THE BEST STATES FOR PHYSICIANS

Ranking the states on:
- Cost of living
- Business taxes
- Physician density
- Average malpractice costs
- Medical practice costs

MedicalEconomics.com

The premiere of new business-oriented programs
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
- Review immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX
- In a postmarketing observational study, an increased risk of Guillain-Barré syndrome was observed during the 42 days following vaccination with SHINGRIX
- Syncope (fainting) can be associated with the administration of injectable vaccines, including SHINGRIX. Procedures should be in place to avoid falling injury and to restore cerebral perfusion following syncope
ARE YOU OVERLOOKING PATIENTS LIKE JENNIFER, AGE 52?

PATIENT STORY:

Who’s in Jennifer’s Life?
• Her husband and two kids in high school
• The employees in her flower shop
• Her running buddies

Lifestyle:
She eats healthy, walks every day, and runs a few times a week

Medical History:
No current medical issues

Interaction with HCP:
Diligent about annual physicals and is proactive in discussing lifestyle changes to ensure she stays healthy

Recommendation Opportunity:
When discussing prevention during her annual exam

Recommend SHINGRIX Because:
She is always proactive about her healthcare

NO MATTER HOW HEALTHY SHE MAY FEEL, JENNIFER’S AT RISK FOR SHINGLES

She’s 52 years old and never felt healthier. But she’s still a candidate for SHINGRIX, a vaccine indicated for prevention of herpes zoster (shingles) in adults aged 50 years and older. Consider the patients in your office:
Are you overlooking patients like Jennifer?

Important Safety Information (cont’d)
• Solicited local adverse reactions reported in individuals aged 50 years and older were pain (78%), redness (38%), and swelling (26%)
• Solicited general adverse reactions reported in individuals aged 50 years and older were myalgia (45%), fatigue (45%), headache (38%), shivering (27%), fever (21%), and gastrointestinal symptoms (17%)
• The data are insufficient to establish if there is vaccine-associated risk with SHINGRIX in pregnant women
• 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
• Vaccination with SHINGRIX may not result in protection of all vaccine recipients

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


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SGXJRNA210077 September 2021
Produced in USA.
BRIEF SUMMARY

SHINGRIX (Zoster Vaccine Recombinant, Adjuvanted)

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

1 INDICATIONS AND USAGE

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

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

2 DOSAGE AND ADMINISTRATION

2.2 Administration Instructions
For intramuscular injection only.

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

2.3 Dose and Schedule

Two doses (0.5 mL each) administered intramuscularly according to the following schedule:
• A first dose at Month 0 followed by a second dose administered 2 to 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)].

5.3 Syncope

Syncope (fainting) can be associated with the administration of injectable vaccines, including SHINGRIX. Syncope can be accompanied by transient neurological signs such as visual disturbance, paresthesia, and tonic-clonic limb movements. Procedures should be in place to avoid falling injury and to restore cerebral perfusion following syncope.

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.

Adults Aged 50 Years and Older

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 (25%) subjects were aged 50 to 59 years, 4,488 (15%) subjects were aged 60 to 69 years, and 17,531 (60%) 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%), followed by Asian (18%), Black (1.4%), and other racial/ethnic groups (6%); 58% were female.

Solicited Adverse Reactions: In Studies 1 and 2, data on solicited local and general adverse reactions 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 and general adverse reaction following administration of SHINGRIX (both doses combined) were pain (78% redness (88%), and swelling (26%); and myalgia (45%), fatigue (45%), headache (38%), shivering (27%), fever (21%), and gastrointestinal symptoms (17%).

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

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

<table>
<thead>
<tr>
<th>Adverse Reactions</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 n = 1,315</td>
<td>Placebo n = 1,312</td>
<td>SHINGRIX n = 1,311</td>
</tr>
<tr>
<td>Pain</td>
<td>88</td>
<td>14</td>
<td>83</td>
</tr>
<tr>
<td>Pain, Grade 3†</td>
<td>10</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Redness</td>
<td>39</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>Redness, &gt;100 mm</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Swelling</td>
<td>31</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Swelling, &gt;100 mm</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Myalgia</td>
<td>57</td>
<td>15</td>
<td>49</td>
</tr>
<tr>
<td>Myalgia, Grade 3*</td>
<td>9</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Fatigue</td>
<td>57</td>
<td>20</td>
<td>46</td>
</tr>
<tr>
<td>Fatigue, Grade 3*</td>
<td>9</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Headache</td>
<td>51</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>Headache, Grade 3*</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Shivering</td>
<td>36</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Shivering, Grade 3*</td>
<td>7</td>
<td>0.2</td>
<td>5</td>
</tr>
<tr>
<td>Fever</td>
<td>28</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>Fever, Grade 3*</td>
<td>0.4</td>
<td>0.2</td>
<td>1</td>
</tr>
<tr>
<td>GI†</td>
<td>24</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>GI, Grade 3*</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Total vaccinated cohort for safety included all subjects 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, and 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 reactions was lower in subjects aged 70 years and older compared with those aged 50 to 69 years.

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

(continued on next page)
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 (2.3%, 3%, 4%, and 4%, respectively) compared with Dose 1 (24%, 14%, and 14%, respectively). Grade 3 solicited general adverse reactions (headache, shivering, myalgia, and fatigue) were reported more frequently by subjects after Dose 2 (2.3%, 3%, 4%, and 4%, respectively) compared with Dose 1 (1.4%, 1.4%, 2.3%, and 2.4%, respectively).

Unsolicited Adverse Events: Unsolicited adverse events that occurred within 30 days following each vaccination (Day 0 to 29) were recorded on a diary card by all subjects. In the 2 studies, unsolicited adverse events occurring within 30 days of vaccination were reported in 51% and 32% of subjects who received SHINGRIX (n = 14,645) or placebo (n = 14,660), respectively. (Total Vaccinated Cohort). Unsolicited adverse events that occurred in ≥1% of recipients of SHINGRIX and at a rate at least 1.5-fold higher than placebo included chills (4% versus 0.2%), injection site pruritus (2.2% versus 2%), malaise (1.7% versus 0.3%), arthralgia (1.7% versus 1.2%), nausea (1.4% versus 0.5%), and dizziness (1.2% versus 0.8%).

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

Serious Adverse Events (SAEs): In the 2 studies, SAEs were reported at similar rates in subjects who received SHINGRIX (2.34%) or placebo (2.2%) from the first administered dose up to 30 days post-last vaccination. SAEs were reported for 10.1% of subjects who received SHINGRIX and for 10.4% of subjects who received placebo from the first administered dose up to 1 year post-last vaccination. One subject (0.01%) reported lymphadenitis and 1 subject (<0.01%) reported fever greater than 39°C, there was a basis for a causal relationship with SHINGRIX.

Optic ischemic neuropathy was reported in 3 subjects (0.02%) who received SHINGRIX (all within 50 days after vaccination) and in 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 according to a 0- and 2-month or 0- and 6-month schedule. The safety profile of SHINGRIX was similar when administered according to a 0- and 2-month or 0- and 6-month schedule and was consistent with that observed in Studies 1 and 2.

6.2 Postmarketing Experience

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

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

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

• Nervous System Disorders
  Guillain-Barré syndrome.

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

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

The risk of GBS following vaccination with SHINGRIX was assessed in self-controlled case series analyses using a risk window of 1 to 42 days post-vaccination and a control window of 43 to 183 days post-vaccination. The primary analysis (claims-based, all doses) found an increased risk of GBS during the 42 days following vaccination with SHINGRIX, with an estimated 3 excess cases of GBS per million doses administered to adults aged 65 years or older. In secondary analyses, an increased risk of GBS was observed during the 42 days following the first dose of SHINGRIX, with an estimated 6 excess cases of GBS per million doses administered to adults aged 65 years or older, and no increased risk of GBS was observed following the second dose of SHINGRIX. These analyses were based on 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.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

The data are insufficient to establish if there is vaccine-associated risk with SHINGRIX in pregnant women [see Use in Specific Populations (8.1) of full prescribing information].

8.2 Lactation

Risk Summary

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

Adults Aged 60 Years and Older

Of the total number of subjects who received at least 1 dose of SHINGRIX in Studies 1 and 2 (n = 14,645), 2,243 (15%) were aged 60 to 69 years, 6,837 (47%) were aged 70 to 79 years, and 1,921 (13%) were 80 years and older. There were no clinically meaningful differences in efficacy across the age groups [see Clinical Studies (14.1, 14.2, 14.3) of full prescribing information].

The frequencies of solicited local and general adverse reactions 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).

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What is the most physician friendly state?

Every year, our partners at Physicians Practice® conduct an analysis of which states are the most physician friendly, using a variety of criteria to create an objective rating. Some of the criteria include tax rates, malpractice costs, quality of life and the costs of running a medical practice. Medical Economics® is proud to present a slice of this data in this issue, and readers can visit PhysiciansPractice.com for the full results.

Choosing a location to practice in is a very important choice that often doesn’t feel like a choice, as physicians tend to gravitate towards certain locations because of where they went to medical school and residency, family ties and other reasons. Putting some conscious thought into what physicians want out of life — rather than letting the winds blow you where they will — is an important step for young physicians charting their life goals.

“Where do you want to live, and where do you want to spend the rest of your life?” said Louis Levitt, M.D., M.Ed., in our cover story accompanying the data. “It’s very difficult to change locations once you get involved in a practice, so you should first decide where you want to live and what type of environment you want to practice in.”

Beyond our cover package, we have more great content in this issue, including:

The fourth and final installment of our “Future of Primary Care” series exploring the expanded role of non-physician providers and their fight for increased practice independence.

A feature that drills into some practical tips for practices to improve their patient bill collection rates.

Two columns from two different physicians on some big-picture issues facing medicine, including the impending Medicare payment cuts for doctors and what we need to do to make the health system better for primary care physicians. Agree or not with their takes, you won’t want to miss them.

As always, please reach out if you have any comments or questions on our content, and we’re always interested in story ideas. Reach out to Editorial Director Chris Mazzolini at cmazzolini@mjhlifesciences.com. Thanks for reading! 

Mike Hennessy Jr.
President and CEO
of MJH Life Sciences®
December 2022
Volume 99 Issue 12

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Where do you want to live?
The first big question a physician should ask themself when considering a practice location, according to Louis Levitt, M.D., M.Ed., vice president/secretary of the Centers for Advanced Orthopaedics in Washington, D.C., is, “Where do you want to live, and where do you want to spend the rest of your life?” Levitt feels that “it’s very difficult to change locations once you get involved in a practice, so you should first decide where you want to live and what type of environment you want to practice in.”

Although physicians can commute, a long or difficult commute can add stress to a job that is already prone to high levels of burnout.

The type of practice determines the space
An equally important consideration for physicians is thinking about the type of practice they intend to create, according to Eric Passon, CEO and founder of Ancore Health, a Tennessee-based consulting and analytics firm that works with physician practices.

How to select a practice location

By Jordan Rosenfeld

Physicians just starting out or looking to get into independent practice after working as an employee have to start with the basics, and one of the most important is finding a location and setting up a practice. When it comes to picking a practice space and location, it is not as simple as geography; experts suggest that physicians need to consider demographics, income flow and even their future goals to be competitive.
Wondering where to open your new medical practice? Curious where your state (or district, in the case of D.C.) stacks up when it comes to being physician friendly? Need something to rib your out-of-state colleagues about at the next conference? Every year, Medical Economics® sister publication, Physicians Practice®, does a deep dive into a number of criteria important to physicians, in terms of both lifestyle and finances.

These rankings are based on six criteria using data from publicly available sources and Physicians Practice® partners. The criteria include the following:

- Cost of living
- Physician density
- Amount of state business taxes collected
- Average malpractice insurance rates
- Quality of life
- Geographic practice cost indices (GPCIs)

SEE RANKINGS ON PAGE 8
“Selecting your location could be wildly different if you’re starting up a primary care practice focused on Medicare Advantage lives or an orthopedic practice that has an ambulatory surgery center tied to the practice. You need the space to be an attractive area that is convenient for patients to attend.”

Physicians will also want to think through workflow operations and design, Passon says. “It gets more complex as you get into adding ancillary components, such as MRI, CT, a basic X-ray or a lab.”

**Design with COVID-19 protocols in mind**

Additionally, Passon feels that in the pandemic era, practices need to be designed with sensitivity to not have large groups of people sitting in a room. “You really have to think through the ways of designing a more elegant space that allows for patients to enter and exit without sitting in the traditional waiting room. So how do you build the practice in such a way that it’s conducive to clinical workflows but still allows for that type of experience?”

**Create convenience for your patient population**

Finding a practice location is more than just thinking about what part of town you want to work in, Passon insists. It’s important to be near the patient population the practice is serving. Being convenient to the patient is a way of being competitive, Passon urges. “The actual space would need to be convenient, whether you’re moving into an existing space or you’re building out a new space from that perspective.”

If the physician offers any services that are performed at nearby hospitals, then proximity to those hospitals can also further offer the convenience that will keep a practice competitive, Passon says.

One of the often-overlooked aspects of convenience is parking, says Mark Leondires, M.D., medical director at Illume Fertility, in Norwalk, Connecticut. Parking can be hard to come by in a rental. “The lesson I’ve learned is always consider parking. Landlords are notoriously stingy (about) giving you assigned parking spaces, but if you can get them for your patients, it gives you considerable cache when it makes it easier for them to get in and out.”
Do market research on other doctors

Being the new doctor in town might seem promising to a physician setting out on their own, but if there are other physicians in town, a new one could merely be saturating a region. It is important to distinguish oneself.

Leondires says, “It’s really good to have good market research regarding the other physicians in the area that are offering the same services, and also that the demographics of the population support it.”

He urges physicians to ask themselves, “What competitive advantage do you offer?” There may be specific advantages, such as being a woman opening an obstetrician-gynecologist (ob-gyn) practice in an area with only male ob-gyns, or being multilingual. It might make sense to open a practice in a more rural area where there is less competition.

“Make sure you have a very good team that’s committed to your success, from an accountant to a real estate professional to a lawyer, and good market analytics to understand where your needs are and help you succeed,” Leondires says.

Furthermore, he points out that if a physician is leaving a hospital or a group practice to start up an independent one, there may be noncompete clauses in a contract that can shape the location, so pay attention to those.

Buying and build-outs

Although most physician practices will probably rent, at least in the beginning, most locations won’t be perfectly set up to accommodate a practice, Leondires says. This may require a build-out, and not every landlord is amenable to having their space redesigned and remodeled, so that will be an important conversation to have. Additionally, build-outs can cost a lot of money.

The alternative to renting is to buy a property, which Leondires calls a big commitment, especially for someone who may still be building up a patient base. “The time to buy office space is when you know you have a dedicated patient population so you have a viable practice for the next twenty years, because that’s probably how long you’ll end up with a mortgage.”

The downside of buying a building is that you become less portable, he says. “Let’s say you open a
One of the considerations when opening an independent practice is to "Do your due diligence. Make yourselves knowledgeable about the world of business."

If you're trying to open your own practice, you have to recognize that there may be at least one, if not two years, that you're not making any money," Leondires says. "Make sure you have the financial bandwidth to tolerate that because it takes time for patients to switch doctors, to get on insurance plans, and for existing physicians to change referral patterns."

Passon recommends having at least six months' worth of expenses in savings before setting out to rent or buy office space. There are also all the other costs associated with maintaining the technology of an electronic health record and a practice management system that may also be able to offer secure telehealth, Passon added. There may also be employee costs if a physician hires administrative staff, a practice manager, and billing staff.

Private practice may be disappearing
Before worrying about practice location, Levitt adds that it is worth considering that "private practice is disappearing. Ten years ago, 75% of doctors were in private practice and 25% were employed. In ten years, there's been a flip of that statistic."

It's far more common for physicians to enter group practices, where they can share expenses, overhead and even workload. However, if the circumstances are right to open an independent practice, Levitt urges physicians to "Do your due diligence. Make yourselves knowledgeable about the world of business."*

Methodology

Physicians Practice® averaged each state’s ranking in the six criteria. GPCIs were used to break any ties.

Cost of living
The cost-of-living ranking was based on data from the Missouri Economic Research and Information Center, which itself based its ratings on averaging the indices of cities and metropolitan areas in each state.

Physician density
The physician density rankings are based on the Association of American Medical Colleges’ 2021 State Physician Workforce Data Report. This biennial report is based on data from the American Medical Association, the U.S. Census Bureau, the American Association of Colleges of Osteopathic Medicine, and the National GME Census.

State business taxes collected
This ranking was based on the Tax Foundation’s Facts & Figures 2022: How Does Your State Compare? In particular, Physicians Practice® used Table 3, which ranked the states on five criteria: corporate tax, individual income tax, sales tax, unemployment insurance tax, and property tax.

Average malpractice insurance
The raw data used to calculate the average malpractice insurance cost was provided by the Cunningham Group. That data was then averaged out by Physicians Practice®.

Quality of life
For the quality-of-life metric, Physicians Practice® used Wallethub’s Best States to Retire rankings, which were based on adjusted cost of living, low annual cost of in-home services, their own taxpayer ranking, percentage of the workforce aged 65 and older, museums per capita, theaters per capita, percentage of population aged 65 and older, life expectancy and property crime rate.

GPCI
CMS uses GPCIs to adjust Medicare physician payments to account for geographic differences in physicians’ costs. Each GPCI corresponds to one of the three main components of a Medicare physician payment. They are physician work, practice expense, and malpractice expense. For the purposes of these rankings, Physicians Practice® averaged the three GPCIs together for each state and the major municipalities contained in each state. The lower the GPCI, the higher the ranking. Because of the importance of these criteria, specifically practice expenses, Physicians Practice® used GPCI rankings as a tie-breaker in the event of a tie.
By Craig M. Wax, D.O.

FIXING MEDICAL CARE

The pride of ownership

RESTORING THE TRUSTED PATIENT-PHYSICIAN RELATIONSHIP

Human nature and history provide ample solutions for successful motivation and action. In Fixing the primary care system after the COVID-19 pandemic, in Medical Economics®, July 2022, Timothy Hoff, Ph.D. made some excellent observations and good points and opened a critical dialogue for bettering medical care. In this article, I take his strategic blueprint for fixing primary care to a more detailed level to achieve our mutual goals, elaborating through the use of quotes from recent articles on these issues by various experts and myself.

The main goal of this plan is the pride of ownership for both the patient and the physician.

1. **Patients must own their health.** Individuals have an intrinsic right to own themselves and their bodily autonomy. Individuals must be responsible to themselves for their state of health and health outcomes. They must choose and pay. First, dollar costs must be their responsibility from the outset. In this way, patients learn through natural consequences to do routine body, mind and spirit maintenance and be attentive to issues as they crop up. This is the pride of ownership. “People spending more of their own money on routine health care would make the system more competitive and transparent and restore the confidence between patients and the doctors without government rationing,” states Benjamin S. Carson, Jr, M.D., a retired pediatric neurosurgeon. Patients must choose physicians and services with their own individual value systems and buy-in, literally and figuratively, to be motivated to take appropriate action.

2. **Patients must have informed consent to review, accept or deny any service, treatment or medication.** Recently, government, employers and schools have forced experimental interventions on both individuals and the public at large. There was no informed consent acceptance of the risks, benefits and understanding of alternatives. “In other words, patient-centered medical ethics demand that you have the right to understand and choose each unique intervention separately based on its own merits and risks” (Craig M. Wax, D.O., Physician Outlook, Aug. 7, 2021).

3. **Physicians must own their practice businesses.** They must be responsible to themselves and patients for ethical, efficient and effective practice. This too is the pride of ownership, and would restore the patient-physician therapeutic relationship. Both parties would deal directly with service and payment, eliminating pirating middlemen and extraneous noise. “Solo and small physician practices were increasingly put out of business, and hospitals hired physicians to serve the mighty electronic data masters — government and third-party payers” (Craig M. Wax, D.O., KevinMD.com, Nov. 7, 2019). “Give payment control to the primary care physician and the patient,” says Timothy Huff, Ph.D. Incentives for patients and physicians align when patients choose and pay, and physicians own their own practice business. Both parties are responsible to each other for the service and the outcome in direct care.

**Cut out the middlemen.** Eliminate unnecessary layers that are costly and bloated and divert the focus on the individual patient. Third parties, such as managed care insurance, pharmacy benefits managers (PBMs) and government programs, must steer clear of interfering in medical decision-making and violating patient and physician privacy. PBMs, for instance, extort drug manufacturers for kickbacks, disguised as “rebates,” which are rendered legal by the federal government for decades. For details on these schemes read, “America, its pharma middlemen, and legal thievery,” by Marion Mass, M.D. (Courier Times, May 5, 2021). True insurance is urgent but managed care is insurgent and divergent. “True insurance is an inexpensive tool to curb catastrophic financial loss. But government regulations prevent its sale, and we are left with junk plans with narrow networks that are more expensive than ever. There should be as many health insurance options as the industry can dream [up] and patients will support.” (Craig M. Wax, DO, in “Eliminating the 6 degrees of patient-physician relationship,” Medical

5. Physicians, their groups and affiliated businesses should be able to own hospitals. Laws and Medicare regulations enacted over the last fifty plus years prevent physicians from owning and running hospitals. Section 6001 of the so-called “Affordable Care Act” of 2010 added new regulatory restrictions and requirements for physician-owned hospitals. Currently, both giant for-profit and not-for-profit companies own hospitals. What makes huge monopolies and oligopolies in a service area more responsible, efficient and economical than an invested physician-owned medical center? Physicians have significant professional and personal interest in patient medical care, and significant liability as well. They would be the best to share a financial interest as well, given their investment and liability.

We must all recognize that government and third-party entities have intruded on the patient-physician relationship, wreaking havoc and exponentially raising costs over the last half century. Profit-seekers such as the American Hospital Association, American Medical Association (owners of the Current Procedural Terminology coding system), Pharmaceutical Research and Manufacturers of America, Blue Cross Blue Shield Association insurance and the American Association of Retired Physicians have been among the top spenders for congressional lobbying in recent years. Conflicts of interest abound. They write the laws and pay the politicians to execute them on all sides. It has been asked, for instance, why PBMs exist. The answer is, “because political campaigns are expensive.”

“When I became a physician, I made an implicit commitment to deliver quality care to all of my patients. I will never be able to deliver on that promise until the middlemen are cut out and physicians’ voices are leading our health care system,” explain Gary Price, M.D., and Tim Norbeck in “PBMs: Driving Up Costs and Lowering Quality Care in America,” Forbes, Aug. 22, 2019.

It is long past time to restore the patient-physician relationship by the pride of ownership:

1. Acknowledge the intrinsic patient right and responsibility for their own decisions and costs,
2. Restore patient informed consent for every procedure, test, treatment and medication,
3. Enable physicians to own their practice businesses and hospitals to engender responsibility, prevent liability and assure alignment of incentives with patient health outcomes.
4. Cut out the middlemen profiteers who detract from care and add to cost such as PBMs and managed care conglomerates.
5. Recognize that free market competition provides patients with unlimited choices, options, highest quality and best price. Prevent government and corporate conglomerates from destroying markets, products and patient choice.

As a proper health investment advisor, a physician should have a fiduciary relationship directly with the patient to assure moral, ethical and effective care recommendations are rendered in an efficient, cost-effective and timely way. This is true shared decision-making at its finest. Third parties and government entities destroy the privacy, responsibility and benefits of both parties (Craig M. Wax, D.O., “The Patient-Physician Relationship Is a First-Degree Interaction,” Physician Outlook, October 1, 2020). =

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Physicians may deal with life and death issues every day, but few may want to think about the eventuality of their own end. And yet, not only do physicians need to think about it, they need to plan their estate to protect their assets, manage their long-term health care, and make matters easier for their next of kin.

Estate planning and elder care attorney Rebecca Goldfarb, J.D., co-owner of Goldfarb & Luu in Tarzana, California, said, “The benefit of an estate plan is to get your wishes honored, to avoid court, and to maintain family harmony.”

Age doesn’t matter
Although there are a few legal issues that are unique to health care, such as the need to protect against malpractice litigation, the stage and age of the physician shouldn’t matter when it comes to getting started on estate planning. Younger physicians may be less inclined to think about estate planning, but there is never a bad time to get those plans underway, according to Jeffrey Asher, J.D., principal at Law Offices of Jeffrey A. Asher, PC, in New York and Connecticut.

“You deserve to control who makes financial decisions and health care decisions in the event you can’t make them yourself, and how your property goes when you pass away or suffer a mental incapacity,” Asher said.

Power of attorney
The most important first step is to designate a power of attorney, according to Mackenzie Sorich, J.D., owner of View Ridge Family Law and Estate Planning in Seattle, Washington. “Power of attorney directs someone to make decisions on your behalf if you’re alive and incapacitated,” Sorich said.

Not having this legal relationship can lead to significant problems, she explained. “You can’t even manage the payments on a mortgage, or the rent, unless you have a power of attorney, or (family) go through a long-drawn-out process of establishing a conservatorship or guardianship,” she said.

Decide on a will or a trust
Once you have your power of attorney covered, you want to decide between the two primary methods of protecting assets — to draw up a will or create a trust. Although a will is the simplest and cheapest method, Asher noted, it is not the most protective, and a will always requires a court to process.

“A will is a one-sided document. I create it, it names my executor, and tells the world where I want my stuff to go,” Asher said. “But no part of that will is valid until a court sees it, verifies it, and there are no challenges to it. Then my executor is appointed to act on my behalf and carry out its instructions.”

Most states don’t require an executor to be notified in advance of their role, so sometimes this can also take a person by surprise, Asher explained.

Additionally, a will is problematic if the physician has family members they specifically do not want their assets to go to. A disinherited child, or even an ex-spouse, for example, could still sue in court for a right to a share of the estate, and even win, Asher said. Only a trust will allow the physician full control over the direction of their estate after death.

Different kinds of trusts
The most common form of trust is a living trust, created while the person is still alive, said Goldfarb. A trust is kinder to the physician’s beneficiaries,
especially if the physician has a private practice, which may have more complex business arrangements as well as the need to arrange for continuation of care of patients. “That’s a burden you’d be putting on your next of kin,” she said.

Trusts can also help if a physician owns assets in more than just the state they live in, Asher added. Deeds to properties can all be entered into one trust, streamlining and consolidating the assets and making it simpler to redirect after death.

Trusts are also a good way for physicians to both protect their assets and qualify for Medicare health insurance. They may need this in order to pay for long-term care without depleting assets for beneficiaries, Asher said.

Then there are irrevocable trusts, which could be especially useful to physicians who exist in an environment that is prone to malpractice claims because, Asher said, “When something goes wrong, and someone is hurt or dies, people are often looking for someone to blame. An irrevocable trust helps to protect assets from creditors seeking to take money.”

The primary reasons that people avoid making trusts and opt for wills, even though wills must go through probate in court, is that trusts cost more and require more paperwork, Asher explained. But a physician should look at their goals and decide accordingly.

**Succession and business planning**

Estate planning for physicians must also consider succession and retirement planning. This is because physicians need to decide who will make financial and health care decisions, which includes taking over or managing patients if the physician becomes incapacitated or dies.

It’s important to find out the rules in your state regarding business operations and succession planning, according to Yana Feldman, J.D., owner of New York Legacy Lawyers By Yana Feldman & Associates PLLC in Brooklyn, New York. “For example, in New York a medical practice cannot really operate unless the owner — or owners — is a physician,” she said.

If a physician is in solo private practice, it is not a bad idea to appoint another doctor to manage the practice, even if only to get it ready to sell, in case of incapacity or death, Feldman said. “It’s much easier to sell a going concern that’s operating, that has people coming in, than if you have to put a padlock on the front door and say ‘Wrong, Dr. Smith isn’t available, all appointments canceled,’” she explained.

Estate plans can also be updated as needed. “If you create a solid plan, it becomes easier to do small updates over time,” Sorich said. “You’ll have a foundation.”

Feldman urged physicians not to wait to set up their estate planning, because accidents and unpleasant surprises do happen, which she sees all the time. Not being prepared often leaves next of kin in the lurch, scrambling to figure things out, while money and assets are on the line.

**Finding a good estate planning attorney**

Goldfarb stressed that not all estate planning attorneys are qualified to do all the things a physician might need and want. She said to avoid “generalist” lawyers and pick someone who specializes in estate and business law. Additionally, this lawyer should be able and willing to educate the physician. She recommended some questions to ask:

- How do you figure out all my wishes?
- How long do you spend in the planning meeting?
- Will you teach me, seeing I don’t know anything about estate planning?
- Do you maintain a lifelong relationship with me and reach out to me to update my plan?

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Many investors view the current stock market the way Charles Dickens, in “A Tale of Two Cities,” described the period preceding the French Revolution: “It was the worst of times.” These days, however, may actually be what the author, in the same unforgettable sentence, also termed “the best of times” — to invest, that is. In the market, these extremes are often present simultaneously, or at least overlap. What many people think are the worst of times to invest are often actually the best, and vice versa. And one of the best times is when there are good reasons to believe the bull will morph into a young bear.

There are significant indications that the market may have already hit the bottom of the current bear cycle. And if it hasn’t, the bottom is probably not far off. Anticipating a bear bottom (no pun intended) is not like microsurgery. For long-term investors, success doesn’t depend on absolute precision. It’s more like horseshoes, hand grenades and nuclear weapons, being close enough definitely counts.

Calling the bottom precisely — a nearly impossible feat — isn’t the point. The point is not to fall into that common trap: selling low out of disgust when values decline and then buying back high after the recovery is well underway. Many surveys exist that show this to be how most individual investors undermine themselves.

The goal is to hang tight and add to equities after a sustained uptrend begins or appears on the horizon. You may not get all the market’s recovery gains this way, but you also won’t suffer losses from lunging at a faux recovery. The key is to see recoveries coming or to at least recognize them after they’ve arrived.

You’d be hard-pressed to convince many investors that things are looking up these days, as they’re in a foul mood over the economy. Continued high inflation is prompting the Federal Reserve to raise the federal funds rate to douse the still-hot economy and tamp down inflation. This triggers rises in other rates, and the resulting fears fester, becoming a general malaise that is exacerbated when people conflate the economy with the market.

Although the economy does affect the market to a certain extent, they are different entities with different dynamics. They are like estranged cousins who may see each other at Thanksgiving but otherwise rarely speak because they are fundamentally different: Economic data is necessarily backward-looking, and the market is perforce forward-looking.

Thus, confusing the two can lead to misplacing forecasts of economic downturn on market projections, even if these forecasts prove to be correct. One of the greatest bull markets of all time began in the U.S. during the Great Recession. Another bull market started in 1982, when inflation was also high.

The foul mood of investors over the economy and the market is conveniently keeping values down, providing an opportunity for gains. Of course, investing now would require a conviction that we’re at a propitious point, that the market is likely to rally in the near term. Which not to say that our highly volatile market won’t descend from here, losing its October gains before beginning to trend upwards. That could easily happen, but it’s not the question those inclined to invest should be asking. What they should be asking is: Will major indexes retrace their mid-June lows and then take many months to reach current levels?
Not obsessing over buying at the bottom means accepting some red ink in your holdings for a while — and not knowing when it will turn black. But, as your mother may have told, patience is a virtue. Waiting is part and parcel of accepting the idea that you can’t pinpoint the bottom. The idea is to shorten the wait, but not to wait so long that when you do get in, you commit the blunder of buying high.

Here are some positive indications that the worst is probably behind us, and that 2023 will likely be a better year.

**Periods after midterm elections are historically good, as they typically result in divided government, which markets like because it reduces uncertainty.** In the 12-month periods after midterm elections, the S&P 500 has been positive every time since 1946, with an average gain of 15.1% compared with 7.1% in non-midterm years. This is highly significant because few patterns are rarely as stable as this one.

**Midterm elections, of course, always fall in the fourth quarter, which is as typically good a quarter for market indexes as the third (particularly September) is a bad one.** As we approached the fourth quarter, various analyses show that the market, which was long overbought, is now oversold, indicating a likely uptrend from new investment because cash sitting on the sidelines gets sent into the game. And cash inflows from big institutional investors — always a sign that the pros like conditions — has recently been increasing. At this point in a bear market, it doesn’t take much good news for a broad array of investors to start piling in.

The frequency of daily up-and-down movements of 1% to 3% that we’ve seen in recent weeks is fairly typical of market bottoms or, at least, of periods close to bottoms. And as of mid-October the market had exhibited more negative 1% days than in any year since 1931. Moreover, the market’s gain pattern from mid-September to mid-October — five days of gains of 2% or more — is similar to those that occurred ahead of market bottoms in 2020 and 2018. This clustering of highly volatile days and healthy gains could indicate that, black swan events notwithstanding, the market might be on track to show more upside than downside, but not without being quite messy in its herky-jerky ascent.

**Bears only roam for so long before going back into hibernation.** Historically, the average bear market lasted 289 days. The current one officially started the first week of January; thus, average duration would have had it ending the third week of October. If this bear’s longevity proves to be more or less average, it may be holed up in its cave this month or the next.

These times are so bearish that they’re bullish — for those contrarians who, anticipating growth, buy low when stocks are shunned. Messages of market doom and gloom are everywhere. Headlines about “lost wealth” abound, and talking heads shake woefully over fallen indexes. But one must remember that paper losses aren’t real unless one sells. Being a contrarian means being out of step. And out of step is a good thing to be when most people wait for the rest of the herd to start buying and end up paying high prices for equities, significantly limiting eventual gains. True contrarians are likely attuned to the current abundance of signals that the bear is ending or that it will end soon.

Well before the bear market is officially over, the market’s long-term upward arc will resume. More than any other factor, this arc is driven by the digital revolution, the 21st century’s equivalent of the industrial revolution that affects not just tech products and services but virtually every industry. As for tech itself, the sector is way down and likely to come roaring back after fears about interest rates abate.

By the time that happens, we’ll already be looking back on 2022, in a sort of Western version of the Chinese zodiac, to the Year of the Bear.

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Fallout from the FTX bankruptcy and the future of crypto

By John M. Mason

The digital world is going to survive. Digital is the future of finance.

But digital is going to be regulated.

The recent experience with the failure of FTX (FTT-USD) shows us, as stated in the Financial Times, that the digital world will become as fully regulated as financial services businesses.”

The current situation is going to accelerate the move to greater regulation.

At present, the digital world is going through “the weeding out” stage of what works and what doesn’t work in a space that is remarkably changed. The transformation the world is moving through is breathtaking. But a world that is transforming can be a painful process.

Lots of people have lost lots of money.

But as Andy Kessler states in The Wall Street Journal, “Bubbles collapse when no one else buys in.”

The problem right now, as Kessler notes, is that the crypto market “is backed by nothing but air.” But the technology behind the crypto market, behind the digital market, is incredible, and will find a place in the financial world.

After all, finance is nothing but information, and modern information technology is providing the world with the tools to grow and spread information.

Originally, cryptocurrencies were praised as the new “medium of exchange” for the world. They were to provide the payment system for the future.

The fact that cryptocurrencies would also be a “store of value” was important, but was not originally at the top of the list of characteristics that would cement the role of cryptocurrencies in the world.

Serving as a medium of exchange would guarantee the role of cryptocurrencies in the world. There was a real purpose for these cryptocurrencies, cementing their value to the world.

Whoops! Something went out of line. The medium of exchange ability of the cryptocurrencies was not secured when the asset was introduced to the world. As a consequence, cryptocurrencies had to justify their existence by being just a store of value, but it was not readily apparent that they really brought something of added value to the world.

The bubble

Cryptocurrencies did not catch on quickly after their introduction. For example, Bitcoin was introduced in 2009.

As I showed in a recent post, nothing much happened for the first ten years or so of Bitcoin’s existence. Then in 2020, the price of Bitcoin began to rise.

The apparent cause of this rise was the massive amount of money that the Federal Reserve System was injecting into the US financial system. These monIES were being injected to protect the United States against a financial collapse that might be started by the consequences of the Covid-19 pandemic and the subsequent recession that followed.

The price of financial assets rose dramatically during this time, and the rise in these prices took on the form of a financial bubble. The spread of financial resources moved into most sectors of the financial world. Traditional asset managers benefited from the spread of this money, but new areas also benefited from the movement.

One highly reported sector that benefited greatly from this spread was the “blank check” company, or Special Purpose Acquisition Company (SPAC), that flourished during the 2021-2022 period. Blank check companies are having problems all over the place now, and deals are just not being cut.

Bitcoin made its move, and its price rose to over $67,500 on November 8, 2021. Since then, the path has been downward. In the past day or so, Bitcoin has been...
down around $16,000.

And the S&P 500 Index (SP500) reached an all-time high on January 3, 2022, but has since tumbled as the Federal Reserve has tightened up its monetary policy. A lot of sectors prospered during the past two years, but now a lot has changed and many of those same sectors have suffered in the reversal.

This is what happens when you have asset bubbles.

**The other side**

FTX is now “on the rocks.” It is struggling for its life.

Sam Bankman-Fried is said to have apologized for his failure. He is also looking for $8 billion to plug the hole in his ship and keep it afloat for the near term.

As we read in the *Financial Times*:

“The nascent crypto industry was already struggling with a price crash triggered by the end of the cheap money era. The humbling of Sam Bankman-Fried (SBF) is a further blow.

“The collapse of FTX has been likened to a bank run: Account holders were rushing to get their crypto assets but were being blocked from doing so.”

The next step: regulation, and lots of it.

Gary Gensler, chair of the U.S. Securities and Exchange Commission, has already accelerated the move. Gensler was already on the track to greater regulation for the crypto world.

Now the door has opened wide for him. If he doesn’t get most of what he wants now, I would argue that he has really muffed a “gimme putt.”

This is the history of innovation.

Eventually, the sector comes to the point where regulation is almost required. When the market consequences connected with the innovation become hurtful and much is lost, people step back and let the regulators in the door. In fact, they welcome them in.

The future is digital, there is no question in my mind about that. The future includes crypto. Information grows and spreads. That is what history tells us.

But getting there can be very painful to many and it can be very difficult finding the “best” path to the future. It happens. FTX is just another step down the road.

**Regulation coming**

Regulators are facing something that they have never really faced before: globalization. The collapse of FTX, which filed for bankruptcy in the U.S. in November, has set the scene.

The regulators cannot back off now. Events are thrusting markets into places of no return.

First, the regulators are dealing with modern information technology. The advancements in this space are enormous and are a challenge to oversee even in their simplest form. But the evolution of modern information technology advancements is global in nature and hence outside of any real geographic oversight.

As Martin Arnold states in the *Financial Times*: “One of the biggest problems confronting regulators is the difficulty in pinning down where many crypto asset providers were based.”

Historically, regulation is set up for specific legal entities and specific geographic territories. This specificity does not exist for current crypto asset providers.

In the case of FTX, there is a “multijurisdictional web of wholly owned subsidiaries and intercompany loans including entities in the Bahamas, Cayman Islands, Antigua and Barbuda, as well as the U.S., Japan, Germany and Switzerland.”

Modern information technology is global and must be perceived to operate in a global fashion. Unfortunately, all this liquidity floating around is enabling crypto players to take advantage of opportunities that are available to them. FTX was just one of those players.

But the situation is getting more serious. The crypto world must be brought under control.

This, I believe, is going to be quite some battle. Unfortunately, this battle is going to be taking place at the same time that world central banks are facing very severe inflationary problems.

The world is in a great disequilibrium and these problems are going to have to be worked out over time. My concern is that many individuals are going to suffer a lot of pain.”
Being a primary care physician isn’t the most enticing job right now. The average salary is six figures below that of most specialists, according to Medical Economics® survey data, yet primary care physicians must treat everything from a sprained ankle to heart arrhythmia. Time with patients is short, and the administrative burden is high, and with an increasing shortage of primary care physicians, patient needs are only going to add to the workload.

With too few physicians to go around, nurse practitioners (NPs)—and to a lesser extent physician associates (PAs)—are stepping in to fill the gaps. But physician groups such as Physicians for Patient Protection (PPP) and the American Medical Association are pointing out that NPs are not necessarily joining physician practices, but are using the physician shortage to attain full practice authority. This allows them to compete directly with physicians, adding one more headache to the primary care physician’s list of ailments.

PPP leaders decry this shift to non-physician led care, and worry that the lower cost of NPs combined with their less rigorous training requirements will lead to poor patient outcomes while threatening the jobs of primary care physicians. But NPs counter that when it comes to primary care, they are as effective as doctors, serve rural areas more often, and with so many patients needing care, the argument over jobs is moot.

So the primary care physician may be left wondering how they fit into a future of fewer physicians, rising numbers of non-physician providers and an aging population that will strain the health care system like never before. Will they be the quarterback of a growing primary care team, or be relegated to the bench in favor of cheaper, less-educated replacements?

The scope of the shortage and what it means for physicians

Any professional group representing primary care will tell you doctors are already feeling the strain of too many patients for too few physicians. And it is only going to get worse if something doesn’t change. The Association of American Medical Colleges (AAMC) is projecting that by 2034 there will be a shortage of primary care physicians of between 18,000 and 48,000 — and if equitable care for all individuals is the goal, then another 35,000 to 50,000 physicians are required.

The Association for Advancing Physician and Provider Recruitment reported that in 2021, the percentage of physician searches filled decreased for the fourth straight year, with primary care being one of the most difficult to fill. In addition, the percentage of physician searches still open at year-end increased to 47%.

These numbers spell trouble for many patients. “As the shortage grows, access is going to
The U.S. population is growing and aging, and the older the population, the more health care it will require. But the physician workforce is aging along with it.

“Within the next 10 years, tops, we will get to a point where two out of every five practicing physicians in the nation are 65 years of age and over,” says Dill. “That’s not sustainable in terms of meeting the health care needs of a nation. We really need to step up and start training more, but we have to start doing it now, because it takes (about) a decade to train a new cadre of physicians.”

Dill says there’s not much more productivity that can be squeezed out of the current primary care physicians. Team-based care that brings in more non-physicians is an option, but it requires management and coordination as well, which also takes up physician time.

“In the end, we really just need more physicians,” notes Dill.

Experts say it is in this context of unmet care needs that NPs are gaining full practice authority as states scramble to make sure residents have access to care, and the American Association of Nurse Practitioners (AANP) says this is a benefit to patients.

“Time and again, we see that when states adopt full practice authority, the ranks of nurse practitioners grow,” says April N. Kapu, D.N.P., APRN, ACNP-BC, FAANP, FCCM, FAAN, president of AANP. “According to a 2018 report produced by UnitedHealth Group, authorizing full practice authority for NPs nationwide would increase health care access for approximately 31 million people living in primary care health professional shortage areas. The National Academies of Sciences, Engineering, and Medicine Future of Nursing report further reinforces that NPs must be granted autonomy and institutional authority to achieve the goals of strengthening health access and equity. NPs and other APRNs (advanced practice registered nurses) are more likely to treat Medicaid and uninsured patients, and to travel to areas where the need for care is greatest.”

David Blumenthal, M.D., M.P.P., president of the Commonwealth Fund, agrees that NPs may be a partial solution.

“There is some hope that non-physician primary care clinicians — nurse practitioners and physicians assistants — can fill some of the gaps,” says Blumenthal. “And if we had robust, community-based health workers to provide some of the very basic primary care services that we lacked, such as monitoring health in the home and providing immunization and providing basic health services, which has been successful in many other countries, that could partially ameliorate the problem.”
Relying on NPs and PAs may be especially necessary in rural areas where finding a primary care physician is more difficult than in an urban area. “I think for some small places, having NPs and PAs might be just fine,” says Davis Patterson, Ph.D., director of the Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center at the University of Washington School of Medicine in Seattle. “There are places where NPs and PAs staff emergency departments after hours and those kinds of things. We just have to be realistic about what the right solution is in using our workforces flexibly in ways that can help. If it’s a difference between not having someone in that community versus having someone, it doesn’t matter if it’s a physician, because if you have no one, your quality of care in that community is really going to suffer.

“We need more robust primary care, and there is plenty of room for more primary care if we look at the big picture, because we don't have enough of it. I think primary care physicians in particular should be more worried about the decline in primary care overall.”

**Boosting the number of primary care physicians**

Adding more primary care physicians is easier said than done. Becoming a physician in the United States requires graduate medical education (GME) in the form of a residency, but congress put a cap on Medicare support for GME in the late 1990s, and only 1,000 new slots have been authorized since then and that happened last year.

“We are turning out as many new physicians as we can with the GME we have, but we need more,” says Dill. “There’s no way around that. If they would raise the cap another 4,000 or 5,000 slots, that would be immensely helpful.”

There is some growth in slots funded outside of Medicare, but it is slow, says Dill.

Overall, the U.S. has over 36,000 GME slots available each year, which are filled with a combination of both domestic and international medical students. But experts point out that these are for all specialties, and with primary care being at or near the bottom of the pay scale, it isn’t always the most desirable for students who may incur substantial debt while attending medical school.

“Physicians taking care of their patients cost less than nurse practitioners,” says Christopher Garofalo, M.D., a family medicine physician and member of PPP. “If congress really wants better care access for patients, with better access to their physicians and lower costs, we should be fighting to have more physicians available to patients.”

But short of congressional action, experts don’t see much changing in the number of GME slots, meaning physicians will continue to be in high demand and some portions of the country will not have a doctor within a reasonable distance. This continued shortage also likely means that NPs will retain their full practice authority in 26 states and both they and PAs are likely to expand their ability to practice independently as patients in rural areas struggle to find doctors.

“That’s going to definitely be difficult,” says Garofalo, referring to revoking full practice authority in states. “It’s hard to put the toothpaste back in the tube, and it will be difficult to roll those back.”

**Only a team can win**

In the end, there are just more patients in need of primary care than there are providers of any education level to provide it, according to experts. The only way to help patients is to think about primary care in new ways.

“Everybody needs to work collaboratively if we want to change health care in this country,” says Jennifer M. Orozco, D.M.Sc., PA-C, DFAAPA, president of the American Academy of Physician Associates. “There is absolutely no reason why 95 million Americans should be without access to primary care, and that’s only going to grow with our aging population. Looking down the road, we will never have enough physicians, PAs or NPs. I don’t care how many training programs opened in the next year, we will not get enough people off the ground to take care of people.”

She says that only by innovating and forming teams made up of all caregivers can primary care be maximized, a concept Patterson agrees with.

“We need to be thinking about care teams, because it is not just one person going it alone,” says Patterson. “Teams may look a little different in rural areas. It’s not physicians versus NPs versus PAs; none of them practice in isolation. We need to put our attention on how we can create more robust teams, and that means NPs and physicians and PAs working together as well as working with other types of providers and health care support people.”

Patterson says that the best way to get there is to train all providers side by side so there are no silos and each clinician learns to work with other types of professionals. “I think this might really alleviate some of the concerns and lead to more collaborative approaches to things rather than sort of just protecting turf,” he says.

“All that matters at the end of the day is patients; it’s not about money or this or that,” says Orozco. “It’s about how we are going to start getting patients better, and that is going to be through preventive services and decreasing those chronic conditions. And there is just no way that physicians alone can get it done.”
Collecting money from patients is an ongoing challenge that has only worsened with high-deductible health plans. Traditionally, physicians have accepted this challenge as the status quo, instead choosing to overlook unpaid balances and provide the care that patients need. However, experts say the COVID-19 pandemic has prompted them to rethink this strategy and take a more proactive, business-savvy approach.

**Patient collections: A complex issue**

“Medical practices are really in a lot of trouble right now — especially independent primary care practices — because of lower reimbursement,” says Rozmin Bapat, CCS-P, CPB, CPC, CPCO, CPMA, president of CodeRite Healthcare Consulting. “A lot of doctors are asking patients to pay up front. Sending statements is a big cost drain on their revenue.”

Still, asking for payment and receiving it are two different things. Asking is, of course, the first step; however, practices also need to address this major barrier: Patients don’t understand their health insurance benefits, including what they owe and, more importantly, why.

“What we’ve seen is that office staff are not trained properly,” says Bapat. “They can’t explain the bill, and it leads to more patient frustration.”

Another layer of complexity? *The Wall Street Journal* reported earlier this year that certain credit-reporting firms have already started to remove medical debt that consumers pay after their bill goes to collections—debt that can sometimes remain on a credit report for up to seven years. Starting in 2023, some credit-reporting firms will also remove unpaid medical debt of less than $500. Asking patients to pay their medical bill may become more difficult when there are fewer financial consequences.

**Patient collection strategies for success**

Experts provide the following strategies to ease the burden of patient collections and improve cashflow and revenue:

1. **Leverage the No Surprises Act (NSA).** “With the NSA, it’s all about informing people of what their out-of-pocket [cost] will be and then facilitating that collection,” says Krisi Hutson, MBA, senior director of product development at Availity. “Patient education is no longer a ‘nice to have’—it’s a mandate.”

   Specifically, medical practices must provide patients with a good faith estimate of cost for the services they will receive, explains Hutson. To do this, they can use fee schedule-based estimator tools within their practice management system or more advanced tools that integrate with multiple payers to provide service-specific benefits and permit providers to create and process mock claims, she adds.

   Another option is to pull reports from the billing software or create a spreadsheet of every payer’s allowable (contracted) rate for each service. This will help the front desk collect the most appropriate out-of-pocket dues from the patients, says Bapat.

   One aspect of the NSA that independent providers might not know? If they’re a convening provider (i.e., one who orchestrates care with other providers), they may be responsible for providing patients with good faith estimates for each of the providers involved in the patient’s care, says Hutson.

   For example, an internist schedules a colonoscopy and then performs that colonoscopy in an outpatient hospital department. In this case, the internist is the convening provider and is thus required to provide the patient with good faith estimates for costs of the following: anesthesia, anesthesiologist, surgical procedure, facility overhead, and postoperative medication.

   The good news is that educating patients can make it easier to collect the amount they owe, says Hutson. “The collection of patient responsibility is much less cumbersome when there is clarity and transparency,” she adds.

2. **Collect the amount the patient is responsible for as close to the time of service as possible.** “Pre-service or at the point of service is best,” says Hutson. “The farther away from the care, the easier it is for patients to re-prioritize...”
their finances.” Note that doing this may require new workflows such as verifying benefits and eligibility a few days prior to the service as well as on the date of service, she adds.

3. Focus on staff training. Up-front collections or those taken before service has been provided may be a significant departure from what patients have always known. This is especially the case if a practice’s standard procedure has been to bill the insurance company first and then balance bill the patient, explains Hutson.

“Having a well-trained confident staff is important,” she says. “Put the time into mock training scenarios. Walk them through handling objectives. Make sure they’re comfortable stating what the practice expects of patients.”

For example, when collecting the patient’s financial responsibility at check-in, staff should feel comfortable saying, “We need to collect $25. How would you like to pay — cash, check, or card?” rather than “Are you able to pay your copayment today?”

Staff should also be able to explain concepts such as deductible, copayment, coinsurance, and out-of-pocket maximum to patients, says Bapat. In addition, they should understand how to interpret insurance benefits. For example, a patient might have a deductible that doesn’t apply to an office visit, only to a hospital visit. As a result, the patient may only owe a copayment.

“A lot of physicians don’t invest in this type of training because they feel that the front desk is such a revolving door,” says Bapat. If front desk turnover is problematic, she suggests training the office manager instead so this individual can, in turn, educate new hires. Partnering with a reputable consulting company that understands revenue cycle can also assist in training the staff, she adds.

4. Create a written financial policy (or update your existing one) to include language about up-front payments. Let patients know that full or partial payment is due at the time of service. Provide the policy to patients at check-in and ask them to sign it, says Bapat. Front staff and physicians themselves should also be prepared to answer questions, such as “Why has the policy changed?” or “What if I’m not prepared to pay today?”

For example, in terms of why the policy has changed, Bapat suggests the following response: “Patients are contractually bound to pay this amount when they sign up for insurance coverage, and now our practice is enforcing it on the front end. We’re asking you to honor it.”

If patients are not willing to pay, Hutson says physicians will need to determine whether they will still be willing to see them. “It will depend on the doctor’s philosophy,” she adds. One option is to simply say, “If you’re not comfortable paying today, we can reschedule your appointment to a time when you’ll have the financial resources to pay.”

As part of this policy, also be sure to provide options for financial assistance, such as loan programs or debt relief services, says Bapat.

5. Use caution with collection agencies. Collection agencies are always an option, but they should be a last resort, advises Hutson. “If you’re going to spend extra dollars, do it on pre-service collection,” she emphasizes. “With collections, you’re going to spend a minimum of 35% to 45% the minute you send it out the door. If you take that money that you would lose on collections and invest in one or two financial counselors, over the course of a few years you’re going to break even — and you’re also going to improve your patient satisfaction scores.”

6. Prepare to issue refunds. Collecting the amount the patient is responsible for before services are rendered is never an exact science because amounts are always an estimate. This means practices may need to issue refunds if they collect more than what the insurance company deems the patient ultimately owes, says Bapat.

She suggests running a monthly refund report from within the practice management system. Then check to ensure those refunds are legitimate, meaning that a payer didn’t accidentally overpay the claim. Also check to determine whether there are any pending claims to which the refund could be applied.

Once the practice is sure the patient is owed that money, the clock starts ticking in terms of when it must issue that refund, says Bapat. Each state has its own specific requirements for other payers, she adds.

Bapat suggests budgeting a couple thousand dollars a month for refunds. “Believe it or not, creating and maintaining this budget is still cheaper than invoicing patients after services are rendered and following up with unpaid balances,” she adds.

7. Make it easy for patients to pay. Providing patients with multiple options to pay their bills (e.g., cash, check, credit/debit card, text to pay, or email to pay) can increase the likelihood that patients will follow through with payment, says Bapat.

Looking ahead
Experts agree that now is the time to improve the patient collections process. “Health care organizations need to compensate staff, invest in new technology, and support the services they offer to patients,” says Hutson. “Reimbursement for health care services is essential to sustaining high quality care to the communities they serve.”
CUTS TO PHYSICIAN REIMBURSEMENT

Why Richard Nixon’s ghost is haunting CMS

IN AUGUST 1971, ostensibly in response to out-of-control inflation, then-President Nixon announced that economy-wide wage and price controls would take place after the 1972 election. This was the result, according to the Washington Examiner in 2011:

By the time Nixon reimposed a temporary freeze in June 1973, Daniel Yergin and Joseph Stanislaw explain in “The Commanding Heights: The Battle for the World Economy,” it was obvious that price controls didn’t work. ... Occasionally, though, we learn something from our mistakes. As (Secretary of the Treasury) Shultz told Nixon in 1973, at least the debacle had convinced everyone “that wage-price controls are not the answer.”

We did not learn.

For at least 60 years, the United States has been in the throes of handwringing over ever-increasing costs for medical care. A multitude of remedies have been suggested, and a multitude of laws with snappy-sounding titles have been passed. These efforts have been ineffective, with inflation-adjusted health spending growing at a 5.5% rate between 1960 and 2013 while the gross domestic product grew at a 3.1% rate, according to the U.S. Centers for Medicare & Medicaid Services. This corresponds to a per capita spending increase from $147 per person to $9,255 per person, an average growth rate of 8.1%.

There are several components to the problem: hospitals and other medical businesses, administrative costs, insurance companies, pharmaceutical companies, and of course physicians. (This article cannot exhaustively review the contributions of all five constituencies but will focus on contrasting what savings opportunities there may be with physician reimbursement vs. hospital reimbursement.) The other four participants in this scramble for cash have been quite adept at deflecting attention away from themselves and toward the one for whom there is perhaps the least potential for savings — physicians.

The “solution” the federal government instituted was Nixon-style wage and price controls on the health care sector, gradually ratcheting down payments for the past 30 years. Predictably, the controls have produced shortages in the area most targeted, primary care, where we are experiencing a deepening crisis.

This year’s discussion follows the script we have seen for many years: CMS is proposing draconian cuts of 4.5% in Medicare payments for physician work, while increasing payments to hospitals by 4.3%.

Further cuts in physician reimbursement will not cure runaway medical costs but will compromise the quality of care

As a thought experiment, consider what would happen if we “saved” all physician fees by cutting reimbursement to zero. It would mean a savings to the system of about 10%, which would be invisible after two years, given the overall medical inflation rate of 6.5%. The cost of this 10% savings, though, would be the total loss of physician services, which is obviously untenable.

No one proposes cutting reimbursement to zero, but CMS is tiptoeing up to a line with its annual cuts. Between 100% cuts and 0% cuts, there is a tipping point — a point at which physicians will begin leaving in droves, and simultaneously students will recognize they can’t possibly make a decent living in medicine. They will exercise their other options, starving the system of the new physicians we need.

To understand the impact of these continued cuts on individual physicians, we must examine what has happened to individual physician reimbursement. Although a recent American Medical Association publication documented an 11% increase in physician costs to the system over the past 20 years, this is a total cost: the cost of all physicians in the system. In that time, the number of physicians has increased by 43%, resulting in a decrease in per physician reimbursement of 23%.

This is worsened by the fact that now more than 50% of physicians are employed, according to AMA data. Their employers of course collect the money categorized as “physician reimbursement” and take more than 20% of collections for themselves,
further reducing the physician’s take-home pay. Adding to the damage is the fact that the Consumer Price Index has risen by 50% during this period. Most wages have increased at a comparable rate, but not physician pay — it has been decreasing. At the same time, there is the swelling student debt load that physicians must take on.

There are in fact alarming signs we have already passed the tipping point. A survey of physicians indicated that one in five intends to leave practice in two years, and one in three says they will reduce their work hours in the next year, according to a study in Mayo Clinic Proceedings. In a situation in which it is recognized we have a serious shortage of physicians, retaining physicians already in place would be an economical and immediate response to the problem. Yet the continued downward pressure on physician reimbursement is driving physicians away.

Talented students considering medicine as a career will look at these trends — increasing debt and decreasing reimbursement — and be realistically concerned about whether they will be able to pay off the debt.

**Physician expertise is necessary to minimize the costs to the system**

What we in medicine understand but the non-physicians directing payment cuts do not, is that the cost of the physician is small compared with the cost of services ordered for patients. Diagnostic imaging stands as a good example. Nurse practitioners get absolutely no training either in interpretation or appropriate ordering of imaging exams. Nevertheless, in many environments, they are empowered to order these expensive tests. A physician who avoids one unnecessary CT scan or MRI scan a day has more than covered the difference between the physician pay and the non-physician practitioner pay for that day. And that is only imaging. The system must have experts directing diagnostic testing and treatment plans.

This was proved in findings from a study conducted at Hattiesburg Clinic. They have now defined the economic consequences of allowing inexpert NPPs to direct care. Unsupervised NPPs ordering tests and referrals were found to cost the clinic $10.4 million per year. It is important to recognize that the Hattiesburg Clinic is an accountable care-type organization. As such, unnecessary testing is an actual loss to the business. They were therefore motivated to track their costs and control them. We will not see a similar study coming from a fee-for-service hospital because there is no motivation to control over-ordering.

The Hattiesburg experience recapitulates the findings of a Mayo Clinic paper. NPPs were empowered to request specialty consultations and 59% of such consultations were found to be unnecessary: a waste of time and money.

None of this is surprising to those who work in the system. We know those who are untrained cannot be expected to order tests and consultations correctly. We know they have not been trained to construct a differential diagnosis. Without that training, it is impossible to design testing and treatment plans.

**If not through physician reimbursement, where can economies be found?**

Costs for inpatient and outpatient hospital care have gone up more than 60% in the past 20 years. Let us take an example: the finances of one of the nation’s 417 hospital systems.

OhioHealth owns 12 of the nation’s 6,093 hospitals. It is one of the top 18 systems in terms of Moody’s bond ratings. As such, it is somewhat of an outlier, but it is still instructive to examine.

The amount of cash this system has amassed is truly breathtaking, as is the increase in the past 5 years. In 2017, the reserve fund was $3.6 billion, and in 2022 it had increased to $6.7 billion. This is during a period in which the system built one hospital and bought another, and suffered setbacks due to the pandemic. Yet its cash reserves still nearly doubled in 5 years. For context, OhioHealth’s cash reserves are greater than the gross domestic product of 55 of the world’s nations. And this is only one of 417 systems in the United States.

How has our government responded to this? In 2020 and 2021, OhioHealth received a pandemic bailout of $209 million. CMS had proposed a 3.2% increase in Medicare payments to hospitals for next year, but this was increased further and now is scheduled to be 4.3%.

Just like the Nixonian wage and price controls, the controls on the medical economy introduced by the central planning agency, CMS, have produced serious distortions in the economy. Those delivering care who have less political power are gradually being forced out of the market, while some institutions, with more political power, have become rich.

There is another interesting parallel to the Nixon economics. Nixon actually didn’t think the cuts would change the economy. His true intent was to look like he was doing something, for political impact. It is clear that now there is also an overriding political expediency factor allowing the targeting of physicians while shielding the other four sectors. Politicians create the appearance of doing something, while protecting their campaign contributors.

This conclusion is clear: After years of cuts to physician reimbursement, there is no room left for further cuts without pushing the entire medical profession over a cliff.

**Philip Shaffer, M.D.,** graduated from The Ohio State University with a BS in chemistry degree, and went on to medical school at the University of Toledo College of Medicine and Life Sciences. He completed radiology residency and a nuclear medicine fellowship at Ohio State.
More than 10 million people misuse opioids every year, according to the National Center for Drug Abuse Statistics. Overdose deaths involving opioids increased 519.38% from 1999 to 2019. These and similarly alarming statistics are why the U.S. Department of Health and Human Services (HHS) officially declared the opioid crisis a public health emergency in 2017.

More recently, HHS announced it will provide nearly $1.5 billion to states and territories to help address the opioid epidemic. The grant funding opportunity will be available through the Substance Abuse and Mental Health Services Administration (SAMHSA). Meanwhile, the Centers for Disease Control and Prevention (CDC) has finalized voluntary guidelines in November on when to initiate opioid prescribing, selection and dosage, duration and follow-up, and assessing risks and addressing harm.

It’s all part of an effort to support physicians in the quest to help patients struggling with opioid use disorder. At the heart of these efforts? Coded data.

“The coded data drives public policy,” says Toni Elhoms, CCS, CPC, CPMA, CRC, chief executive officer at Alpha Coding Experts, LLC, in Orlando, Florida. “It drives the SAMHSA funding. It’s all connected to the resources that are going to be provided to patients. It’s critical for physicians to code to the highest level of specificity.”

Jaci J. Kipreos, CPC, CPMA, CEO of Practice Integrity, LLC, in San Diego, in agrees. “We need to raise awareness of the importance of the data,” she says. “Primary care physicians are truly the gatekeepers and can help identify the scope of this problem. The data they report is critical.”

Experts agree that to combat the opioid crisis, physicians need to shift their mindset and start focusing on data integrity. It starts by addressing the following common myths:

**“ICD-10-CM codes don’t affect my reimbursement.”**

Not true, experts say. For example, most International Classification of Diseases Tenth Revision, Clinical Modification (ICD-10-CM) codes for opioid-related disorders are hierarchical condition category (HCC) codes, meaning they affect risk-adjusted payments for Medicare and many commercial payers.

In some cases, they could even yield higher-level evaluation and management codes due to higher-complexity medical decision-making, says Erica Remer, MD, CCDS, an independent clinical documentation integrity consultant in Cleveland. For example, a patient’s opioid-related disorder may affect what medications a physician prescribes, the dosage of those medications, or what additional tests they order.

“If you address the opioid use disorder in some way, you should document what you did and...
code the diagnosis,” says Remer. Elhoms agrees, adding that physicians may be undercoding their evaluation and management (E/M) level without even realizing it. For example, if a physician ends up addressing social determinants of health, the E/M code could shift from level three to level four. Or when coding the E/M level based on time, helping a patient address their opioid use could even mean billing a prolonged services code, she adds.

“You might also be leaving money on the table by not billing for services you’re already providing,” says Elhoms. For example, a physician provides an E/M service, screens for opioid use disorder, and provides a brief 20-minute intervention after detecting the patient may be struggling with abuse or dependence. In this case, they may be able to bill CPT code 99448 as well as the E/M service with modifier -25, she adds.

There are also implications under Medicare’s Merit-based Incentive Payment System, particularly when patients with an opioid abuse disorder receive at least 180 days of continuous pharmacotherapy treatment, notes Elhoms.

“ICD-10-CM codes are playing a bigger role as Medicare engages in direct contracting with primary care physicians,” says Elhoms.

“The alternative payment models are all based on the data, and most of it is diagnosis code data. You can get custom rates from Medicare if you have solid data.”

“I never know which opioid use disorder code to choose.”

Report one of the following ICD-10-CM codes for opioid-related disorders:

- **F11.1-** (opioid abuse)
- **F11.2-** (opioid dependence)
- **F11.9-** (opioid use)

The tricky part is differentiating between abuse, dependence, and use—terminology that originated in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), says Remer. The current DSM-V instructs physicians to diagnose patients with an opioid use disorder when they determine at least two of the following symptoms have occurred within the last 12 months:

- Spends a lot of time using substances
- Has cravings for drugs or alcohol
- Gives up activities to use drugs instead
- Uses hazardous substances
- Has legal problems due to drug abuse
- Has mental health problems due to substance abuse
- Neglects major roles (in family, work, school) to use
- Has physical health problems related to use
- Shows repeated unsuccessful attempts to quit or control use
- Experiences social and interpersonal problems related to drug use
- Shows tolerance
- Uses larger amounts of substance(s) for longer than intended
- Experiences withdrawal symptoms when stopping use

When patients have two or more of the symptoms listed above, their opioid use disorder is considered mild. In ICD-10-CM, mild opioid disorder indexes to opioid abuse, explains Remer. However, when they have four or five symptoms, their opioid use disorder is moderate. When they have six or more symptoms, it’s considered severe. Both moderate and severe disorders index to opioid dependence, she adds.

ICD-10-CM code F11.9- is for patients who take opioids but don’t meet substance use disorder criteria. Code Z79.891 is for long-term use of opiate analgesics (as prescribed).

However, once physicians determine whether to report use, dependence, or abuse, they still should narrow down the codes even more, says Remer. For example, they may need to specify whether the patient is in withdrawal or whether they have intoxication or an opioid-induced psychotic disorder.

“Convenience is compelling, and doctors often use whatever code they can find,” says Remer. “However, this is problematic. If you don’t pick the right code, then trying to do epidemiologic research is very difficult.”

Remer suggests setting certain codes as “favorites” in the electronic health record for easy access. However, the physician should always make sure that the code accurately reflects the clinical picture as specifically as possible.

“I don’t know how to bring up the topic.”

Incorporate questions about opioid use into your patient health
questionnaire or use a separate opioid use assessment tool as part of your patient intake process, says Elhoms. Also leverage your medical assistant to gather as much social history data as possible, she adds.

“I don’t have time to address opioid use disorders.”

The good news? You don’t necessarily need to. That’s because you can always make a warm referral to a mental health specialist, says Elhoms. “Reach out to your local public health department that may already have a list of mental health providers, support groups, and resources in your area,” she adds.

Another option is to provide and bill for psychiatric collaborative care (Current Procedural Terminology codes 99492-99494). Under this model that pays approximately $154 for the first 70 minutes in the initial month, physicians generate revenue when they co-manage patients with a psychiatrist or other behavioral health professional and provide ongoing care management and support.

“I don’t want to label patients.”

Now that patients have access to their visit notes, Elhoms says some physicians worry that patients will be upset if they document a substance use disorder of any kind. That’s not the approach to take, she says. “It’s a mindset shift. Physicians need to avoid pretending like it’s not there. They need to pull it out and be more proactive about addressing it,” she adds.

Physicians are getting less reimbursement, but expected to do more. It’s easy to forget that your practice is also a business with its own costs and revenue to balance.

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TECHNOLOGY / OPINION
By Joshua Tarkoff, M.D., MBA

WHY IMPROVING COMMUNICATION CAN REDUCE PHYSICIAN BURNOUT

I don’t know any physician who hasn’t experienced some form of burnout — even before the pandemic. It certainly has happened to me, about a year after I completed my training and started my career as a pediatric endocrinologist.

There weren’t enough hours in the work day to complete all the documentation, so I started bringing it home. You see the kids, have dinner, go to the gym, and then get back to work. And then you’re on call for a day or a week, and more work piles up. Each day, you get a little less sleep and a little less sleep and the next thing you know, it snowballs until you start to examine your life choices.

I feel very fortunate to have gotten through that rough patch and reached a healthy balance between my work life and my personal life. The secure communications platform my hospital purchased certainly has helped, reducing the hassle of trying to communicate with physicians, other care providers, staff, and patients.

Barriers to communication

According to a 2017 report, more than half of all physicians reported spending 10-plus hours a week on administrative duties. The same report from 2022 shows that amount of time had increased by half, to more than 15 hours each week for every physician. That’s 15 hours a week we’re not seeing patients and making diagnoses.

The same survey queried physicians about their main job frustrations, and bureaucratic chores such as charting and paperwork top the list. In fact, 60% of physicians chose bureaucracy related to paperwork as the main frustration, far outpacing other leading responses such as lack of respect (39%), too many hours (34%), and too little pay (28%). Together, these factors certainly contribute to burnout, with 54% of doctors saying that burnout has a strong impact on their lives.

The burnout statistic for physicians was double that of the general population — before the pandemic hit the world, with health care bearing the full effects. So what’s the answer to physician burnout caused by too much work and too many administrative duties? It’s to work smarter and not harder, an area where communications technology has helped me and my hospital.

Finding a better way

The shift to the electronic medical record was an overall positive for patients to reduce the incidence of preventable errors through missing paperwork, illegible handwriting, and failure to notice potential drug/drug interactions, among other reasons. But it greatly increased the amount of work that physicians and support staff had to perform.

Phone messages now compete with portal messages, prior authorization documentation, electronic chart reviews, and more. Oftentimes, I just want to talk to a physician, nurse, or patient without jumping through hoops or navigating communication layers. What I did before, of course, was use the most-direct method, which often wasn’t secure. We’ve all used iMessage, WhatsApp, and our personal cellphones to not only talk about patients but exchange data.

The security of health communications is the reason my hospital invested in a new communications platform that integrates with our EHR. But we’ve found it does so much more. About 80% of my practice time is spent as a consultant. Another physician refers a patient to me; I examine the patient and communicate next steps back to the physician. Through an app, we can use our personal devices to find each other quickly and easily through chat, exchange information or have a discussion, and get back to our day. No more scrolling through my contact list or struggling to find the on-call physician or technician for a particular specialty.

Two-plus years in, we’re still finding new communications uses.

Finding a solution that cuts through the clutter and facilitates fast and easy communications certainly makes my life easier. And it makes patients’ lives better. Faster and more effective communications means care is delivered quicker, treatment plans come together more easily, and patients can go home sooner.

What’s not to like? »

Joshua Tarkoff, M.D., MBA, is medical director of IT at Nicklaus Children’s Health System.
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<tr>
<th>Model</th>
<th>Capacity</th>
<th>Weight</th>
<th>Depth</th>
<th>Height</th>
<th>Color</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>AV-4</td>
<td>4 Cu.Ft.</td>
<td>100 lb.</td>
<td>61.5&quot;</td>
<td>20.75&quot;</td>
<td>Black</td>
<td>$1,299.00</td>
</tr>
<tr>
<td>AV-6</td>
<td>6 Cu.Ft.</td>
<td>105 lb.</td>
<td>61.5&quot;</td>
<td>22.5&quot;</td>
<td>Black</td>
<td>1,499.00</td>
</tr>
<tr>
<td>AV-12</td>
<td>12 Cu.Ft.</td>
<td>130 lb.</td>
<td>61.5&quot;</td>
<td>24.5&quot;</td>
<td>Black</td>
<td>2,831.00</td>
</tr>
</tbody>
</table>

Pharma-Lab Refrigerators
From 15 to 20 Cu.Ft.

<table>
<thead>
<tr>
<th>Model</th>
<th>Capacity</th>
<th>Weight</th>
<th>Depth</th>
<th>Height</th>
<th>Color</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALVRN</td>
<td>15 Cu.Ft.</td>
<td>120 lb.</td>
<td>57.5&quot;</td>
<td>24.75&quot;</td>
<td>Black</td>
<td>2,301.00</td>
</tr>
</tbody>
</table>

Pharma-Lab Freezers
From 16 to 30 Cu.Ft.

<table>
<thead>
<tr>
<th>Model</th>
<th>Capacity</th>
<th>Weight</th>
<th>Depth</th>
<th>Height</th>
<th>Color</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALFRN</td>
<td>16 Cu.Ft.</td>
<td>130 lb.</td>
<td>61.5&quot;</td>
<td>22.5&quot;</td>
<td>Black</td>
<td>2,795.00</td>
</tr>
<tr>
<td>ALRFN</td>
<td>40 Cu.Ft.</td>
<td>220 lb.</td>
<td>61.5&quot;</td>
<td>22.5&quot;</td>
<td>Black</td>
<td>5,219.00</td>
</tr>
</tbody>
</table>

Meets CDC guideline for Covid Vaccine Storage
Adaptive & Visual High/Low temperature alarms
Optimized efficient performance for stable temperature
Eco-friendly natural refrigerants for a greener footprint

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COUPON CODE GETMDD
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Below are a few handy steps for determining the ideal accucold refrigerator size for your site:

1. Estimate the maximum number of doses of promptly-prepared vaccine you will need to store in your refrigerator.

Refrigerator: Add the number of doses on hand (current inventory from your last order form) + 100 doses.

Public Vaccine: Add 100 doses.

Private Practice: Add 100 doses.

Total doses: Add up the total doses:

Doses (small inventory) + 100 doses.

Maximum doses = X 1.36

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Medical Economics.com
3 WAYS TO START IMMEDIATELY INCREASING REVENUE

1 Neuro-Cognitive Testing
- Medicare mandates yearly cognitive assessment
- Takes 10-15 minutes to prep patient, 20 minutes to test
- Analyzes: brain health (EEG), brain processing speed (Evoked Potentials), heart health (EKG), mental health (neuropsychology)
- Reimburses using 6 CPT codes, National Average = $750 - $1000 per test
- Each test is processed into a fully-finished, clinically actionable report
- Easy to understand biomarkers facilitate more informed medical interventions, such as biofeedback

2 ANS Testing
(can be combined with SUDOMOTOR into 1 full system)
- Takes less than 10 minutes to perform, software provides verbal cues
- Tests for autonomic balance, vascular health, physical/mental stress, peripheral nerve health and other critical hidden risk factors
- Reimburses $170/test using 3 CPT codes
- Provides a 1 page summary up to a full 24 page comprehensive report

3 SudoMotor Testing
(can be combined with ANS into 1 full system)
- Takes 3 minutes to analyze a patients’ hands and feet
- Provides a 1 page summary report
- Assesses peripheral nerve health (c-fiber function) and asymmetry between each hand and foot
- Reimburses $130/test (national average)

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ON AIR:
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season-1
Respiratory syncytial virus (RSV) is a common and contagious virus that typically produces mild, cold-like symptoms but can put older adults at risk for severe outcomes.1,2,*

Each year in the US, approximately 177,000 older adults are hospitalized and an estimated 14,000 of them die due to RSV infection.2

*The CDC states that adults at highest risk for severe RSV infection include older adults, especially those 65 years and older, adults with chronic heart or lung disease, and adults with weakened immune systems. Data are limited in assessing the risk of severe outcomes due to RSV infection in adults 60-64 years of age.3,4

CDC=Centers for Disease Control and Prevention; CHF=congestive heart failure; COPD=chronic obstructive pulmonary disease.

References: