschew paper money, the move to a digital-only currency is likely to come about once regulation catches up to the market. She says cryptocurrencies should fall into the part of an investor’s portfolio allocated for real assets, commodities or real estate — investments that are more volatile.

“Most advisers, if they have an allocation to commodities or real estate in their portfolio, it’s going to be 5% or less. It’s going to be a small allocation,” she says. “So it’s not a big part of the portfolio.”

Most importantly, Andrews recommends that her clients seeking to add cryptocurrencies to their portfolio create a separate account with a set amount of money in it that they’re completely comfortable losing.

“So just imagine that’s going to zero. That probably won’t happen — but could,” she says. “And then we can do those kinds of things. But it would not be for your serious nest egg. (You’re) not going to retire on this money.”

**Nothing wrong with healthy cynicism**

Daniel Griffith, senior vice president and director of wealth strategy for Huntington Private Bank, says that a healthy cynicism about the cryptocurrency market is wise. His own institution does not offer them as part of their core investment portfolios.

He says that when an investor looks to enter any market, it is important to consider whether the asset is right for what their trying to accomplish. If a physician who is fully invested in their retirement wants to enter the cryptocurrency market, they should only use any extra funds they have sitting on the side; these are dollars that would normally be spent on discretionary items.

“If they’re saying, ‘I want to take money out of my retirement and do this,’ or ‘I want to put some of my retirement funds into cryptocurrency,’ that’s when we get a little more suspicious because the risk tolerance is a little bit different there,” he says.

Volatility is the byword for cryptocurrencies. Although some investors see that as a plus, many see the risks outweighing the positives of entering the market. Griffith says that some of the risks he sees in the cryptocurrency market as it stands now include the risk that the open-ledger nature of blockchain leaves the investor open to theft and to examination by the IRS.

“Taxation of these assets is kind of in flux a little bit too. A lot of people think of it as a replacement for cash, but it’s really taxed as a property. So it’s subject to capital gains and ordinary income treatment in certain situations,” Griffith says, adding that the Biden administration has earmarked funds to crack down on reporting in the cryptocurrency market, tying it to new rules for banks and financial institutions.

Another risk that Griffith says investors should be aware of is the literal threat of actual loss — specifically, that it’s possible for an investor to simply lose access to their cryptocurrencies.

“There are plenty of stories of people who have old Bitcoin on a computer, and they’re not able to access it,” he says.

The nature of the market and how hot it has become in recent months have also opened the door to malicious actors who seek to scam the unsuspecting out of their assets. “There’s not, at this stage of the game, insurance to cover that,” Griffith says.

**Is this a bubble?**

There is concern that cryptocurrency — like the housing market in the late 2000s and internet startups in the late 1990s — is just a bubble that could leave latecomers holding the bag while early investors run away with massive windfall profits.

In his estimation, which he makes clear isn’t investment advice, Killermann says he does not believe that the cryptocurrency market is a bubble but, rather, a new avenue for investing just finding its way.

“We’re in the early parts of a technology that has implications (that) can change the way we look at finance, the way that we look at record keeping and securing data, and all of the surrounding topics,” he says. “So will we see more volatility, huge drops and huge gains, moving forward in the crypto industry? I personally think absolutely. We have no idea where we’re going to land.”

Griffith says that only time will tell but that one thing is obvious: “What we can be sure of is that the volatility that we’re experiencing right now is not likely to end anytime soon.”
Q&A

ONC director Micky Tripathi: The future of health IT

by Jeffrey Bendix, Senior Editor

When it comes to working on behalf of health data interoperability, few people are better qualified than Micky Tripathi, Ph.D., M.P.P., the new head of the Office of the National Coordinator for Health Information Technology (ONC).

Tripathi has spent his career in the health information technology field, most recently as chief alliance officer for Arcadia, a health care data and software company. While there, he served as project manager of the Argonaut Project, an industry collaboration to accelerate the adoption of Fast Healthcare Interoperability Resources (FHIR).

Earlier, Tripathi was president and CEO of the Massachusetts eHealth Collaborative, a nonprofit health IT advisory and clinical data analytics company. Before that, he founded and was CEO of the Indiana Health Information Exchange.

Tripathi recently spoke with Medical Economics about his goals as ONC director, especially in the areas of health data interoperability and electronic health record (EHR) usability. The interview has been edited for length and clarity.

Medical Economics (ME): What are your top priorities for ONC?

Micky Tripathi: I divide them into two categories. One is the immediate priorities with respect to the pandemic, and those are related to trying to help with specific things like improving the scheduling experience that patients have so that vaccination gets easier.

And we're doing a lot of work in public health. We're working on an executive order in partnership with the CDC (Centers for Disease Control and Prevention), looking at evaluation of public health systems, evaluating what we've learned through the pandemic and then making some recommendations about the future.

Then we have the regular stuff that ONC does — first and foremost being interoperability. We have a couple of dimensions of that. One is information blocking. The applicability date for the (21st Century Cures Act) information blocking rule was April 5, so we're doing a lot to educate the industry to help it move forward on that.

We also have the Trusted Exchange Framework and Common Agreement, which is the nationwide interoperability governance. The final thing I would add is we're doing a lot of work in social determinants of health and outcome disparities and how can we think better, deeper, more broadly about how to enable health information technology to identify and help to solve the disparities in health care that exist today.

ME: I don’t usually think of HIT (health information technology) as having a role in that. Can you explain in more detail what form that would take?

Tripathi: The first step to even knowing how we're doing with respect to health equity and health disparities is to be able to measure it, and you can’t
measure it unless you’re capturing the right data so that you’re able to ask, “How am I doing once I stratify according to different demographic characteristics?”

So that’s fundamental to HIT. You’ve got to have that data capture in EHRs and then structure it in a way that you can aggregate it and run the kind of analytics to be able to understand that minority, marginalized, underserved communities are getting disparate care compared to other groups. Then ideally you want to be able to provide decision support or tools back to providers and other frontline people who are using those systems to be able to help them take actions when their areas are identified. So all of those are part of HIT.

ME: I want to go back to the 21st Century Cures Act. ONC has said its initial focus is on the elements in the core data for interoperability, such as transitions of care and clinical information reconciliation. Why focus just on those elements?

Tripathi: Information blocking covers the broader category of information called EHI, or electronic health information, which is (a of piece) of the designated record set, which is defined in HIPAA (Health Insurance Portability and Accountability Act of 1996). That’s what the Cures Act said is EHI, which is basically everything you or I might have in a provider’s office, assuming they use an EHR and whatever has been migrated to an electronic form.

So information blocking covers all of that. We recognize that it’s hard to just flip the switch overnight and say all of that should be made available on demand when we haven’t been doing that. It’s not a common practice, and systems aren’t set up to do it.

Provider organizations don’t have workflows for that. We realize it’s a complicated thing to do.

So we said let’s focus at the beginning on what we call the Core Data for Interoperability, which every certified EHR system is already required to be able to generate, either in the form of a continuity-of-care document or soon in a FHIR API (application programming interface). So we said those things are already available because providers are already required to exchange those for transitions of care, for example. So why don’t we start with those, and we’ll call that EHI for the first 18 months; and after that, hopefully everyone is understanding information blocking and the workflows, and then you can open it up. And it also prepares them for how they are going to open it up beyond those data sets.

ME: Pulling back a little to the issue of interoperability generally, on a scale of 0 to 10, with zero being no ability to send data and 10 being the ability to do it as easily as we send regular emails, where would you say our health system falls now?

Tripathi: It depends on what you’re doing and what health system you’re in. For example, if you’re in an academic medical center and you’re on a fully certified EHR system that’s connected to CommonWell or Carequality or a health exchange, that exchange is actually happening in the background already, millions of times a day across the country. And that’s a continuity-of-care document that contains the CDI we were just talking about, which is 24 to 25 data elements. And those are like if you and I sat down and said what do we think are the basic elements that the physician should...
be able to have access to on any given day for any given patient. You and I would come up with pretty much what’s in the CDI. It’s problems, allergies, meds, dates of encounters, most recent lab results, etc.

So that’s exchanged in those systems today. It doesn’t even require effort. Providers in a large system will see it in the background and often they don’t realize that it’s come in from other places. Similarly, if you’re on any system and you want to do e-prescribing, you can do it pretty much out of the box on most EHR systems in a very automated way that’s familiar now.

On the other hand, if we’re talking about the ability to, in any setting, be able to get a record in almost any place, if you’re on like a small vendor that isn’t connected to one of these nationwide networks, then there’s going to be a gap there because all those systems haven’t adopted the technologies and not all of them are connected to the network.

The last thing I would say is we’re never going to feel like we’re at a 10 because just like when we first got our cell phone, it was pretty primitive but we thought it was the coolest thing in the world. But if we went back now and asked, “Am I satisfied with that?” the answer would be “Absolutely not. It’s terrible.”

It’s the same way today with interoperability. We’re always going to want more. Next it’s going to be what about genetic information? What about algorithms, why don’t we have those? So I don’t want to pretend there aren’t problems and gaps, but I think it depends on the use case.

ME: Doctors often complain that EHRs are designed as billing and coding tools rather than for their ability to improve clinical care. Can ONC do anything to change that?

Tripathi: We’re very sensitive to that, and we completely appreciate that clinician burden from health information technology is a huge issue. We’ve worked on the clinician burden report, and we continue to look at burden issues that come from the HIT itself as well as the things that are pushed through the HIT. One of the things we’ve started to understand as we think about these systems is that a lot of what physicians feel as “burden from the system” (are sometimes) things that organizations are pushing through the system that (physicians) didn’t do before — more documentation requirements, for example. Then the EHR gets blamed for that when it’s actually just a vehicle for things that couldn’t have been done in the paper world and now are being pushed through that system.

So we work a lot with our partners at the Office of (Burden Reduction and Health Informatics) at CMS to try and understand these burden issues and how can we reduce (them) through better usability and through reduction of some of those requirements — because some aren’t really necessary or they are very cumbersome because what naturally happens in these kinds of transitions is you take a paper process and try to ram it through an electronic system it wasn’t designed for. If you said this is an electronic system, we should think of it natively, we could probably take better advantage of the electronic tools that we have.

We do what we can to highlight those through our program on clinician burden. We also have usability as a part of the certification that vendors are supposed to go through. Then we also have things like in the next generation of
EHR certification, we are requiring real-world testing rather than just testing in a laboratory, which as we know, just like with drugs, there's a big difference between testing something in a lab and testing it with people in the real world.

\[\text{\textbf{ME: Is there any evidence that EHR vendors are focusing more on usability now than they were five or 10 years ago?}}\]

\[\text{\textbf{Tripathi: I think there is. There's a very heterogeneous set of vendors so it's hard to say this is true for every vendor. But I think vendors have big usability programs, and they have physicians on staff and they have programs (in which) they apply usability science as well as input from physicians who are using the system. An individual may feel frustrated by their system; they may feel like it isn’t usable. That doesn’t necessarily mean there haven’t been usability considerations behind the system. It's just that it's a complex system, and it can't be perfect for everyone.}

But I will add two things: Systems don't get better without people using them and providing feedback. Software engineers sitting in a room by themselves can't design a perfect system. They need to be able to put those in the field and get constant feedback from users. So as we're maturing, I think we're starting to see those systems are better.

The second thing I'd point out is that the whole move toward FHIR APIs, which are now required by ONC regulations, is that you ought to be able with your EHR to download apps and use them on your EHR, just like you do on your phone. And the beauty of an app on your phone is that when you open it, it’s usable in ways that you want it to be.

And that's what apps in the API world promise as well — that if you’re in your EHR system, you ought to be able to have a set of apps that don’t lock you in to that EHR system. If you have a different way of doing something, you can do it through an app as well. I think that’s a really important part of usability that may not be obvious now to a lot of doctors, but it is coming in the next few years as apps and APIs start to mature.

\[\text{\textbf{ME: Does ONC have the ability to nudge EHR manufacturers in that direction and make sure they're following through?}}\]

\[\text{\textbf{Tripathi: Absolutely. Our regulations — the information blocking rule and the corresponding EHR certification rule — require that the vendors make available FHIR APIs. And those are supposed to be open APIs so that apps from the outside can connect to them without special effort. And there's a whole set of provisions that are part of that regulation to make sure that's a level playing field, so you don't have vendors trying to close out things that they see as competitive or create too many burdens for a provider to be able to get an app on to their system. There are fixed dates that the vendors are required to meet. And that's the hope — that we can create platforms you can have apps on of your choosing. And hopefully that makes it a better experience for everyone.} \]
Telehealth in 2021: How to keep getting paid

The flourishing of telehealth in 2020 was driven not just by necessity, but also by a significant loosening of governmental regulations and of reimbursement requirements by payers. Waivers were granted during the public health emergency that allowed the use of traditionally noncompliant communications platforms, such as FaceTime and other consumer-level technologies. Practices have been able to grab most any technology and expect to get paid for the appointment.

Today, both states and payers are already changing their rules and laws rapidly. A good first step for many practices is to wean themselves away from noncompliant communications to immediate implementation of a Health Insurance Portability and Accountability Act-compliant telehealth solution, which will be essential when the public health emergency is terminated.

To ensure that you will continue to be paid for your telehealth services, here are three best practices to be aware of:

Closely monitor bulletins and announcements regarding telehealth from any insurance payers that your practice accepts.

Payer policies are changing rapidly and unexpectedly. Do not assume that policies that applied in 2020 will continue. Make monitoring of payer policies at least a monthly discipline.

When you verify that a particular patient’s insurance accepts telehealth, determine if the coverage specifies the use of the payer’s approved telehealth vendor only. In that case, appointments conducted on the practice’s telehealth platform may not be covered. In some cases, state telehealth regulations might specify that the telehealth appointment must be allowed to be conducted with the patient’s regular provider, which could supersede the payer’s requirements. However, even if your state has such a requirement, be extra careful in 2021.

There may be a gap between the implementation of state requirements and the provider contracts and policies that would postpone application of the state requirements until 2022.

What many providers and their staff may also not realize is that Employee Retirement Income Security Act rules override state laws regarding employer-based plans, so it is not safe to assume that a health plan covers telehealth services under the state-mandated guidelines. Always confirm the specific plan benefits for telehealth, and instruct billing staff to watch for payment discrepancies as the situation with the public health emergency evolves.

Update and clarify your practice’s financial policy regarding collection of copays for telehealth services.

To provide much-needed care during the pandemic, policies regarding collection of copays became very lax in many health care practices. Now is the time to remedy that. A clearly stated practice of collecting patient payments before service, just as would be done if the patient came into the office, should be in place, and practices should not hesitate to reschedule appointments if payments aren’t made. A procedure to maintain a credit card on file simplifies timely payments. Make sure patients receive a copy of your policies so that they know what and how much to expect to pay. When patients are unclear as to the amount owed, they tend to put off paying their health care bills.

There’s no doubt that telehealth is here to stay. Both practitioners and patients have discovered that telehealth is a viable approach to health care delivery. In fact, patients love the convenience of telehealth and now expect it as a delivery option. If a practice doesn’t offer telehealth, patients may go elsewhere. Therefore, it’s critical that independent practices stop considering telehealth a fortunate stopgap and make sure they are laying the groundwork to make telehealth a robust part of their care delivery — and their bottom line.

Terri Joy, MBA, CPC, CGSC, COC, CPC-I, is a billing subject matter expert at Kareo and has more than 20 years’ experience in physician billing and revenue cycle management. Send your tech questions to medec@mjhlifesciences.com.
The benefits of purchasing a concierge practice

Independent or employed, primary care physicians are facing one of the most tumultuous health care environments in decades. As many of the earliest adopters of the concierge medicine model head toward retirement, how can the next generation best realize the opportunity to acquire a financially stable, thriving practice and achieve personal and professional fulfillment? Younger doctors seeking an entry into the rewards of the membership medicine model are increasingly able to find their perfect match by taking the reins from a retiring concierge physician.

The essays below are authored by two physicians who made the decision to purchase a practice from a retiring physician, who explain why they made the choice and how it has benefited their careers.

How I changed my career and transformed my life by acquiring a concierge practice

by Claudia Perdei, M.D.

My route to becoming a concierge physician may not be traditional, but having successfully navigated this life-changing trajectory in 2019, it’s one I would unhesitatingly recommend to fellow travelers — even more so today. I share my experience here because I understand the hesitation many doctors have of making such a significant career and life change and the fear of not succeeding. But two years later, I can look back and see some very evident truths: It was the right move and the right way to accomplish it, and I am so grateful that I was able to launch a thriving independent practice that continues to grow.

This is not a story of sudden and serendipitous good fortune, but one of methodical, thoughtful planning that can be replicated by other physicians. For me, the seeds had been planted long before I encountered a widely respected concierge physician in Delray Beach, not far from my own private practice. I had previously explored making the change to personalized medicine, but an analysis of my practice showed it was not likely to succeed with my current patient panel. Determined to find another way, I was delighted to meet Dr. Bryan Wasserman at a social gathering and learn that he wanted to retire in the next year — but not before he found a successor who would ensure continuous care for his loyal, profoundly older (average age 89) patients with multiple chronic conditions. Stepping into the shoes of this dedicated physician who had built a successful concierge practice by carefully tending to his patients’ needs represented the opportunity I was seeking.

With the help of practice transition experts Specialdocs Consultants, I lined up the other essential members of my team, including a lawyer, an accountant and a lender. The entire process was straightforward and transparent. The numbers for projected income, patient panel and practice expenses clearly showed the potential to realize a return on investment within a year or two of purchase. With the loan in place, I was ready for the next crucial phase.

The eight-month transition process was
My rapid journey from employed physician to thriving, independent and joyful concierge doctor

by Carrie Cardenas, M.D.

My transition to concierge medicine can be summed up most aptly by the phrase “carpe diem.” Seize the day. Although I had been considering this practice model for some time, a lightning-fast response was needed when the opportunity arose. With the support of a team of experts, my experience acquiring an established concierge practice in San Diego was swift, seamless and sweet.

Initially I cared for patients at my own clinic and then as part of a program to ease patients’ transition from hospital to home. My yearning to return to a practice centered on building relationships with patients became stronger each year, but with it came the realization that traditional fee-for-service models had evolved in exactly the opposite direction. Rushed, impersonal visits had become the unfortunate standard of care. Concierge medicine appeared to present an ideal solution, with a sustainable practice model based on membership fees and a greatly reduced patient panel that allowed individualized care. However, as a hospital-employed physician, I was missing the key to success: long-term relationships with patients.

I was stuck but found my solution when two well-regarded physicians were looking for a successor to purchase their concierge medicine practice in 2018. They had gained a reputation for clinical excellence and the loyalty of hundreds of patients over more than three decades. The only drawback: Just 90 days were given to finalize the acquisition and launch a new practice.

My emotions ran the gamut from fear to excitement. Overriding all was the strong feeling that this was a once-in-a-lifetime opportunity. But I needed to confirm that before making the leap. With the help of Specialdocs Consultants, we used every minute of that whirlwind 90 days to literally pull apart the practice and determine if acquisition was feasible. We considered everything from the current stability of the practice to the growth of the surrounding neighborhood, and we swiftly developed a transition plan. I entered my new life as a concierge doctor thrilled — but well aware of challenges ahead.

The quick ramp up gave me no time to know patients or gain their confidence before taking the reins of the practice. Every patient I saw during the first year was new to me. I am gratified to report a retention rate of more than 90%, and I’ve since added many patients of my own. At first I frequently heard “that’s not how we used to do things.” But with patience and time, I built trust and reshaped the practice to reflect my vision. In 2020, my husband, Dr. Hector Cardenas, joined me; together, we introduced programs that became treasured offerings.

I wholeheartedly recommend concierge medicine and this unique path to it, with some advice:

- Bring in the experts early. I leaned on Specialdocs’ experience and insights throughout the transition process and still do.
- Assess the potential for attracting new patients by making sure the practice you acquire is in a growing, vibrant community.
- Build in a period of support from the retiring physician to reassure patients that the coming “changing of the guard” is a welcome one.
- Care for yourself throughout the process by practicing what you preach to patients: eat well, exercise, get sleep and manage stress. Change is challenging, but this one gives you the chance to practice medicine as you’ve always envisioned. —

Carrie Cardenas, M.D., is co-owner of Cardenas Internal Medicine in San Diego.
Motivating patients to achieve heart health

by Keith Loria Contributing Author

Cardiovascular disease remains the leading cause of death and morbidity worldwide, including in the United States.

Randolph P. Martin, M.D., FACC, FASE, FESC, emeritus professor of cardiology at Emory University Healthcare and chief medical officer for Caption Health, notes we live in an obesogenic, salty and sedentary environment, so thinking about preventative cardiology has never been more important than it is today.

“We’re in an environment now where obesity is rampant and becoming an issue for the young and old alike; our diet tends not to be conducive to healthy living, and we’re increasingly sedentary,” he says. “I try to encourage patients, family and friends to live both a heart-healthy and active life, as that will not only decrease their chances of heart attacks and strokes but help them simply feel better and more able to enjoy life.”

Following a healthy lifestyle can help prevent heart disease and the causes of heart disease, such as diabetes and hypertension. Additionally, healthy living helps prevent some significant cancers and may, in fact, help prevent other diseases like dementia and Alzheimer’s.

Internist Vicken Zeitjian, M.D., a cardiovascular fellow at The University of Texas Health Science Center at San Antonio, notes that self-care and making adjustments are a huge part of heart health.

“I recommend all my patients … adhere to a heart-healthy diet, exercise daily or at least five times per week, aim to reach ideal body weight, … quit bad habits like smoking and help minimize their comorbidities like treating obstructive sleep apnea, hypertension, hypercholesterolemia and diabetes,” he says.

Promoting heart health

Arash Bereliani, M.D., FACC, a clinical associate professor of medicine and cardiology at UCLA’s David Geffen School of Medicine and an attending cardiologist at Cedars-Sinai Medical Center in Los Angeles, notes the first step in promoting heart health for patients is to motivate them.

“For some patients, positive reinforcement, such as feeling better and having more energy or living long enough to see their grandchild get married, is effective,” he says. “For others, a negative reinforcement such as ‘If you don’t change your life habits or if you don’t watch your diet, you might need heart surgery soon or you might end up having a stroke’ can do the job.”

Bereliani always gives patients hope that they have a chance to prevent those conditions, adding that it’s vital you don’t cause fear or anxiety.

“I emphasize to them that they should not get scared but, rather, get motivated to take care of themselves,” he says. “The challenge as a physician is to know which tactic to use to make them understand and to motivate them the right way to take steps to take care of their heart health. Using the wrong technique could backfire and either cause more anxiety and fear, which (are) harmful, or might not do anything to change their behavior.”
He recommends that everyone older than 40 have a baseline checkup for underlying heart disease by a cardiologist who is well trained and knowledgeable in the field of prevention and who knows what tests to order.

Then there are the basics, Bereliani explains, like regular exercise, the right diet, stress reduction and a good night’s sleep. Additionally, mild to moderate alcohol consumption for patients who do not have high blood pressure or diabetes or liver disease could be beneficial.

Martin has a three-step blueprint for fostering heart health.

“My first three actions are always to listen, talk and then encourage patients to lead a heart-healthy lifestyle,” he says. “I try to be encouraging (and) sympathetic for how hard it is to do all this and give them ways to go after one thing at a time. I also try to emphasize that these steps aren’t just good for them — (they’re) good for their families, children, loved ones and friends.”

He also points patients to an August 2009 article from the Archives of Internal Medicine titled “Healthy Living is the Best Revenge,” which highlights that there are no magic pills and that the future of health care really begins with each one of us.

Motivating patients to change

Explaining this to patients is one thing, but getting them to actually make the changes is quite another. Martin finds that being a motivational listener is effective.

“Just telling a patient what to do often doesn’t help, but listening and showing empathy for how hard all of these things can be to tackle at once can help,” he says. “It’s easier to point out the gaps between where they should be and where they are — and then encourage them to make some lifestyle changes. I also make sure to keep up with my patients a lot and compliment them when they’re making progress.”

One of the key things he encourages his patients to do is know their numbers: blood pressure, weight, waist-hip measurement, cholesterol and blood sugar.

“I keep encouraging my patients. I tell them it’s tough, and we tackle one thing at a time,” Martin says. “If they’re having problems with smoking cessation, then I get them help and resources, like those from the (Centers for Disease Control and Prevention). If they’re having trouble getting active, I tell them to just start walking and give them a regime for that. I also encourage them to check out apps like those recommended by sites like the Mayo Clinic — there are blood pressure apps, stress management apps, heart rate monitor apps and so on.”

A diet rich in fruits, vegetables, high fiber, low cholesterol, monounsaturated fats instead of saturated fats, and omega-3...
fatty acids is ideal for heart health, according to Zeitjian. A Mediterranean diet also reduces the risk of cardiovascular disease.

In Bereliani’s practice, they have a program that enables the team of nurses and assistants to continuously engage with patients via phone calls, Zoom meetings and emails to make sure the patients follow his recommendations.

“Our newsletters and social media also constantly remind our patients the importance of taking care of their heart health by implementing my recommendations,” he says.

And when he realizes a patient is not following his advice, Bereliani sets up an office meeting with them to try to understand the psychology behind their nonadherence.

“Many of these patients have underlying psychological issues such as anxiety, depression or trauma,” he says. “Once I discover their psychological barrier, I either discuss the case with their family, with the permission of the patient of course, and using a team approach, we come up with a plan to address the underlying issue. Once the underlying issue has been addressed, the patient is very likely to start taking care of himself or herself.”

Preventative care
Preventative cardiology is one of the most important aspects of the field. Many cardiovascular diseases such as coronary artery disease, heart failure and arrhythmias are a result of multifactorial components — principally, lifestyle habits, comorbidities and genetics.

“We can only focus on the first two,” Zeitjian says. “In terms of what you can do, think of the acronym COSHED (cholesterol, overweight, smoking, hypertension and exercise), which literally means ‘hit on the head’ (and) is figuratively what would happen if we do not focus on prevention.”

The new advancements in preventive cardiology have enabled physicians to not only determine one’s current risk of heart disease but to accurately predict one’s future risk of a heart attack or heart disease.

“If the right testing is performed and if the right treatments and prevention are implemented, no one should die of heart disease at least until at a very old age,” Bereliani says. “Unfortunately, many physicians and cardiologists either do not perform the right tests or do not implement the right preventive strategies for their patients. Most cardiologists are very good at treating heart disease when it has already occurred but not very good at preventing heart disease.”

Zeitjian notes that despite the tremendous advancements in the field, primary prevention nearly always results in longevity as opposed to secondary prevention. “Most of my patients are referred for established cardiovascular disease, and we have medications and procedures (that) can treat them. However, they have increased morbidity and mortality despite our interventions,” he says. “No matter where you stand on the health spectrum, it is never too late to invest in yourself. Prevention can not only prolong life, but improve the quality of your life.”

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Things You Should Know About PCSK9 Inhibitors for Cardiovascular Risk Reduction

Release Date: July 1, 2021
Expiration Date: July 1, 2022

Learning Objectives
Upon successful completion of this activity, you should be better prepared to:

- Assess recent efficacy and safety data and guideline recommendations for the use of PCSK9 inhibitors for CV risk reduction in patients who have not achieved lipid treatment goals
- Identify patients most likely to benefit from the addition of nonstatin therapies to their treatment regimen

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2. Go to gotoper.com/go/lipid-pcsk9-cardiovascular to access the online version of the activity and complete the posttest.
3. Answer the evaluation questions.
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To learn more about this topic, including information on the latest evidence on PCSK9 inhibitors in the reduction of low-density lipoprotein cholesterol (LDL-C), non–high-density lipoprotein cholesterol, and lipoprotein(a) while maintaining a favorable safety and tolerability profile, go to gotoper.com/online-cme-activities/enduring-activity/pce-pcs21

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Hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD) are associated with significant morbidity, mortality, and financial burdens. Studies show that lowering low-density lipoprotein cholesterol (LDL-C) levels corresponds with plaque stabilization, plaque regression, and decreased rates of CV events.\(^1,2\) Goals for lowering LDL-C are outlined in consensus guidelines.\(^3-5\) Still, a significant portion of patients may not meet these goals despite optimal statin therapy or combination therapy with ezetimibe and would benefit from the addition of a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor to their hyperlipidemia regimen. Clinical studies have unequivocally shown that the addition of a PCSK9 inhibitor to statin therapy prevents CV events by lowering LDL-C, and this drug class is overall well tolerated.\(^6,7\) Here are 3 things you should know about lipid management with PCSK9 inhibitors for CV risk reduction.

1. **PCSK9 inhibitors and statins work via different pathways and may be used together.** Untreated individuals with familial hypercholesterolemia (FH) have up to 20 times increased lifetime risk of premature heart disease.\(^8\) The search for genetic mutations causing FH identified gain-of-function mutations in PCSK9.\(^9\) This laid the groundwork for understanding the PCSK9 pathway, and ultimately the medications now known as PCSK9 inhibitors. PCSK9 is a proprotein convertase involved in the degradation of LDL receptors in the liver. In FH, mutations in the PCSK9 gene reduce the number of LDL receptors on the surface of hepatocytes and decrease their ability to clear LDL cholesterol from the plasma. Blocking the activity of PCSK9 with monoclonal antibodies diminishes the degradation of LDL receptors and increases LDL receptor clearance and, as a result, LDL cholesterol levels fall. Because PCSK9 inhibitors and statins work via different pathways, they may be used together or alone in cases of statin intolerance to help patients reach their lipid-lowering goals.

2. **Patients with the highest ASCVD risk can benefit the most from PCSK9 inhibitors.** The American College of Cardiology/American Heart Association (ACC/AHA) Multisociety Guideline on the Management of Blood Cholesterol was most recently updated in 2018, and it emphasizes lipid management to reduce ASCVD risk.\(^3\) For all individuals, the first step to reduce this risk is adopting a heart-healthy lifestyle followed by statin therapy as first-line pharmacological therapy for the treatment of hyperlipidemia. The third key component focuses on identifying patients who could benefit from additional nonstatin therapy, including ezetimibe and PCSK9 inhibitors. The ACC/AHA guideline includes definitions of high-risk and very high-risk (VHR) patients. High-risk conditions are defined as age greater than or equal to 65 years, heterozygous familial hypercholesterolemia (HeFH), prior coronary revascularization outside of the major ASCVD events, diabetes, hypertension, chronic kidney disease with estimated glomerular filtration rate of 15-59 mL/min/1.72 cm\(^3\), current smoker, and LDL-C greater than or equal to 100 mg/dL despite maximally tolerated statin therapy and ezetimibe. Very high risk for future ASCVD events includes a history of multiple major ASCVD events (acute coronary syndrome [ACS] within 12 months, myocardial infarction, ischemic stroke, peripheral arterial disease defined as claudication with ankle-brachial index < 0.85, or previous revascularization or amputation, or one major event with multiple high-risk conditions). For patients with VHR ASCVD, the recommended LDL-C threshold is less than 70 mg/dL and 50% from baseline. European guidelines are more aggressive; the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS) published a new guideline with the following recommendations: LDL-C should be lowered as much as possible, specifically a goal of less than 55 mg/dL in patients with VHR, including those with established CVD or FH, and a goal of less than

### LDL-C Goals Vary Across Different Guidelines

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<th>2018 ACC/AHA</th>
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<td>&lt; 70 mg/dL</td>
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40 mg/dL in the highest-risk patients. A recent consensus statement by the American Association of Clinical Endocrinology (AACE) and the American College of Endocrinology (ACE) on the management of hyperlipidemia partly aligns with the European guidelines, recommending LDL-C goals of less than 55 mg/dL, particularly in patients with the highest CV risk. In all, the patients with the highest ASCVD risk will achieve the greatest benefit from nonstatin therapies. PCSK9 inhibitors can yield a substantial change in LDL-C levels that results in absolute risk benefit.

Two PCSK9 inhibitors have been available since 2015, alirocumab and evolocumab, with growing evidence to support their role in patients with FH and in those with CVD or at high risk of developing it. The pivotal CV outcomes trials—FOURIER (evolocumab) and ODYSSEY OUTCOMES (alirocumab)—compared these agents with placebo in patients with known atherosclerotic disease and an LDL-C level above goal, with most of the patients on statin therapy. In both trials, PCSK9 inhibitors demonstrated average LDL-C reduction of 60% compared with placebo, with commensurate robust reductions in CVD events. Both agents had a favorable safety profile. Additionally, the randomized controlled GLAGOV trial demonstrated that among patients with angiographic coronary artery disease treated with statins, addition of subcutaneous evolocumab, compared with placebo, resulted in a greater decrease in percent atheroma volume.

The FDA indications for alirocumab and evolocumab are HeFH (LDL > 190 mg/dL), homozygous FH (LDL > 400 mg/dL) and ASCVD (myocardial infarction [MI], stroke, transient ischemic attack [TIA], peripheral arterial disease [PAD]) requiring additional lowering of LDL cholesterol (LDL > 70 mg/dL). Despite supporting efficacy and safety evidence, PCSK9 inhibitors are still used sparingly in clinical practice. Two retrospective studies reported that only 1% of patients with ASCVD or FH are prescribed a PCSK9 inhibitor.

PCSK9 inhibitors carry a high cost, and possible prescription barriers are related to insurance approval. To help ensure preauthorization for use of a PCSK9 inhibitor as add-on therapy for secondary prevention, it is important to document the following:

- Presence of clinical ASCVD (eg, coronary artery disease, ACS, history of MI, stable or unstable angina, revascularization, stroke, TIA, or PAD)
- Presence of FH, as appropriate (eg, LDL-C ≥ 190 mg/dL, family history of first-degree relatives with premature ASCVD or elevated LDL-C, positive genetic testing indicating functional mutation)
- Results of a lipid panel obtained within the previous 30 days
- Use of adjunctive nonstatin lipid-lowering therapy
- Statement that the patient is not at LDL-C goal despite maximally tolerated statin therapy, or that the patient is not on high-intensity statin therapy due to statin intolerance

### KEY REFERENCES


For a full list of references go to gotoper.com/go/lipid-pcsk9-cardiovascular
CME POST-TEST QUESTIONS

1. Landmark trials FOURIER, evaluating evolocumab, and ODYSSEY OUTCOMES, evaluating alirocumab, demonstrated that the addition of these PCSK9 inhibitors to a statin resulted in an average LDL-C reduction of approximately what proportion?
   - A 15%
   - B 30%
   - C 60%
   - D 75%

2. Which of the following patients would benefit the most from further LDL lowering?
   - A 45-year-old woman with hypertension, hypothyroidism, and LDL of 120 mg/dL
   - B 60-year-old man with CAD, type 2 diabetes and LDL of 60 mg/dL
   - C 55-year-old man with TIA, hypertension, and LDL of 75 mg/dL
   - D 62-year-old woman with nonischemic cardiomyopathy (ejection fraction of 37%) and LDL of 90 mg/dL

To learn more about this topic, including information on the latest evidence on PCSK9 inhibitors in the reduction of low-density lipoprotein cholesterol (LDL-C), non–high-density lipoprotein cholesterol, and lipoprotein(a) while maintaining a favorable safety and tolerability profile, go to

gotoper.com/online-cme-activities/enduring-activity/pce-pcs21
Things You Should Know About Cardiovascular Risk Reduction in Type 2 Diabetes

Harold Edward Bays, MD, FOMA, FTOS, FACC, FNLA, FASPC
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To learn more about this topic, including information on type 2 diabetes treatment guidelines, recent real-world evidence, and clinical decision-making for this patient population during the COVID-19 pandemic, go to gotoper.com/online-cme-activities/cpc/cpc-acp21t2dm

Learning Objectives
Upon successful completion of this activity, you should be better prepared to:
• Examine current treatment guidelines for patients with Type 2 diabetes (T2D) for effective management of cardiovascular (CV) risk.
• Evaluate the real-world evidence for reducing CV events and hospitalizations to improve outcomes for patients with T2D.

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Cardiovascular disease (CVD) remains the leading cause of morbidity and mortality in patients with Type 2 diabetes (T2D). Eighty percent of patients with T2D will ultimately die from a CV cause compared with 30% of individuals without diabetes. Recent cardiovascular outcomes trial (CVOT) data evaluating the use of sodium-glucose cotransporter-2 inhibitors (SGLT2i) and glucagon-like peptide-1 receptor agonists (GLP-1 RAs) have led to a substantial change in the standard of care for patients with T2D and established atherosclerotic CVD (ASCVD). In 2020, several medical societies updated their treatment guidelines accordingly. Here are 3 things you should know about CV reduction in T2D.

**Diabetes is a cardiometabolic disease that can benefit from treatment with cardiometabolic therapies.**

Diabetes is largely considered a disease of elevated blood glucose; clinical trials consistently demonstrate an improvement in microvascular outcomes in patients with T2D with intensive versus conservative glucose control. However, similar results have not been seen in CV outcomes in patients with T2D, despite the clinically important differences in hemoglobin A1c (HbA1c) achieved between treatment groups in glucose-lowering trials. Unexpected results from the EMPA-REG OUTCOME and LEADER trials shifted the landscape of CV risk management in patients with T2D as SGLT2i and GLP-1 RAs demonstrated reductions in CV events and mortality, likely through mechanisms independent of their glucose-lowering effects. The EMPA-REG OUTCOME trial showed that empagliflozin reduced the relative risk of CV death by 38%, all-cause mortality by 32%, and hospitalization for heart failure (HF) by 35% when added to standard of care in patients with diabetes and CVD. The LEADER trial demonstrated a 13% significant risk reduction in major adverse cardiovascular events (MACE) with liraglutide versus placebo added to standard-of-care treatment in patients with T2D and high CV risk.

These findings led to the understanding that SGLT2i and GLP-1 RAs are not solely antidiabetic agents but cardiometabolic drugs particularly useful for CV risk reduction. Recent meta-analyses of CVOTs show that GLP-1 RAs reduce MACE by 12% in patients with T2D, and SGLT2i reduce the risk of CV death and hospitalization for HF by 23%.

**Updated society guidelines strongly recommend an SGLT2i or GLP-1 RA in patients with T2D and established CVD or at high risk of it.**

Several societies have provided new guidelines to help guide CV specialists with the initiation and monitoring of SGLT2i and GLP-1 RAs with the goal of reducing CV risk. Updated guidelines by the American College of Cardiology, American Diabetes Association (ADA), European Society of Cardiology, and European Association for the Study of Diabetes all strongly recommend an SGLT2i or GLP-1 RA in patients with T2D who already have or are at high risk for CVD. The 2020 ADA Standards of Medical Care in Diabetes published specific recommendations for incorporating CV risk–lowering antihyperglycemic agents into the treatment algorithm. Metformin remains the gold standard for initial therapy for newly diagnosed patients, but when patients experience reduced response or intolerance to metformin, a dual-therapy approach using drugs from another class (eg, GLP-1 RA, SGLT2i, dipeptidyl-peptidase-4 [DPP-4] inhibitor) in combination with metformin can be considered.

**ADA Guidelines Suggest:**

Add another agent for patients with reduced response or intolerance to metformin

For patients with ASCVD, the second agent in a combination strategy should have the ability to reduce CV risk, limiting the choices to specific GLP-1 RAs or SGLT2i.
1 RAs (liraglutide, semaglutide, and dulaglutide) or the SGLT2i empagliflozin and canagliflozin. If the HbA1c goal is not attained after 3 months of dual therapy, then triple therapy should be implemented. Current ADA and American Association of Clinical Endocrinologists treatment guidelines recommend achieving and maintaining an HbA1c of <6.5% to 7% in non-pregnant individuals with minimal hypoglycemia to prevent negative micro- and macrovascular outcomes. A less stringent HbA1c goal of 7.5% to 8%, or even slightly higher, is appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced complications, or extensive comorbid conditions and for patients in whom the target is difficult to attain despite intensive self-management education, repeated counseling, and effective doses of multiple glucose-lowering agents.

CVOTs and real-world evidence show that SGLT2i can directly improve CV outcomes.

In addition to the CVOTs, four large real-world studies have reported the CV outcomes of SGLT2i in patients with T2D.

In the CVD-REAL, EASEL, and OBSERVE-4D studies, the risk of HF hospitalization was significantly reduced by up to 61% with SGLT2i compared with non-SGLT2i glucose-lowering agents. Furthermore, the ongoing EMPRISE program aims to assess the comparative effectiveness, safety, and impact on health care utilization of empagliflozin, based on real-world data from two commercial databases and the Medicare database in the United States.

A first interim analysis from EMPRISE reported a reduced risk for HF with empagliflozin compared with DPP-4 inhibitors and GLP-1 RAs. These results further substantiate data from the EMPA-REG OUTCOME trial. Although safety outcomes are not yet available from EMPRISE, data from the EMPA-REG OUTCOME trial showed an overall similar rate of serious side effects with empagliflozin compared with placebo. Real-world data on GLP-1 RAs are also emerging; recently published results from the PATHWAY 2-OADs trial using propensity score–matched cohorts demonstrated that GLP-1 RAs carried significant benefits for both glycemic control and weight management over additional oral antidiabetic agents or insulin, respectively.

Despite strong clinical trial data and available real-world evidence, a recent study found that among patients with T2D and CVD, only 1.4% received an SGLT2i and 1.6% received a GLP-1 RA.

Although effective in reducing CV outcomes, SGLT2i or GLP-1 RAs are prescribed in <2% of patients with T2D and CVD.

These fractions were much smaller than the percentage of patients prescribed insulin. Also, the prescription pattern varied per specialty: primary care physicians (PCPs) accounted for 53.4% of SGLT2i prescribers, endocrinologists for 30.3%, and cardiologists for 6.0%. For GLP-1 RAs, PCPs accounted for 45.1%, endocrinologists for 45.0%, and cardiologists for 1.4%. Several obstacles to more widespread uptake by cardiologists have been reported; lack of knowledge about these therapies and perceptions that diabetes care is best left to other specialists may be the major impediments.

KEY REFERENCES


For a full list of references go to education.gotoper.com/activity/crr21print
CME POST-TEST QUESTIONS

1. A 59-year-old man with long-standing Type 2 diabetes (T2D), peripheral neuropathy, moderate heart failure (HF), and decreased vision had two episodes of nonserious, symptomatic hypoglycemia in the past 4 years. According to American Diabetes Association (ADA) and American Association of Clinical Endocrinologists treatment guidelines, what may be the safest target hemoglobin A1c goal for this patient?
   A. Less than 6.5%
   B. Less than 7.0%
   C. Between 7.5% and 8.0%
   D. No less than 8.5%

2. The patient from the previous question is treated with metformin. His medical history includes T2D, peripheral neuropathy, and moderate HF. According to current ADA and American College of Cardiology guidelines, which of the following agents is the best medical therapy to add to metformin?
   A. DPP-4 inhibitor
   B. Thiazolidinedione
   C. SGLT2 inhibitor
   D. Sulfonylurea

3. A 47-year-old woman with long-standing T2D and atherosclerotic cardiovascular disease (ASCVD) is treated with healthful nutrition, physical activity, and metformin. However, she is still obese and has elevated blood sugars. What would be the best next step in her management?
   A. Add an SGLT2 inhibitor with proven HF benefit to her medications.
   B. Add a GLP-1 RA with proven CVD benefit to her medications.
   C. Add a sulfonylurea.
   D. Add a thiazolidinedione (eg, pioglitazone).

To learn more about this topic, including information on type 2 diabetes treatment guidelines, recent real-world evidence, and clinical-decision making for this patient population during the COVID-19 pandemic, go to gotoper.com/online-cme-activities/cpc/cpc-acp21t2dm

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PHARMA-LAB Refrigerators

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