THE Sequester Squeeze

Already-fragile practices brace for its effects

PLUS

No pain, no gain: An EHR case study
While there are many diabetes complications, **PAINFUL DPN IS ONE THEY CAN’T IGNORE**

Help manage your patients’ painful Diabetic Peripheral Neuropathy with LYRICA

**ONLY LYRICA IS RECOMMENDED AS LEVEL A by AAN evidence-based guideline for the treatment of painful diabetic neuropathy (PDN)**

“Clinically appropriate, pregabalin should be offered for the treatment of PDN (Level A).”

The medical organizations that developed this guideline (the AAN, the American Association of Neuromuscular and Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation) recognize that specific care decisions are the prerogative of the patient and physician caring for the patient, based on all of the circumstances involved.

For full guideline, visit www.aan.com/guidelines.

Level A: Established as effective, based on at least 2 Class I studies.

Class I level evidence includes a randomized, controlled clinical trial of the intervention of interest with masked or objective outcome assessment, in a representative population, and other specified criteria.

AAN: American Academy of Neurology.

**LYRICA is indicated for the management of neuropathic pain associated with Diabetic Peripheral Neuropathy.**

**Selected safety information:**

LYRICA is contraindicated in patients with known hypersensitivity to pregabalin or any of its other components. Angioedema and hypersensitivity reactions have occurred in patients receiving pregabalin therapy.

There have been postmarketing reports of hypersensitivity in patients shortly after initiation of treatment with LYRICA. Adverse reactions included skin redness, blisters, hives, rash, dyspnea, and wheezing. Discontinue LYRICA immediately in patients with these symptoms.

There have been postmarketing reports of angioedema in patients receiving initial and chronic treatment with LYRICA. Specific symptoms included swelling of the face, mouth (tongue, lips, and gums), and neck (throat and larynx). There were reports of life-threatening angioedema with respiratory compromise requiring emergency treatment. Discontinue LYRICA immediately in patients with these symptoms.

Antiepileptic drugs (AEDs) including LYRICA increase the risk of suicidal thoughts or behavior in patients taking AEDs for any indication. Monitor patients treated with any AED for any indication for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior. Pooled analyses showed clinical trial patients taking an AED had approximately twice the risk of suicidal thoughts or behavior than placebo-treated patients. The estimated incidence rate of suicidal behavior or ideation among 27,683 AED-treated patients was 0.43%, compared to 0.24% among 16,022 placebo-treated patients, representing an increase of approximately one patient for every 530 patients treated with an AED.

The most common adverse reactions across all LYRICA clinical trials are dizziness, somnolence, dry mouth, weight gain, constipation, euphoric mood, balance disorder, increased appetite, and thinking abnormal (primarily difficulty with concentration/attention). Pooled analyses showed clinical trial patients taking an AED had approximately twice the risk of suicidal thoughts or behavior than placebo-treated patients. The estimated incidence rate of suicidal behavior or ideation among 27,683 AED-treated patients was 0.43%, compared to 0.24% among 16,022 placebo-treated patients, representing an increase of approximately one patient for every 530 patients treated with an AED.

Lyrica is indicated for the management of neuropathic pain associated with Diabetic Peripheral Neuropathy.

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The most common adverse reactions across all LYRICA clinical trials are dizziness, somnolence, dry mouth, weight gain, constipation, euphoric mood, balance disorder, increased appetite, and thinking abnormal (primarily difficulty with concentration/attention). Inform patients taking LYRICA that dizziness and somnolence may impact their ability to perform potentially hazardous tasks such as driving or operating complex machinery until they have sufficient experience with LYRICA to determine its effect on cognitive and motor function.

Higher frequency of weight gain and edema was observed in patients taking both LYRICA and thiazolidinedione antidiabetic drugs. Exercise caution when coadministering these drugs. Patients who are taking other drugs associated with angioedema such as angiotensin-converting enzyme inhibitors (ACE inhibitors) may be at increased risk of developing angioedema. Exercise caution when using LYRICA in patients who have had a previous episode of angioedema.
LYRICA® (pregabalin) CAPSULES O/W

BRIEF SUMMARY: For full prescribing information, see package insert.

INDICATIONS AND USAGE
LYRICA is indicated for:
- Management of neuropathic pain associated with diabetic peripheral neuropathy

DOSEAGE AND ADMINISTRATION
LYRICA is given orally with or without food. When discontinuing LYRICA, taper gradually over a minimum of 1 week.

Neuropathic Pain Associated with Diabetic Peripheral Neuropathy:
- Administer in 3 divided daily doses
- Begin dosing at 150 mg/day
- Adjust the dose upward to a maximum of 300 mg/day within 1 week
- Dose should be adjusted for patients with reduced renal function

Patients with Renal Impairment:
- In view of the dose-dependent adverse reactions and since LYRICA is eliminated primarily by renal clearance, adjust the dose in patients with reduced renal function. Base the dose adjustment in patients with renal impairment on creatinine clearance (CLcr), as indicated in Table 1. To use this dosing table, estimate the patient’s CLcr in mL/min by estimating the serum creatinine level (mg/dL) using the Cockcroft and Gault equation:

\[
\text{CLcr} = \frac{140 \times \text{weight (kg)}}{72 \times \text{serum creatinine (mg/dL)}}
\]

For patients undergoing hemodialysis, adjust the pre-dose daily baseline dose in renal failure. In addition to the daily dose adjustment, a supplemental dose should be given immediately following every 4-hour hemodialysis treatment (see Table 1).

Table 1. Pregabalin Dose Adjustment Based on Renal Function

<table>
<thead>
<tr>
<th>Creatinine Clearance (CLcr) (mL/min)</th>
<th>Total Pregabalin Dose (mg/day)</th>
<th>Dose Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥100</td>
<td>150 mg/day</td>
<td>BID (twice a day)</td>
</tr>
<tr>
<td>70–100</td>
<td>100 mg/day</td>
<td>BID</td>
</tr>
<tr>
<td>30–70</td>
<td>75 mg/day</td>
<td>BID</td>
</tr>
<tr>
<td>10–20</td>
<td>50 mg/day</td>
<td>QD</td>
</tr>
<tr>
<td>&lt;10</td>
<td>25 mg/day</td>
<td>QD or BID</td>
</tr>
</tbody>
</table>

Supplementary dose following hemodialysis (mg/day):
- Patients on the 25 mg QD regimen: take one supplemental dose of 25 mg or 50 mg
- Patients on the 50–75 mg QD regimen: take one supplemental dose of 75 mg or 150 mg
- Patients on the 75 mg QD regimen: take one supplemental dose of 100 mg or 150 mg

Patients on the 50–75 mg QD regimen should be given a reduced initial dose for pre-existing renal dysfunction. Patients with moderate to severe cognitive impairment should be given a lower initial dose and a slower titration rate than those without cognitive impairment. Various factors may increase the risk for adverse reactions: impairment of hepatic metabolism in patients shortly after initiation of treatment with LYRICA, Adverse reactions included skin rash, urticaria, pruritus, and angioedema. Discontinue LYRICA immediately in patients with these symptoms. Exercise caution when prescribing LYRICA to patients who have a history of angioedema associated with angiotensin converting enzyme inhibitors (ACE-inhibitors), or other conditions, but the absolute risk differences were similar for the epilepsy and psychiatric indications. Anyone considering the use of LYRICA in this condition, particularly in high-risk individuals, should be aware of the potential increased risk of suicidal thinking and behavior.

In view of dose-dependent adverse reactions and since LYRICA is eliminated primarily by renal clearance, adjust the dose in patients with reduced renal function. Base the dose adjustment in patients with renal impairment on creatinine clearance (CLcr), as indicated in Table 1. To use this dosing table, estimate the patient’s CLcr in mL/min by estimating the serum creatinine level (mg/dL) using the Cockcroft and Gault equation:

\[
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\]

For patients undergoing hemodialysis, adjust the pre-dose daily baseline dose in renal failure. In addition to the daily dose adjustment, a supplemental dose should be given immediately following every 4-hour hemodialysis treatment (see Table 1).
Table 3. Treatment-emergent adverse reaction incidence in controlled trials in neuropathic pain associated with Diabetic Peripheral Neuropathy (events in at least 1% of all LYrica-treated patients and at least numerically more in all LYrica vs placebo groups).

<table>
<thead>
<tr>
<th>Body System</th>
<th>Placebo (n=108)</th>
<th>LYrica 150 mg (n=117)</th>
<th>LYrica 225 mg (n=119)</th>
<th>LYrica 300 mg (n=118)</th>
<th>All LYrica* (n=354)</th>
<th>Placebo* (n=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body as a whole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>4 (4.6)</td>
<td>2 (1.7)</td>
<td>5 (4.2)</td>
<td>7 (6.0)</td>
<td>4.5 (2.6)</td>
<td>5 (4.6)</td>
</tr>
<tr>
<td>Accidental injury</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Back pain</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Constipation</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>3 (3.2)</td>
<td>5 (4.3)</td>
<td>7 (5.8)</td>
<td>8 (6.8)</td>
<td>5.6 (3.6)</td>
<td>5 (4.6)</td>
</tr>
<tr>
<td>Headache</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Heart rate</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Metabolic and nutritional disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight gain</td>
<td>6 (6.9)</td>
<td>9 (7.8)</td>
<td>12 (10.2)</td>
<td>10 (8.6)</td>
<td>8.7 (5.4)</td>
<td>9 (8.4)</td>
</tr>
<tr>
<td>Weight loss</td>
<td>4 (4.6)</td>
<td>4 (3.4)</td>
<td>4 (3.4)</td>
<td>4 (3.4)</td>
<td>3.9 (2.5)</td>
<td>4 (3.7)</td>
</tr>
<tr>
<td>Edema</td>
<td>2 (2.3)</td>
<td>2 (1.7)</td>
<td>2 (1.7)</td>
<td>2 (1.7)</td>
<td>1.9 (1.2)</td>
<td>2 (2.0)</td>
</tr>
<tr>
<td>Neoplasia</td>
<td>6 (9)</td>
<td>9 (12)</td>
<td>12 (16)</td>
<td>10 (13)</td>
<td>11.3 (10.5)</td>
<td>12 (10.9)</td>
</tr>
<tr>
<td>Nervous system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Mood</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Vomitus</td>
<td>1 (1)</td>
<td>2 (1.7)</td>
<td>3 (2.5)</td>
<td>4 (3.3)</td>
<td>2.9 (1.8)</td>
<td>3 (2.8)</td>
</tr>
<tr>
<td>Irritability</td>
<td>3 (3.2)</td>
<td>5 (4.3)</td>
<td>8 (6.5)</td>
<td>8 (6.5)</td>
<td>6.5 (3.8)</td>
<td>5 (4.6)</td>
</tr>
<tr>
<td>Motility</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Respiratory system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>1 (1)</td>
<td>1 (0.9)</td>
<td>1 (0.8)</td>
<td>1 (0.8)</td>
<td>0.8 (0.5)</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Special senses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal vision</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Abnormal smell</td>
<td>1 (1)</td>
<td>2 (1.7)</td>
<td>3 (2.5)</td>
<td>3 (2.5)</td>
<td>2.5 (1.5)</td>
<td>3 (2.8)</td>
</tr>
</tbody>
</table>

**Post-progression:**

*Indicates patients primarily consisted of events related to difficulty with concentration/attention also includes other events related to cognition and language problems and slowed thinking.

**No significant treatment-related adverse events:**

Onset of reactions for Patients in the Clinical Studies of LYrica: Following is a list of treatment-emergent adverse reactions reported in patients treated with LYrica during all clinical trials. The listing does not include those events already listed in the previous tables or tables, those events for which a causal relationship was remote, those events which were noted as serious in nature or those for which the significance and clinical relevance were not apparent.

**Pharmacodynamics:**

Multiple dosing of LYrica was co-administered with oxycodone, ketorolac, or ethyl alcohol. Although no pharmacokinetic interactions were seen, additive effects on cognitive and gross motor functioning were seen when LYrica was co-administered with these drugs.

**Use in Specific Populations:**

**Pregnancy:**

Based on animal studies, the risk of fetal abnormalities and malformations with continued use of pregabalin during pregnancy has been observed in at least 55% of all LYrica-treated patients versus 3% of placebo-treatment. No reports of congenital anomalies have been reported in human infants exposed to pregabalin during pregnancy. In addition, animal studies have not shown any adverse effects on the fetus related to pregabalin exposure during pregnancy. The safety of pregabalin for use during breastfeeding is not known.

**Drug Interactions:**

While pregabalin did not affect the pharmacokinetics of warfarin, no studies have been conducted to examine this combination. Additional studies are needed to further examine the effects of concomitant use of pregabalin with other medications that have a narrow therapeutic index or with medications that may have a significant effect on CYP3A4 metabolism.

**Dosage and Administration:**

The recommended dosages for adults vary based on age and sex. In general, the dosage should be titrated upward in increments of 25 mg to 50 mg/day until therapeutic response is achieved. In patients with renal impairment, dosing should be decreased to maintain plasma drug concentrations within the therapeutic range. The recommended dosages for children are not available.

**Adverse Reactions:**

The most common adverse reactions included somnolence, asthenia, and dysesthesia. Other adverse reactions reported included headache, nausea, constipation, vomiting, diarrhea, and nasopharyngitis.

**Contraindications:**

There is no significant safety and efficacy information for use during pregnancy. Pregabalin is not indicated for use during breastfeeding. A history of drug abuse should be obtained from patients and their families, and consideration should be given to the possibility of drug dependence and the risk of relapse in the patient's history. In addition, the duration of pregabalin therapy must be carefully assessed.

**Warnings and Precautions:**

The prescribing information for pregabalin should be used with caution in patients with a history of failed back surgery syndrome, as there is a possibility of adverse events associated with this condition. The prescribing information should also be used with caution in patients with a history of substance abuse or dependence, as there is a possibility of adverse events associated with this condition. The prescribing information should also be used with caution in patients with a history of seizure disorder, as there is a possibility of adverse events associated with this condition.
MEDICAL ECONOMICS  I APRIL 25, 2013

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Already-fragile practices brace for its effects.

How to absorb the cuts
- Key programs, employment segments affected
- Projected Medicare cutbacks
- Comments from our poll

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INSIDE THE AMBULATORY PRACTICE OF THE FUTURE

Patient engagement is the guiding principle behind the Ambulatory Practice of the Future, which was built to test new business and clinical care models that will redefine the rules of patient engagement. Practice founder David Judge, MD, speaks with Medical Economics about building a care team, adopting technology to improve communication among patients and staff, and what it really means to be patient-centered.

MedicalEconomics.com/future

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—Keith Borglum, CHBC
from the Trenches

Don't Neglect Referrals to Weight Specialists

Regarding your article, "The obesity epidemic" (February 25, 2013): A common complaint of my patients is, "Why didn't my family doctor tell me about you sooner?" It is reasonable to refer to a specialist if everything you've tried isn't working or if the patient has a problem that you'd rather not manage.

Don't think you should refer only "extreme cases" to a specialist. If you have a patient whose heart problem warrants a specialist in your mind, then apply the same logic to a patient with a weight problem.

Thomas Marlowe, MD
CHARLOTTE, NORTH CAROLINA

Focus on Helping Large-Sized Patients

Regarding the article, "The obesity epidemic," the trend to obesity in the United States has leveled off since 1999. The average weight of all developed countries has increased with better nutrition, as has the average height.

Second, although correlations exist between obesity and certain health conditions, your article implies that obesity causes diabetes, cancer, hypertension, and heart disease. The Framingham Risk Score does not use obesity. It uses cholesterol, blood pressure, sex, and age, not body mass index (BMI).

Third, the healthiest BMI is actually 25 to 30. This statistic frequently is ignored. Because of cognitive dissonance, many Americans, including physicians, simply want to believe that thinner is better, because thinner is seen as more attractive. A range of healthy BMI probably extends from 18 to 32, depending on the individual's level of activity, body fat and muscle composition, and genetic background.

Fourth, at least 30% of all people with BMI less than 25 are unhealthy. Being thin does not mean being healthy, just as fat does not mean being "morbid" automatically.

Unfortunately, no good treatments for obesity exist. Only a small percentage of people can lose substantial amounts of weight by calorie restriction and keep it off for 5 years.

Exercising leads to better health, at any size. Quitting smoking and not using mind-altering recreational substances to excess are vital. Most Americans could eat more healthfully. Taking needed medications, reducing stress, having hobbies that are creative and active, keeping regular doctor appointments—these behaviors lead to success in health for patients of all shapes, sizes, cultures, and ethnicities.

Lenny Husen, MD
ANTIOCH, CALIFORNIA

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ACP UNVEILS NEW APP FOR CLINICAL GUIDELINES

Internal medicine physicians and other clinicians now can access evidence-based clinical recommendations from the American College of Physicians (ACP) through a new mobile app.

Available for free for the iPhone, iPad, and Android, the app includes recommendations from ACP’s clinical practice guidelines and guidance statements. Users can access clinical recommendations and rationale, summary tables, algorithms, and high-value care advice for all currently active guidelines in a mobile format designed to be easy to read and interactive.

“The ACP clinical guidelines app continues ACP’s goal to improve healthcare quality by disseminating evidence-based clinical recommendations through innovative Web and mobile applications,” says Amir Qaseem, MD, PhD, MHA, FACP, the ACP’s director of clinical policy. “And the app will help save busy clinicians one of their most valued assets: time.”

PROPOSED FEDERAL BUDGET DRAWS MIXED REVIEWS FROM MEDICAL GROUPS

Medical organizations representing primary care physicians (PCPs) and other doctors offered mixed reactions to President Barack Obama’s 2014 budget proposal.

If approved the budget could reduce federal spending by $400 billion over 10 years through changes to Medicare and other healthcare programs; reform the sustainable growth rate, although a replacement model is not detailed; and reduce funding for graduate medical education (GME), which groups say would threaten the future supply of PCPs in the healthcare system.

The American Academy of Family Physicians (AAFP) says it was pleased with the budget’s commitment to reforms to improve patient health and quality of care as well as address health service costs. Specifically, the AAFP applauds the proposed increase on federal taxes on tobacco and provisions that would improve access for low-income families through Medicaid expansion, support of the Patient-Centered Medical Home (PCMH) model, and assistance to the elderly and disabled through Medicare physician payment reform. The organization also says it is “troubled” that the proposed budget would cut funding for GME for teaching hospitals, however.

The American Medical Association (AMA) expresses similar reactions to the proposed budget. For more details about the budget and medical organizations’ reactions to it, see www.MedicalEconomics.com/2014budget.
Despite news report, reliable data on physician bankruptcies lacking

**WALGREENS SET TO OFFER CHRONIC CARE**

Walgreens is ready to take retail clinics a step further, with a recent announcement that the pharmacy chain will begin offering chronic care in addition to immunizations and acute care.

Walgreens will offer chronic care at its more than 330 Take Care locations, excluding clinics in Missouri, the company says. The chronic care services will include assessment, treatment, and management of conditions such as hypertension, diabetes, high cholesterol, and asthma, in addition to preventive health services.

The company cites physician shortages, the expected flood of newly-insured Americans in 2014 created by the Affordable Care Act, and the growing patronage of retail clinics as reasons for its decision to expand.

"With this service expansion, Take Care clinics now provide the most comprehensive service offering within the retail clinic industry, and can play an even more valuable role in helping patients get, stay, and live well," says Jeffrey Kang, MD, MPH, senior vice president of health and wellness services and solutions for Walgreens.

**IT’S A** scary headline, one that screams for physicians’ attention: "Doctors driven to bankruptcy." A recent CNN.com article told the tale of unfortunate and hardworking physicians, who, through no fault of their own, were being forced to shut down their businesses by familiar health industry bogeymen such as malpractice costs, declining reimbursements, and excessive compliance costs.

"It’s a trend that’s accelerated in recent years, industry experts say, with potentially serious consequences for doctors and patients," the article states.

Facilitated by its accompanying hashtag doctors sparked indignation on Twitter. "Great article by @CNNMoney!" said the American Academy of Family Physicians. "We need fundamental changes in how physicians are paid."

"The physician-practice bankruptcy “problem” makes for a volatile headline and sparks an emotional response. After all, with a supposed looming doctor shortage, doesn’t the United States need all the physicians it can muster?"

The only problem with the article: We have no idea whether its basic premise is true. It’s built on one piece of data from Bobby Guy, co-chairman of the American Bankruptcy Institute’s (ABI) health committee, who told CNN that he noticed eight physician-practice bankruptcy filings in March, which he said is a "very unusual" number.

So how many physician practices filed for bankruptcy in February? What about last March, or March 2011? If physician bankruptcies have "accelerated in recent years," then don’t we need some historical comparison data to verify that statement? You’d think so, but that’s not likely to happen.

"Nobody can say for sure because no official source of physician-practice bankruptcy filings exists," Guy said in a phone interview with Medical Economics.

"The evidence is anecdotal, not statistical," says Guy, who tracks Chapter 11 filings as part of his job. "We tend to watch the trends, and to us that seems high."

Statistics published on the ABI’s Web site break down bankruptcies into broad categories, reporting the numbers by filing location or chapter number, for example. It’s impossible, it seems, to obtain a breakdown by industry.

Guy and his colleagues obtained the March number by combing through individual bankruptcy filings. It’s possible more than eight occurred, but Guy can’t say for sure.

To be clear, Guy is just doing his job, but for CNN it’s another story. Should Guy’s admittedly anecdotal evidence be enough of a foundation for CNN to base a report on?

It certainly seems logical that physicians practices could be filing for bankruptcies more often than they were previously. Reimbursements are down. Some patients are foregoing necessary care. Government-mandated electronic health record systems are expensive. Physician burnout is up, and job satisfaction is down.

"My experience is that there are heavy economic pressures on the medical community, and that is driving a trend of financial distress," Guy said.

But without any solid historical data to back it up, the "physician-practice-bankruptcy-is-accelerating" idea is only a theory that may or may not have any basis in reality.
As budget talks continue, you may well be looking for additional expenses to trim and new sources of practice revenue as a result of the $85 billion in federal spending cuts that went into effect March 1.

FOR PRIMARY CARE PHYSICIANS (PCPs) the most immediate impact of the cuts—known as the sequester—will be a 2% reduction in reimbursements to physicians for Part B Medicare claims. Those cuts include reimbursements to practices that have successfully attested to meaningful use of electronic health record (EHR) systems.

"Many of the practices I see are already running on razor-thin margins, so these cuts are a real concern for them," says Mark Master, CPA, a partner in the healthcare services group of EisnerAmper, an accounting and consulting firm in Jenkintown, Pennsylvania, and a member of the Medical Group Management Association (MGMA). "To take 2% away from their Medicare payments comes right out of doctors' pockets."

That is the case with Patricia Roy, DO, a family practitioner in Muskegon, Michigan, and a member of Medical Economics' editorial board.

"At this point, I don't see changing staffing or hiring, but it will definitely reduce my take-home pay," she says.

The same is true for Sal Volpe, MD, a solo internal medicine practitioner in New York, New York, and Medical Economics editorial board member. "I couldn't say to the people who work for me, 'You're all going to make less money for the next year so I can make [the cuts] back,'" Volpe explains. Moreover, he notes, about half of his practice's gross revenue pays for overhead costs, thus doubling the impact of the cuts. "I'm just going to take the hit and shop a little more intelligently for my family," he says.

Volpe thinks that some practices will deal with the cuts by limiting or eliminating year-end staff bonuses. "Those are easier to manage because you don't promise a fixed amount," he notes.

"This kind of uncertainty may force doctors with large Medicare populations to say, 'Maybe I can't take on more Medicare; maybe I shouldn't hire that extra person because..."
Suggestions for absorbing the Medicare sequester cuts

Apart from cutting your own pay, what steps can you take to make up for lost Medicare revenue?

Here are suggestions from the experts:

- **Reduce non-vital services**
  “You can’t change the direction of the wind, but you can trim your sails,” says Judy Bee, principal with Practice Performance Group in La Jolla, California. Bee, a *Medical Economics* editorial consultant, advises starting by looking at reducing services that won’t affect billing or the quality of patient care, such as appointment-scheduling. “Maybe people will have a harder time getting in to see you, but you want to be sure they will get good care once they do,” she says.

- **Pay attention to detail**
  Bill Lewis, CPA, a partner in the medical industry practice of the accounting and consulting firm CohnReznik LLP, advises his clients to question every product and service their practice purchases. “Is it something you really need for your business, or is it just force of habit that makes you continue buying it?” he says. For example, physicians in group practices could belong to different medical societies and brief each other on the societies’ activities, rather than everyone in the practice belonging (and paying dues to) the same groups. “If you’re a small practice, you really have to pay attention to detail,” he says.

- **Add an ancillary service**
  Yet another option for mitigating the impact of the Medicare cuts is to add an ancillary service for which patients are willing to pay cash, such as weight-loss products, sleep testing, or onabotulinumtoxinA injections.

- **Get the right people in place**
  Practice owners need to be sure staff members have the proper training and temperament for the jobs they are doing, Lewis says. A front-office person may be hardworking and loyal, but those qualities do not always qualify someone to be an office manager, he points out. “You want to make sure your engine is working properly, but if you have the wrong person at the wrong task, you’re not being wise with your dollars,” he says.

- **Change your patient mix**
  Another possible strategy is to reduce the number of non-emergent Medicare patients your practice sees—provided you have enough patients covered by insurance that reimburses at Medicare rates or better. The way to do that, Bee says, is by limiting the number of appointments each day for non-emergent Medicare patients. Alternatively, more care of Medicare patients can be handed off to midlevels. “The doctor makes the diagnosis and says, ‘Here’s the treatment plan,’ and all the follow-up is done by the midlevel, who is a cheaper provider,” she says. “It has the additional advantage of keeping the doctor’s schedule open while still providing good care to the patient.”

**At this point, I don’t see changing staffing or hiring, but it will definitely reduce my take-home pay.”**

Patricia Roy, DO
next year it’ll be another 2% and now it really starts to affect my ability to meet payroll,” says Volpe.

(Because Medicare reimburses for 80% of most claims, the net reduction to doctors’ fee payments will be 2% x 80%, or 1.6%.)

**Mood of frustration, pessimism**

As unwelcome as the Medicare cuts are, most primary care practices probably can absorb them if they are a one-time event. (See “Suggestions for absorbing the Medicare sequester cuts” on page 15.) Unless Congress and the White House can agree on other ways to reduce the nation’s budget deficits, however, the cuts are scheduled to continue through 2021 at an annual pace of 2%, with effects that will be felt throughout the healthcare industry and beyond. (See “Annual impacts of federal Medicare funding cutbacks” and “Top 10 employment segments affected by Medicare funding cuts in 2013” on page 20.)

That prospect, combined with the ever-present possibility of far larger Medicare cuts called for under the sustainable growth rate (SGR) funding formula, creates a mood of frustration and pessimism among many doctors.

“When I meet with our members, they roll their eyes and say they’re tired of what seems like another ‘ask’ and another hit from Medicare every few months,” says Jeffrey Cain, MD, FAAFP, president of the American Academy of Family Physicians. “They see these things as part of what they call ‘the hassle of Medicare.’ Family medicine is not as profitable as other specialties, so when they hear ‘2% here, SGR there, invest in this, start using EHRs,’ they get frustrated with the multiple demands.”

Anders Gilberg, senior vice president for government affairs with the MGMA, says, “It’s the threat of always looking on the horizon and seeing a cliff there. That’s what’s causing our members to make the biggest adjustments in their practices, like holding off investing in new technology or opening satellite offices. It’s a complete erosion in the trust they have in Congress and the government to provide any stability for physicians.”

The fact that the cuts extend to reimbursements for attesting to meaningful
use is another cause of frustration. Meg McElroy, MBA, RHIA, consumer engagement subject matter specialist with the American Health Information Management Association, notes that under the meaningful use regulations, eligible providers who waited until 2013 to start the attestation process already were receiving less in reimbursement than those who started earlier ($39,000 versus $44,000). “Now, on top of that, you’re going to be receiving 2% less. That doesn’t sit well, especially with eligible providers in small- to medium-sized practices who don’t have a cushion to fall back on,” she says. “It’s disheartening.”

Roy adds: “Many smaller practices like mine invested heavily to adopt EHR technology and did so with the promise of a certain payback for achieving meaningful use. To reduce that now is really a dishonorable move.”

Adding to the uncertainty is the possibility that commercial insurers will follow Medicare’s lead and reduce their payments when they renew their contracts with physicians. “Since Medicare tends to be the benchmark for so many of these contracts, it would probably follow that there will be a corresponding impact on the private payers,” says Bill Lewis, CPA, a partner in the medical industry practice of the accounting and consulting firm CohnReznick LLP.
The budget sequester’s impact on key federal health and safety programs, fiscal year 2013

<table>
<thead>
<tr>
<th>Department/program</th>
<th>Base funding (in millions)</th>
<th>Sequestration (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>$577,439</td>
<td>$11,851 (2.0%)</td>
</tr>
<tr>
<td>National Institutes of Health</td>
<td>$31,049</td>
<td>$1,553 (5.0%)</td>
</tr>
<tr>
<td>Administration for Children and Families</td>
<td>$19,689</td>
<td>$982 (4.9%)</td>
</tr>
<tr>
<td>Environmental Protection Agency</td>
<td>$9,418</td>
<td>$472 (5.0%)</td>
</tr>
<tr>
<td>Global Health Programs</td>
<td>$8,218</td>
<td>$411 (5.0%)</td>
</tr>
<tr>
<td>Health Resources and Services Administration</td>
<td>$8,109</td>
<td>$365 (4.5%)</td>
</tr>
<tr>
<td>Supplemental Nutrition for Women, Infants, and Children</td>
<td>$6,660</td>
<td>$333 (5%)</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention</td>
<td>$6,019</td>
<td>$303 (5.03%)</td>
</tr>
<tr>
<td>Indian Health Services</td>
<td>$4,483</td>
<td>$220 (4.9%)</td>
</tr>
<tr>
<td>Food and Drug Administration</td>
<td>$4,168</td>
<td>$209 (5.0%)</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration</td>
<td>$3,368</td>
<td>$168 (4.9%)</td>
</tr>
<tr>
<td>Animal and Plant Health Inspection Service</td>
<td>$1,106</td>
<td>$56 (5.0%)</td>
</tr>
<tr>
<td>Food and Safety Inspection Service</td>
<td>$1,055</td>
<td>$53 (5.0%)</td>
</tr>
<tr>
<td>Prevention and Public Health Fund</td>
<td>$1,000</td>
<td>$51 (.5%)</td>
</tr>
<tr>
<td>Occupational Safety and Health Administration</td>
<td>$568</td>
<td>$28 (4.9%)</td>
</tr>
<tr>
<td>Patient-Centered Outcomes Research Institute</td>
<td>$390</td>
<td>$20 (5.1%)</td>
</tr>
<tr>
<td>Mine Safety and Health Administration</td>
<td>$377</td>
<td>$19 (5.0%)</td>
</tr>
<tr>
<td>Federal Drug Control Program</td>
<td>$341</td>
<td>$17 (4.9%)</td>
</tr>
<tr>
<td>National Highway Traffic Safety Administration</td>
<td>$141</td>
<td>$7 (4.9%)</td>
</tr>
<tr>
<td>Office of Healthy Homes and Lead Hazard Control</td>
<td>$121</td>
<td>$6 (4.9%)</td>
</tr>
<tr>
<td>Office of the National Coordinator for Health Information Technology</td>
<td>$17</td>
<td>$1 (5.8%)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>$683,736</strong></td>
<td><strong>$17,225 (2.52%)</strong></td>
</tr>
</tbody>
</table>

Source: U.S. Office of Budget and Management

**Effects extend beyond physicians**

Physicians are by no means the only ones to feel the effects of the budget sequester. Large swaths of the nation’s healthcare infrastructure, including the Food and Drug Administration, National Institutes of Health, and the Centers for Disease Control and Prevention (CDC), also are seeing their funding reduced. (See “The budget sequester’s impact on key federal health and safety programs, fiscal year 2013,” left.)

It’s still too early to say with certainty how these funding reductions will affect PCPs. It’s noteworthy, however, that the American Public Health Association predicts that reductions in CDC funding will lead to 30,000 fewer children and 20,000 fewer adults receiving immunizations, as well as a decreased ability for the agency to investigate multi-state disease outbreaks.

It’s reasonable to assume that at least some of the resulting treatment burden will fall on PCPs, especially with more people having access to health insurance under the Affordable Care Act.

Funding for programs designed to increase the supply of future physicians, such as the National Health Service Corps, Title VII of the Public Health Service Act (the only federal program providing dollars specifically to academic departments and programs to increase the number of PCPs), and graduate medical education generally, also is being cut. “The cuts are hitting practicing physicians, research that is important to medicine in general, and programs for training physicians, so it’s really impacting the healthcare industry from all angles,” says Ray Quintero, director of government relations for the American Osteopathic Association.

Quintero adds that he sees little prospect of Congress reversing the first round of sequester cuts. Longer-term, however, he holds out hope of greater stability for Medicare funding, particularly with regard to the SGR. He points to the Congressional Budget Office’s recent downward revision—from $243 billion to $138 billion—of its estimated...
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Sequestration

Top 10 employment segments affected by Medicare funding cuts

<table>
<thead>
<tr>
<th>Segment</th>
<th>Negative employment impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>92,984</td>
</tr>
<tr>
<td>Physician, dental, and other health practitioner offices</td>
<td>40,220</td>
</tr>
<tr>
<td>Nursing and residential care facilities</td>
<td>38,115</td>
</tr>
<tr>
<td>Medical and diagnostic labs / other ambulatory services</td>
<td>38,350</td>
</tr>
<tr>
<td>Home healthcare services</td>
<td>25,547</td>
</tr>
<tr>
<td>Real estate establishments</td>
<td>22,705</td>
</tr>
<tr>
<td>Food services and drinking establishments</td>
<td>21,865</td>
</tr>
<tr>
<td>Employment services</td>
<td>15,356</td>
</tr>
<tr>
<td>Wholesale trade businesses</td>
<td>8,424</td>
</tr>
<tr>
<td>Insurance carriers</td>
<td>7,472</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>311,038</strong></td>
</tr>
</tbody>
</table>

Source: Tripp Umbach

Annual impacts of federal Medicare funding cutbacks

<table>
<thead>
<tr>
<th>Year</th>
<th>Funding cuts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$10.7 billion</td>
</tr>
<tr>
<td>2014</td>
<td>$11.2 billion</td>
</tr>
<tr>
<td>2015</td>
<td>$11.6 billion</td>
</tr>
<tr>
<td>2016</td>
<td>$12.5 billion</td>
</tr>
<tr>
<td>2017</td>
<td>$12.9 billion</td>
</tr>
<tr>
<td>2018</td>
<td>$13.5 billion</td>
</tr>
<tr>
<td>2019</td>
<td>$14.5 billion</td>
</tr>
<tr>
<td>2020</td>
<td>$15.5 billion</td>
</tr>
<tr>
<td>2021</td>
<td>$16.4 billion</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$108.1 billion</strong></td>
</tr>
</tbody>
</table>

Source: Tripp Umbach

"IT'S THE THREAT OF ALWAYS LOOKING ON THE HORIZON AND SEEING A CLIFF THERE."

ANDERS GILBERG, SENIOR VICE PRESIDENT, MEDICAL GROUP MANAGEMENT ASSOCIATION

Cost for scrapping the SGR, and the introduction in the House of Representatives of the Medicare Physician Innovation Act of 2013, which would repeal the SGR. In addition, he says, the Energy and Commerce and Ways and Means committees of the U.S. House of Representatives are developing a joint proposal for repealing the SGR and moving Medicare away from the fee-for-service model.

"All these proposals are largely consistent with one another, which means everyone is at least speaking the same language, something we haven’t seen in recent years," he says. "Also, the fact that we’re talking about [the SGR] early in the year, rather than in November or December right before cuts are due to take effect, is a hopeful sign."

"If you’re looking on the horizon and seeing a cliff there, what you see is a cliff," says Anders Gilberg, senior vice president of the Medical Group Management Association. "It’s the threat of always looking on the horizon and seeing a cliff there."
YOU CAN HELP SET EXPECTATIONS ON ELECTRONIC HEALTH RECORDS LIABILITY

By GORDON OWNBY, JD

A TOURIST from Arizona suddenly collapses while visiting a boardwalk in New Jersey. The woman’s friends rush her to a local hospital, but she cannot communicate with the medical personnel. Her companions provide the woman’s identification, but they cannot offer any relevant medical history.

Fortunately, under a national system for shared electronic health records (EHRs) now being developed, the physician uses an online portal that provides access to her new patient’s medical file.

As EHRs move toward a system of national access, questions inevitably arise as to the medical liability implications of having access to all records, all the time.

The benefits of national EHR access are too numerous to keep privacy and security concerns from being resolved. As is often the case, however, the law needs to catch up to the technology. More specifically, courts will have to weigh how to treat healthcare providers who have access to data unlike anything previously available.

Unfortunately, medical records sometimes contain lab values and x-rays that were not acted on, even by the doctors who ordered them. Will our New Jersey physician be faulted for not following up on those items herself? Even with perfectly maintained files, what kind of duty will be imposed on a clinician when a mass of raw information from primary care practitioners, specialists, clinics, and other sources is imbedded many screens deep for a patient who is a complete stranger?

Ultimately, the law—and the medical profession itself—will have to answer these and similar questions so that a national EHR system can achieve its full potential to save lives while protecting providers from “gotcha” litigation. Fortunately, ways exist for both—plus technology itself—to move us forward.

In the law, the fundamental principle of duty requires all persons to use ordinary care to prevent others from being injured as a result of their conduct. Any departure from this principle requires balancing certain considerations. Among those factors are the burdens on a defendant and the consequences to the community of imposing a duty.

When a national EHR system emerges, you will need to be confident in your decisions as you navigate through data collected over vast expanses of time and geography. And communities will need to decide whether a more realistic standard exists than requiring physicians to have absolute command of even the most minute entries in these new super-records.

You and your fellow physicians must help the courts reach those destinations through ongoing dialogue and other activities. It will be easy to blame attorneys or the courts if a national system creates a new level of litigation risk, but medical professional liability trials are not lost on the testimony of attorneys. That’s not how it works: Jurors can find against a physician for professional negligence only if another physician says they should.

With a national EHR system, you can seize the opportunity to help establish the appropriate standard of care, one that opens up a new era of patient care while also setting reasonable parameters on what a healthcare provider should be responsible for when an errant entry lurks in the medical file.

Welcome medical record technology as warmly as computerized imaging and pulse oximetry. In fact, a primary benefit of EHRs is not merely the display of information, but also the building of systems of alerts and prompts so that orphaned lab reports and x-rays cannot go unaddressed by the appropriate care providers.

Ultimately, avoiding litigation stemming from shared medical records will take contributions from the law, medicine, and technology itself.

With all three forces going in the right direction, chances will be excellent for our traveler’s safe return home.

The author is general counsel for the Cooperative of American Physicians Inc. Send your primary care-related health law questions to medec@advanstar.com.
Operations

6 steps you can take to remain independent—for now

Evolution is necessary, but it is still possible to survive in solo or small practice if that is your wish

by LISA ZAMOSKY

HIGHLIGHTS
  01 The trend of hospitals acquiring physician practices will cool down, but it will not go away.
  02 The impulse to stay independent, regardless of market trends, is still strong among a significant number of doctors in practice today.
  03 To remain truly independent in the future, primary care practices will need to be set up as medical homes or using some other model that rewards coordinated and comprehensive care.

If Marcus Welby, MD, were in business today, he might have sold his medical practice to the local hospital.

PRACTICING SOLO, or even in very small groups, is becoming an increasingly difficult —although possible—proposition for many family and internal medicine physicians.

Growing regulatory pressures, privacy rules, the burdens of billing and collections, steep investments to incorporate electronic health record (EHR) systems, and onerous requirements of data collection are all difficult to manage on one’s own. These forces, coupled with declining revenues, are causing more doctors in small practices to consider employment over independence.

“What you’re seeing largely is that, as insurers continue to underpay providers, providers have no choice but to go into the arms of someone with more money,” says Joseph Valenti, MD, board member of the nonprofit Physicians Foundation. “Physicians are being placed into an economic situation which is untenable.”

Given that reality, it’s little surprise that a recent survey conducted by the healthcare staffing firm Jackson Healthcare found that not only are hospital acquisitions of physician practices up (52% of hospitals plan to acquire practices in 2013 as compared with 44% in 2012), the majority of those deals—70%, in fact—are initiated by doctors looking to sell.

“We expected hospitals to be acquiring internal medicine and primary care practices, most probably, to develop [accountable care organization (ACOs)]. That’s what we assumed. However, we’re finding that it’s more opportunistic than strategic at
this point,” says Sheri Sorrell, market research manager with Jackson Healthcare. “Physicians are knocking on the door, and hospitals seem to be jumping at the opportunity.”

That doesn’t surprise American College of Physicians President David Bronson, MD, who says it makes perfect sense for doctors to approach their local hospitals or to listen when hospitals approach them. These days, doctors in private practices “are under more and more financial strain and don’t have the capital to invest in things that would help them,” he says.

Although recent acquisitions predominantly are about opportunity, hospitals also cite other reasons for the trend, the Jackson Healthcare survey finds:

- 58% of hospitals are scooping up physician practices to build a competitive advantage;
- 57% say practice acquisition is a doctor recruitment strategy;
- 55% say they want to maintain a competitive advantage; and
- 30% are acquiring practices as part of an ACO formation strategy.

CHARACTERISTICS OF THE SALE

Given the Affordable Care Act’s (ACA’s) emphasis on primary care, it’s not surprising to see that among the practices most desired by hospitals are those focused on general internal medicine and family medicine (see the tables on pages 30 and 31). In time, however, that scenario is likely to change.

According to Lou Goodman, PhD, president of the Physicians Foundation, several specialties, including colorectal surgery, ob/gyn, plastic surgery, anesthesiology, and radiology, thus far have been able to successfully maintain their independence. But in time, he adds, “specialists will be at the mercy of the hospitals. So the trend is [for doctors] to group together and get as large as they can.”

Another interesting aspect to the current acquisition trend is that selling seems to make the most sense for physicians who have been in business for a long time. “A lot of the older doctors are saying, ‘I can’t deal with it—EHR, administration, everything else. I think I’ll sell,’” Sorrell says.

Generally, she says, older doctors are finding compliance with the health reform law to be much more difficult than they anticipated—and a lot more expensive. And, of course, longer-practicing physicians are most likely to have well-established practices, which will be of greater value to hospitals.

But a generational mind-set also is at play here, experts say. Newer doctors—those in their 40s and younger—tend to be much more comfortable with the idea of employment than their older colleagues.

“We find that physicians under 40 are, by and large, employed,” Bronson says.

One reason for that situation is the high cost of medical education. “With medical students coming out [of school] with $300,000 of debt per individual, and then marrying another medical student whose story is the same...they’re in a financial situation where they’re not able to capitalize a practice by themselves,” Bronson says.

Industry surveys also indicate that newer doctors want to be in a system that offers health insurance coverage and doesn’t require them to put in the same hours as was once expected of physicians. “They want to raise their families. For them, employment is attractive,” Bronson says.

The Physicians Foundation has found the same thing in its surveys of doctors. Among the newer set, Goodman says, “the last choice is solo independent practice, which up until the last decade was the number one choice for doctors.”

WILL THE TREND CONTINUE?

If trends continue the way they have been, more than 75% of newly hired physicians will be hospital employees within the next few years, according to a survey conducted last year by the physician search and consulting firm Merritt Hawkins.

The question is, can this spree of physician practice purchases continue?

“It will cool down, but it won’t go away,” Bronson says. “It’s not going to do what it did in the 1990s, where everybody bought everything and then they sold everything,” he adds.

Things are different this time around because market forces, coupled with provisions of the ACA, are forcing more fundamental changes, including clinical integration models and a greater focus on population health. Hospitals may become more selective over time, however, weeding out those practices that are less efficient.
What is the future of independent small and solo practices in primary care?

**COMMENTS**

- "Not looking good under Obama care! Too many taxes passed on for new equipment."
- "Surprised they have survived this long."
- "They're the backbone of medicine to us all!"
- "The control of overhead and provider lifestyle is best accomplished by well-run independents; however, it takes entrepreneurial guts and attention to details. I suspect it pays better, too, at least in my experience (did both)."
- "Primary care is a must. Before specialists, they are the first physicians in society, although it so sad that they are looked down on in the United States. It is all about who makes the most money. They forgot the basic medicine."
- "ICD10 will cost a solo physician $80,000. If ObamaCare doesn’t break me by then, ICD10 certainly will. I’m just glad that I am nearer the end of my career than at the beginning."
- "I’m leaving private solo practice after 10 years. My business is successful despite many bumps in the road. I just can’t see myself staying in medicine for much longer where the responsibility for the patient’s illness is placed squarely and only on the physician with no responsibility to fall on the patient or the insurance companies. I don’t see solo or small groups making it unless they want to sell supplements or some ancillary service. It’s sad, because I think the kind of medicine I practice is really what patients want: personalized service that is available, real, and interactive."

**Q** What do you think the future holds for small and independent solo practices in primary care? *Comment today at https://www.facebook.com/questions/613846655310674*

To view the poll and other responses, visit https://www.facebook.com/questions/613846655310674
Valenti also points to a tendency on the part of hospitals to buy practices that they feel very little commitment toward, creating a high degree of churn in many markets. “One of the trends we’re going to start seeing is all these doctors finding out that it’s not as great as they thought and leaving the hospitals and going back out [to private practice].”

**STAYING SOMEWHAT SOLO**

The impulse to stay independent, regardless of market trends, is still strong among a significant number of doctors in practice today. A survey of more than 5,000 physicians conducted last year by malpractice insurer The Doctors Company found that 56% of respondents believed they were unlikely to change practice models over the next 5 years.

Regardless, it’s clear many will continue to feel the pressure to partner. “Physicians are being forced to look for ancillary sources of income because they just can’t make it on their practices anymore. That’s why you saw physician-owned hospitals open. And then the moratorium came out and made those illegal,” Valenti says.

Still, some options are available to doctors interested in remaining independent in today’s changing environment:

- **Focus on value.** According to Bronson, it’s important for doctors to look for opportunities to provide higher-value care through value-based purchasing approaches, such as ACOs and Patient-Centered Medical Homes. “To do that requires practicing in a clinically integrated system that’s not necessarily financially integrated,” Bronson says. “These clinical integration models can help doctors both improve quality and, hopefully, reward them financially so that they are in a more viable situation.”

- **Gather together.** It’s becoming much more difficult for a very small family or internal medicine practice to survive in many markets today. But physicians who shudder at the thought of selling their practices to become employees should at least look to partner with other practices. This strategy can be a way of increasing efficiencies, lowering overhead, and increasing negotiating power for higher reimbursement.

- **Take control.** “What I would like to see, if we’re going to have consolidation, is that these consolidated groups at least be physician-led and physician-driven,” Valenti says.

  And just that sort of trend is under way, according to Sorrell. “Physician groups are trumping hospitals by developing their own ACOs and then pitting one hospital against another and saying, ‘Okay, who wants to play?’” she says.

- **Explore new models.** Newer medical models, including concierge and micropractices, are working for a small minority of physicians, experts say, although currently they don’t seem to be a remedy for what ails the masses. “Those are experiments right now, and they are interesting concepts, but there is very little of that actually going on at the moment,” Goodman says.

- **Choose carefully.** If you do decide to sell your practice to a hospital, carefully evaluate your purchaser. If possible, avoid joining a hospital with a culture that is going to dictate how you practice medicine.

  “You want to be able to add value to the system so that you are a partner with the hospital, even as you’re employed,” Bronson advises.

- **Look for experience.** Talk with others in the community to assess what kind of experience the hospital has with employed doctors. What’s it like for other physicians working in that environment?

  “You’re going to find places that do it wonderfully well, and you’re going to find places that are very inexperienced and haven’t figured it out yet and make some mistakes,” Bronson says. Learn ahead of time, if possible, which one you’re dealing with.

**A GLIMPSE INTO THE FUTURE**

Will the market be full of independent primary care physicians in the years to come? Generally, the experts think not.

“Over the next 20 years, I would predict that we’re going to see a substantial decline in the truly independent physicians,” Bronson predicts.

As that decline occurs, however, both Valenti and Goodman see unintended consequences associated with widespread consolidation.
Practice setting trends

Healthcare search and consulting firm Merritt Hawkins, part of AMN Healthcare, reviewed the firms’ permanent physician assignments to determine the types of medical settings into which physicians are being recruited. Family and general internal medicine physicians remain the most-sought doctors by medical groups, hospitals, and other healthcare organizations. Practice arrangements are changing, however.

**RECRUITING FOR SOLO PRACTICES**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent of total</th>
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<tbody>
<tr>
<td>Family practice</td>
<td>54</td>
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<tr>
<td>Internal medicine, general</td>
<td>26</td>
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<td>Obstetrics/gynecology</td>
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<tr>
<td>Cardiology</td>
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<td>Primary care</td>
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<td>General surgery</td>
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<td>Urology</td>
<td>10</td>
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<tr>
<td>Hospitalist and rheumatology</td>
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<tr>
<td>Gastroenterology, Nurse practitioner, Oncology, Orthopedic surgery, Otolaryngology, Pediatrics, General</td>
<td>6*</td>
</tr>
<tr>
<td>Emergency medicine, Endocrinology, Diabetes and metabolism, Neurology</td>
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<tr>
<td>Neurosurgery, Physical medicine and rehabilitation, Psychiatry (adult), Pulmonary medicine</td>
<td>4*</td>
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<tr>
<td>Allergy and immunology, Cardiopulmonary surgery, Infectious diseases, Maternal and fetal medicine, Nephrology, Occupational medicine, Pathology, Pediatrics, Subspecialty, Radiation oncoLOGY, Radiology, Vascular surgery</td>
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*The percentage represents each specialty individually, not as a group. For example, gastroenterology = 6% and nurse practitioner = 6%.

**RECRUITING FOR HOSPITAL EMPLOYMENT**

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**PRACTICE ACQUISITION TRENDS**

Staffing firm Jackson Healthcare surveyed hospital chief executive officers, administrators, physician recruiters, chief operating officers and other leaders to determine their actual and planned recruiting as well as the thinking behind it.

**2012 acquisitions by specialty (actual)**

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<th>Specialty</th>
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</table>

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**“Doctors and the health insurance companies seem to be fairly aligned on a lot of issues right now in that if physicians remain independent, the insurance business stays whole. If physicians don’t stay independent and become employed by institutions, those institutions will become so vertically integrated that they will be able to self-insure and write their own insurance,” Goodman says.

That’s something to watch as markets shift around the country.

Still, Goodman acknowledges, true independent practice, if not set up as a medical home or some other model that rewards coordinated and comprehensive care, is just not going to be possible going forward. [25]
**2013 acquisitions by specialty (planned)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent of total</th>
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</thead>
<tbody>
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<tr>
<td>Family practice</td>
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<tr>
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<td>22*</td>
</tr>
<tr>
<td>Primary care</td>
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</tr>
<tr>
<td>Obstetrics/gynecology, Oncology</td>
<td>7*</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>6</td>
</tr>
<tr>
<td>Neurology, Nurse practitioner, Pulmonary medicine</td>
<td>5*</td>
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<tr>
<td>Ambulatory care, Hospitalist, Infectious disease, Pediatrics, General</td>
<td>4*</td>
</tr>
<tr>
<td>Cardiotoracic surgery, Neurosurgery, Rheumatology, Endocrinology, Diabetes and metabolism, Geriatric medicine, Orthopedic (non-surgical), Pain medicine, Radiation oncology, Trauma, Vascular surgery</td>
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<tr>
<td>Anesthesiology, Bariatrics, Emergency medicine, Ophthalmology, Plastic surgery, Psychiatry (adult)</td>
<td>2*</td>
</tr>
<tr>
<td>Colon and rectal surgery, Critical care medicine, Dermatology, Hematology, Maternal and fetal medicine, Nephrology, Occupational medicine, Podiatry, Radiology, Sleep medicine, Sports medicine</td>
<td>1*</td>
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</tbody>
</table>

*The percentage represents each listed specialty individually, not as a group. For example, Cardiology=10% and Orthopedic surgery=10%.

<table>
<thead>
<tr>
<th>Reasons for practice acquisition</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Physicians approach hospital/seek to sell their practices</td>
<td>70%</td>
</tr>
<tr>
<td>Build a competitive advantage</td>
<td>58%</td>
</tr>
<tr>
<td>Part of a physician recruitment strategy</td>
<td>57%</td>
</tr>
<tr>
<td>Maintain a competitive advantage</td>
<td>55%</td>
</tr>
<tr>
<td>Accountable care organization formation</td>
<td>30%</td>
</tr>
<tr>
<td>Improve patient safety</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: "Trend Watch: Physician Practice Acquisitions," Jackson Healthcare

LOU GOODMAN, PHD, PRESIDENT, PHYSICIANS FOUNDATION

IF PHYSICIANS DON’T STAY INDEPENDENT AND BECOME EMPLOYED BY INSTITUTIONS, THOSE INSTITUTIONS WILL BECOME SO VERTICALLY INTEGRATED THAT THEY WILL BE ABLE TO SELF-INSURE AND WRITE THEIR OWN INSURANCE.”

MedicalEconomics.com
RACs REVIEWING POS CODING FOR DOCTOR SERVICES IN AN OUTPATIENT SETTING

We have an office that is part of a hospital. We perform surgical procedures in the office and have been receiving denials for some of our claims. How do we bill these services and get paid appropriately for our work?

Through data analysis (automated review) by the RACs, an outpatient claim is identified reporting the same surgical Current Procedural Terminology (CPT) code for the same patient and same date of service as a professional claim with a reported POS 11. To account for the increased expense that doctors incur by performing services in their offices, Medicare Part B reimburses physicians at a higher rate for surgical procedures performed in their offices.

When doctors perform these services in facility settings (for instance, outpatient facilities), Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate. An improper payment exists when physicians bill these services with an incorrect POS based on the setting in which the services were rendered.

Reviewing surgical CPT codes (10000-60000), RACs are reviewing all surgical Current Procedural Terminology codes. Review your billing practices, paying special attention to POS coding, and ensure that your billing staff is using the correct POS code on professional claims to specify the entity where services were rendered.

The answer to this question was provided by Renee Stantz, a billing and coding consultant for VEI Consulting Services, Indianapolis, Indiana. Send your primary care-related coding questions to medec@advanstar.com.
Circulation education

Stressing smoking cessation, physical activity, portion control, and blood pressure management can help patients with multiple health issues

by BETH THOMAS HERTZ

Diseases of the circulatory system are not just the domain of specialists. The 2010 National Ambulatory Medical Care Survey found that family physicians have more visits for circulatory problems (35% of visits) than cardiologists (19%) in the United States.

CIRCULATORY SYSTEM diseases accounted for about 7,500 office visits a year out of a little more than 1 million in the survey, which is a nationally representative sample survey of visits to nonfederal office-based patient-care physicians, excluding anesthesiologists, radiologists, and pathologists.

Circulatory system disorders such as heart disease and stroke have been the leading causes of death and major causes of disability in the United States for almost a century, even as mortality rates decline. They account for more than $200 billion in annual costs in the healthcare system and are the cause of more than one-third of the deaths in those aged at least 65 years. Also, circulatory disorders often signal other health problems.

Many circulatory problems can be improved with better lifestyle choices, however. As the U.S. healthcare system moves from volume-based to value-based incentives, primary care physicians (PCPs) and others have the opportunity to make major improvements in their patient outcomes by redoubling efforts to counsel patients to adopt good health habits at any age.
YOUR TOP ALLY: THE PATIENT

According to the American Heart Association, a physician's most valuable ally in stroke treatment and prevention is the patient.

Harlan M. Krumholz, MD, an internationally recognized heart disease specialist, believes that PCPs have a pivotal role in providing front-line care that can help patients lower their risk factors for circulatory system diseases, with smoking at the top of the list.

Krumholz is the Harold H. Hines Jr. Professor of Medicine (cardiology) and professor of investigative medicine and of public health (health policy) at the Yale University School of Medicine. He is also director of Yale-New Haven Hospital Center for Outcomes Research and Evaluation. He has authored more than 250 journal articles and chapters on cardiovascular care and serves on many national committees focused on improving the care of patients with heart disease.

"Every appointment needs to be seen as an opportunity to encourage and educate patients to stop smoking," he says. "Too often, this gets pushed aside by fancy risk assessments or lipid tests, but nothing beats making education a priority."

Education should not be limited to smoking cessation, however. Patients need to be informed about the importance of physical activity, meal portion control, blood pressure management, and more, he says.

"You need to let them know what they can do for themselves to improve their health without medications," he says. "Anything they can do to avoid having to take medication is worth it. Pills seem like a simple and easy answer, but all have risks and costs associated with them, for the patient and for society."

Helping a patient make significant lifestyle changes is powerful, he stresses. It offers the possibility of a cure that has no side effects and the opportunity to avoid many other problems, such as hypertension or osteoarthritis. "We just don't have enough respect for the power of lifestyle interventions," he says.

TIME CONSTRAINTS

With PCPs being pressed to see more patients than ever, taking the time to deliver lifestyle coaching can seem impossible. Krumholz suggests, however, that physicians use whatever time they do have in each visit to push the message. Even 20 seconds is worth it, he says.

"Patients hear you, even if it doesn't seem like it," he says. "Offer positive reinforcement of the benefits, and one day they will be ready to make changes."

Having a practice that is a medical home has helped Yul Ejnes, MD, immediate past chairman of the American College of Physicians Board of Regents and a practicing internist in Cranston, Rhode Island, reach out to patients with high-risk factors.

"Part of the solution is to use the clinical staff more efficiently," Ejnes says. "It does not all have to be on the doctor. There is not enough time in the exam room. At least some screening can be done by the staff, and the physician can train them to deliver a consistent message about these issues."

The heart association, the American Stroke Association, and many other organizations also offer a wide range of patient information, tools, and resources online. Although his office has a nurse care manager who can work closely with patients to schedule follow-up appointments for things such as a smoking cessation regimen, he says that even medical assistants can ask about smoking status, note excess weight or blood pressure readings, and give relevant printed materials to patients to take home and think about.

"Sometimes the best thing doctors can do is get out of the way and let the staff help," Ejnes says. "It's not something that only we can do."

Although some insurers now reimburse practices for the time spent on lifestyle education, even practices that are not compensated for it can make it at least somewhat profitable by identifying patients who could benefit from such services—possibly through an electronic health record system—and contacting them later to see how they are doing and encourage them to come back for a followup.

"Sometimes it is useful to uncouple some activities from a visit. Normally, if the patient doesn't come back in, nothing happens," he says.

The extra visits generated by such follow-up can be profitable, and they can help improve your scores on performance measures, which will be increasingly valuable in the future.
AAFP programs

The American Academy of Family Physicians (AAFP) offers several programs to help physicians encourage wellness in the realm of circulatory disorders:

**“ASK AND ACT”**

The AAFP’s tobacco cessation program “Ask and Act” encourages family physicians to ask all patients about tobacco use, then to act to help them quit.

According to the AAFP, strong evidence exists that advice from a healthcare professional can more than double smoking cessation success rates and that patients are more satisfied with their healthcare if their primary care provider offers smoking cessation interventions—even if a patient is not ready to quit.

Resources on the AAFP Web site (www.aafp.org/online/en/home/clinical/publichealth/tobacco.html) are designed to make your interventions with your tobacco-using patients more effective. Information on maximizing billing for preventive services also is included, as well as many links to additional resources.

Materials to encourage patients to quit smoking, including posters, brochures, and pins encouraging them to ask for help, are offered for purchase. One example is packets of “prescription” pads that contain brief, specific patient tips on what to do before, during, and after their quit dates, so patients know exactly what steps to take as they go through their smoking cessation.

**AMERICANS IN MOTION—HEALTHY INTERVENTIONS**

Americans In Motion—Healthy Interventions (AIM-HI) is an AAFP initiative designed to improve the health of patients through a multifaceted fitness program addressing physical activity, nutrition, and emotional well-being in the individual, family, and community.

AIM-HI goals include encouraging family physicians to be fitness role models, improving family physicians’ ability to positively affect the fitness of their patients, and enhancing awareness of the family physicians’ unique ability to promote fitness within their communities.

AIM-HI presents fitness—physical activity, nutrition, and emotional well-being—as “the treatment of choice” for prevention and management of many chronic conditions. AIM-HI helps family medicine practices create a fitness focus through implementation of these critical strategies:

- raising awareness among clinicians and office staff regarding their own personal fitness,
- creating an office environment that is conducive to integrating AIM-HI concepts into everyday office routines, and
- using the AIM-HI philosophy and tools to help patients improve their fitness.

For more information, visit www.aafp.org/online/en/home/clinical/publichealth/aim/about.html.
PERSISTENCE PAYS OFF
Both experts agree that although PCPs already know the value of counseling patients to help them make healthier choices, it is essential that they do not get discouraged if patients do not respond right away to their encouragement to stop smoking or take other steps.

“Many won’t act on your advice, but there are enough success stories to show us that repetitive messaging is effective,” Krumholz says. “Patients hear you, and your work really does pay off in the end.”

Don’t view patients’ unsuccessful attempts at change as failures, Ejnes adds. Stay positive and open-minded.

“Reassure patients that many people do not succeed on their first attempt and that we can learn from what didn’t work and change our approach next time,” he says. “Scolding them is not terribly effective. Be positive and productive.”

Another potential benefit of continuously repeating the message about healthier choices is that if you can change one patient’s lifestyle choices, it can have a ripple effect on their social networks. Some of their friends will be influenced to make changes, a trend that is beneficial to the community far beyond your actual patient base, Krumholz says.

WORKING WITH SPECIALISTS
Another aspect of improving circulatory health and the costs associated with it is not only your ability to know when to refer to a specialist but also how to manage that referral for maximum outcomes.

“Care coordination is something we need to do better,” Ejnes says. “If a patient is seeing a [PCP] and a cardiologist, who is checking their lipids and managing their cholesterol?”

When you do refer a patient to a specialist, make communication a priority so that your patient’s efforts at improving his or her health are maximized.

Circulatory disease demographics
The 2011 National Health Interview Survey, a multipurpose health survey conducted by the Centers for Disease Control and Prevention’s National Center for Health Statistics, provides insight into which patients are most likely to present with circulatory problems.

It found that 11% of adults aged at least 18 years had ever been told by a doctor or other health professional that they had heart disease, 6% had never been told they had coronary heart disease, 24% had been told on two or more visits that they had hypertension, and 3% had ever been told they had experienced a stroke.

Men were more likely than women to have ever been told they had coronary heart disease, but the prevalence of stroke in men and women was similar.

The survey found a positive relationship between age and the presence of heart disease (including coronary heart disease), hypertension, and stroke: As age increased, the percentages of adults with these conditions also increased.

Being educated mattered, but so did poverty. As educational levels increased, the percentages of adults with coronary heart disease, hypertension, and stroke decreased.

Adults in families that were poor or near poor were more likely to have ever been told they had these types of conditions than were adults in families that were not poor.
The motivational interview

The American Heart Association recommends physicians use the following script of five Rs when interacting with patients who are not ready to quit smoking:

**RELEVANCE**
Personalize why quitting to relevant to them, such as the health benefits they will gain.

**ROADBLOCKS**
Ask the patient what are his or her barriers to quitting. Is the patient afraid of weight gain? Depression? Withdrawal symptoms?

**RISKS**
Ask the patient to identify the negative consequences of tobacco use, such as stroke, heart attack, or shortness of breath.

**REWARD**
Ask the patient to identify the rewards of stopping smoking, such as saving money or setting a good example for their children.

**REPEITION**
Repeat these steps at each appointment. Remember that nearly half of all smokers try to quit each year, and most will make several attempts before they succeed.

Preventing death and disability from cardiovascular disease

Cardiovascular disease (CVD) is the number one and most costly killer in the United States and a major cause of disability. It cost the United States a projected $503 billion in medical expenses (direct costs) and lost productivity (indirect costs) in 2010.

According to the Centers for Disease Control and Prevention Heart Disease and Stroke Prevention Program, the past 50 years have seen significant progress in the battle against heart disease, stroke, and other forms of CVD. According to the National Institutes of Health, 1.6 million lives have been saved since 1977 that otherwise would have been lost to heart disease and stroke, and other forms of CVD. According to the National Institutes of Health, 1.6 million lives have been saved since 1977 that otherwise would have been lost to heart disease and stroke. An estimated 44% of the decrease in heart disease deaths from 1980 to 2000 was a result of prevention through the reduction of risk factors.

According to the American Heart Association, avoiding key risk factors and receiving early diagnosis and correct treatment are essential to combating heart disease and stroke. Not smoking, maintaining a healthy weight, and controlling blood sugar, blood pressure, and cholesterol may add 10 years of life.

**OTHER FACTS:**
- An estimated 47% of U.S. adults at least 20 years have total cholesterol levels of 200 mg/dl or higher. A 10% decrease in these levels population-wide may result in about a 30% cut in the incidence of coronary heart disease.
- One in three U.S. adults has high blood pressure. About 69% of people who have a first heart attack, 77% who have a first stroke, and 74% with congestive heart failure have blood pressure above 140/90 mm Hg.
- Only 27% of respondents in a 2005 study knew heart attack signs and symptoms and would call 911 first if someone were having a heart attack or stroke.
- People free of risk factors have lower healthcare costs and are far less likely to develop CVD.

After 2 decades of progress, however, the percentage of Americans without major heart disease risk factors is dropping and now stands at less than 10%.

“AT LEAST SOME SCREENING CAN BE DONE BY THE STAFF, AND THE PHYSICIAN CAN TRAIN THEM TO DELIVER A CONSISTENT MESSAGE ABOUT THESE ISSUES.”

YUL EJNES, MD
3 STEPS TO CONTROLLING STAFF COSTS

by KEITH BORGLOM, CHBC

After provider compensation, costs for support staff are the biggest expense of running a medical practice. Even with good practice management, you and your practice manager may feel that you never can get staffing levels just right, which is understandable. Too many variables are involved to achieve perfection.

BECAUSE WORK generally expands to fit the time available, excess staffing costs can result from employees being added during periods of high load—during flu season, or when converting to open-access scheduling, for example. Staff members then might be permanently retained even after work patterns change, seasonal impacts end, or short-term projects are completed.

On the other hand, understaffing may reduce costs over the short term, but it usually increases the emotional costs of physician stress and staff complaints of overwork, and it can reduce your efficiency to the point where costs increase as a percentage of collections.

Here are three steps to determining the appropriate staffing balance for your practice.

Establish a budget. One of the solutions to finding the right staffing balance is to establish a staffing budget. The first step to doing so is to look at benchmark data for practices that are similar to yours. The two best sources of staffing data:

- for small and solo practices— the National Society of Certified Healthcare Business Consultants (NSCHBC) Statistics Report for small and solo practices, and
- for large and multispecialty practices—the Medical Group Management Association Costs Survey.

Both organizations offer sample reports online, at www.nschbc.org and www.mgma.com, respectively.

According to the NSCHBC, median staffing for solo and small primary care practices is three to four full-time equivalent support staff per doctor, presuming no nonphysician providers or ancillary services and approximately 20 to 25 patient office visits per day. The budget for this level of staffing typically approaches 20 to 24% of gross collections.

Adjust for your practice’s circumstances. The next step in determining the proper staff size is to adjust the benchmarks you find to account for the particular circumstances of your practice, such as staff productivity, payer mix, use of quality measures, and local wage levels. An older physician whose patients have aged with him or her will have different staffing needs than a newer doctor with a younger patient mix.

It also is important to consider the skill level of staff members. We all have observed those exceptional people who seem to effortlessly do twice as much work as their colleagues.

Once you have tailored the benchmarks to your circumstances, you will have a custom tool that you can use to evaluate staff costs and can easily update to compare with the national surveys. For example, if the surveys show that costs have increased 2% in a particular year, then you can apply that adjustment to your custom benchmark.

Obtain input from staff. The final step in the process is to discuss your findings with your staff members and solicit their input for staying within budget, then review the data monthly. First, all should read the book The One Minute Manager by Kenneth Blanchard, PhD, and Spencer Johnson, MD.

The bottom line to investing in budgeting, just as it is in investing in other good practice-management behavior, is a flowing, more profitable, and less stressful practice.

The author is a medical practice management consultant in Santa Rosa, California, and a Medical Economics editorial consultant. Send your practice finance-related questions to medec@advanstar.com.
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No pain, no gain

_Beautiful Economics_ EHR Best Practices Study leader talks about his EHR implementation and vendor switch and shares tips for success

_by DANIEL R. VERDON, Group Editor, Primary Care_

It was Friday—a morning that was the culmination of months of planning for the office-based physician and his staff of five employees.

For DR. George G. Ellis Jr., MD, who owns a busy solo internal medicine practice in Boardman, Ohio, this day was going to be challenging. He knew it, and so did his staff. Hundreds of hours had been invested in tutorials, and thousands of dollars in computer hardware, set up, logistics, health information technology (HIT) support, system preparation, connectivity, and readying for months of detailed patient data entry.

For Ellis, it was his “go-live” day. It’s a day that is about as welcomed in a physician’s practice as black Friday to a stockbroker. There’s going to be a downturn in productivity, Ellis says, and you can only hope there isn’t a complete crash.

For any physician, office manager, and staff experiencing the first day’s use of a new electronic health record (EHR) system with active patients, it’s an event as memorable as some of history’s greatest tragedies.

Why? Consider exactly what is happening during an EHR implementation. The practice and its team members not only are adopting an entirely new electronic means of data capture, they are reinventing and reimagining just about every process in the practice, from patient data entry, insurance eligibility, billing, coding, communication with patients and staff, all the way to follow-up appointment reminders.

And although Ellis clearly understood the pain associated with any EHR implementation, regardless of system, he also could see the long-term vision as it related to engaging patients in new ways, recording medical and billing data, and ultimately improving patient care with so much access to relevant data about the practice’s patient panel, their health statuses, immunization rates, practice finances, denial rates, etc.

On this Friday, Ellis, who leads and par-
Participates in the 2-year Medical Economics EHR Best Practices Study, implemented athenahealth’s cloud-based service that has a comprehensive and integrated EHR with practice management, patient communications, and care coordination capabilities.

Although Ellis says it is a robust platform that takes time to learn and effectively use, it has incorporated some very useful tools related to its core functions. In this report, Medical Economics takes a closer look at Ellis’ practice and his strategy for implementing the system, as well as his quest for achieving meaningful use, and we share some of his “best practices” after 9 months since first implementing athenahealth’s system.

**BACK TO THE BEGINNING**
Ellis is no stranger to EHR systems. This is his fourth system, dating back to 1992. When he decided to switch from a server-based system to the athenahealth’s cloud-based system in December 2011, he knew that he would leave a tremendous amount of historical patient data behind. The practice made the decision that they would not operate in parallel systems, which is a move most HIT experts laud.

“We did not transfer data from the old system,” he says. “It just wasn’t worth the effort to do it.”

For most solo, office-based practices, the undertaking and expense to port over past medical records is nearly a deal-breaker when implementing these systems, Ellis adds.

When you work in a very busy practice with an open patient panel, the proposition is almost too much for a small staff. Ellis’ practice has 4,800 to 4,900 patients in its panel. Located just outside of Youngstown, Ohio, in a largely blue-collar community with a higher-than-average Medicare base, the practice employs an office manager, two receptionists, a medical assistant, and a billing person.

The practice, Ellis says, typically sees 10 new patients a week and shuffles between a total panel of 120 to 160 patients a week. The pace of the practice is fast, and he relies heavily on his staff, notably his medical assistant (a trained paramedic), who helps set up patients before encounters.

Although the average office visit lasts about 15 minutes, new patients typically take longer—closer to 30 minutes. Acute problems can be addressed in about 10 minutes, he adds.

All of these elements also are important considerations in assessing the functionality and fit of an EHR system, Ellis adds. The practice’s structure, Ellis explains, is important because the EHR system needs to help the practice maintain its pace and viability. Understanding an EHR’s capabilities upfront, and evaluating the system based on the needs of the practice, is extremely important for every physician. He took the time, and he believes the homework paid off.

In fact, the integration of clinical, management, analytics, billing, patient commu-

**5 TIPS for an EHR implementation**

1/ Pick the right electronic health record (EHR) system for your office. Identify the needs of your practice, and then make certain the system can adapt to meet those needs.

2/ Be thorough in your due diligence when it comes to hardware and software selection.

3/ Train. Train some more.

4/ Educate your staff and patients about the need for the implementation. And be open with your staff and patients about the short-term realities and long-term improvements associated with it.

5/ Experiment with the functionality of your EHR to make certain you are getting the most benefit from its use. Appoint and train “super users” in the practice to help answer questions during the implementation.

**REVENUE REALIZATION RATE**
This chart shows how well the practice of George G. Ellis Jr., MD, resolved claims through a revenue realization rate compared with the national benchmark. Ellis attributes it to more aggressive management of revenue cycle and claims processing. Ideally, after 6 months, at least 95% of a given month’s charges should be fully adjudicated—either paid or adjusted. Other outstanding amounts are overdue to your practice and require additional work.

<table>
<thead>
<tr>
<th>Month</th>
<th>Rate</th>
<th>Benchmark rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2012</td>
<td>86.8%</td>
<td>96.7%</td>
</tr>
<tr>
<td>September 2012</td>
<td>93.8%</td>
<td>97%</td>
</tr>
<tr>
<td>October 2012</td>
<td>92.1%</td>
<td>95.2%</td>
</tr>
<tr>
<td>November 2012</td>
<td>89.6%</td>
<td>88.6%</td>
</tr>
<tr>
<td>December 2012</td>
<td>79.1%</td>
<td>92.5%</td>
</tr>
<tr>
<td>January 2013</td>
<td>34.3%</td>
<td>88.6%</td>
</tr>
</tbody>
</table>

**Revenue realization rate**

**Benchmark rate: Internal medicine, nationwide (189 practices)**
Denial rates
The following table presents the denial rate information for your practice over the past 12 months. The numbers in the table represent the percentage of claims that scrub, receive a front-end denial, or receive a back-end denial. A "..." in a cell means there were no claims that month.

<table>
<thead>
<tr>
<th>Year</th>
<th>Scrub rate</th>
<th>Front-end denial rate</th>
<th>Back-end denial rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2012</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>March 2012</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>April 2012</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>May 2012</td>
<td>57.5</td>
<td>0.0</td>
<td>4.2</td>
</tr>
<tr>
<td>June 2012</td>
<td>10.3</td>
<td>0.9</td>
<td>4.2</td>
</tr>
<tr>
<td>July 2012</td>
<td>6.8</td>
<td>1.9</td>
<td>6.9</td>
</tr>
<tr>
<td>August 2012</td>
<td>4.8</td>
<td>0.6</td>
<td>2.5</td>
</tr>
<tr>
<td>September 2012</td>
<td>8.1</td>
<td>0.2</td>
<td>5.7</td>
</tr>
<tr>
<td>October 2012</td>
<td>7.5</td>
<td>0.0</td>
<td>6.9</td>
</tr>
<tr>
<td>November 2012</td>
<td>5.7</td>
<td>0.3</td>
<td>6.6</td>
</tr>
<tr>
<td>December 2012</td>
<td>5.1</td>
<td>0.5</td>
<td>5.0</td>
</tr>
<tr>
<td>January 2013</td>
<td>6.6</td>
<td>0.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Annual</td>
<td>7.9</td>
<td>0.5</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Monitoring accounts receivable

<table>
<thead>
<tr>
<th>Year</th>
<th>Days</th>
<th>Benchmark rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2012</td>
<td>55.9</td>
<td>33.2</td>
</tr>
<tr>
<td>June 2012</td>
<td>36.9</td>
<td>34</td>
</tr>
<tr>
<td>July 2012</td>
<td>32.6</td>
<td>34.6</td>
</tr>
<tr>
<td>August 2012</td>
<td>28.3</td>
<td>35.4</td>
</tr>
<tr>
<td>September 2012</td>
<td>35.3</td>
<td>34.9</td>
</tr>
<tr>
<td>October 2012</td>
<td>29.3</td>
<td>32.5</td>
</tr>
<tr>
<td>November 2012</td>
<td>32.1</td>
<td>32</td>
</tr>
<tr>
<td>December 2012</td>
<td>28.8</td>
<td>32.2</td>
</tr>
<tr>
<td>January 2013</td>
<td>33.6</td>
<td>33.2</td>
</tr>
</tbody>
</table>

As part of his evaluation, Ellis wanted a vendor with a solid reputation and a system with low upfront costs, a growing base of users, and depth in clinical and practice management functionality. And he wanted a system that not only closely matched the workflow of his practice, but also could be customized to help him see the volume of patients typical for his practice. He also knew that he wanted the ability to streamline and improve communication with his patients electronically.

As part of the Medical Economics 2-year EHR Best Practices Study, which paired 29 physicians with nine EHR vendors, Ellis was offered athenahealth’s service for 2 years as part of the joint agreement to participate in the study.

Once the end-user license agreement was signed, it triggered another very important, and often underused, aspect of implementation: training.

In fact, before the go live date, he and his staff performed online training tutorials during non-office hours. He paid them for the next 12 weeks of training. In fact, in the end, online tutorials helped, but working in the system before going live would have been a far stronger approach.

The practice had developed two “super users,” and that was extremely helpful before the go-live date.

A DAY AT THE OFFICE
When a patient steps into the office, he or she is asked to complete demographic questionnaire that covers past medical problems, family history, social history, and everything relative to that visit. The office staff collects the patient’s insurance information, collects a co-pay, and takes a photograph for the record. This begins the process of data entry into the system. And it remains one of the most time-consuming and important aspects to implementing an EHR, Ellis says. In essence, the practice is laying the foundation of data that will accompany all subsequent encounters. It’s the piece of an implementation that takes the most time, but one
that pays dividends long-term.

During the go-live day, Ellis says, the productivity in his office slowed to a crawl as his patients supplied data and his staff entered them into the EHR and began to see patients and document the encounters. They were learning new aspects of the system not previously encountered, but they were trying to communicate with patients and practice an entirely new workflow as far as check-in, processing, performing the patient encounter, and check-out.

“We started putting every patient in the system as if it was the first time he or she was being seen,” Ellis says. “It was very disruptive. I felt like the engine fell out. During that first day, we saw 10 patients in 10 hours.” A typical day sees closer to 40 patients, and on some days, even more.

Not only was the first day taxing on the staff members, but they also had to explain to patients why they needed to re-enter demographic data in the system. “It was just a really slow process in the beginning,” Ellis recalls.

Although improvement was noted during that first week, it took the practice’s team close to 3 to 4 weeks to show noticeable speed at processing. During that first month of implementation, Ellis’ practice was seeing less than half of his normal volume. Although physicians should anticipate a 30% drop in productivity, they also need to plan for it financially and its impact to the operation, Ellis says. And importantly, physicians should set a timeframe for the practice to bounce back to normal productivity levels. Note: Ellis didn’t draw a paycheck for 3 months.

NO PAIN, NO GAIN

As the team improved its competency in using the system, and when Ellis began seeing a return to normalcy, the practice began implementing some of the advanced features of the system.

Data mining, denial reports, revenue metrics, patient portal establishment, email communication with patients, advanced callback features, appointment reminders, claims scrubbing, coding issues—all were features that began to offer insight into his practice and his patient panel.

Ultimately, Ellis attested for meaningful use in about 100 days after implementation. The process was made simpler by one of athenahealth system’s features, he says.

Long-term, the practice has returned to normal volume, as shown in “Ellis appointment count” below. It’s also important to note that his practice went live on May 18, 2012.

In terms of tracking accounts receivables, the practice had its worst showing during the first month and has since recovered.

The system’s focus on revenue cycle management (see the related story beginning on page 44), Ellis says, has improved its cash flow, submission of claims, reduction in denials, and collecting from private and public payers.

MORE ON PATIENT COMMUNICATION

And, importantly, access to a secured online portal to communicate with patients via email and enabling patient access to health information including education materials is helping the practice engage patients in new ways and build efficiency. In fact, Ellis was surprised at the interest of his patients as it relates to accessing and engaging the practice in their care online. He communicates via email with patients every day and is actively using advanced features associated with the online portal that allow:

- message exchange,
- review and payment of billing statements,
- appointment requests,
- researching of health topics,
- review of personal health information,
- completion and updating of medical forms, and
- updating of a patient’s profile and contact information.

When it comes to metrics, Ellis says the practice is moving forward and showing improvements in many of the core measures outlined the government’s EHR incentive program for meaningful use 1 and 2.

He also looks forward to the day when physicians will have the ability to communicate with each other and share medical information in secured ways, all in an effort to create new efficiencies in the delivery of care.

“That’s what this is all about—improving the health of patients and creating an efficient system that allows our practice to offer advanced care and further develop our services to remain economically viable,” Ellis says.

MedicalEconomics.com
Medical Economics’ study enters second year; participants identify best practices

More than a year ago, Medical Economics connected 29 primary care physicians (PCPs) with nine electronic health record (EHR) system vendors to document best practices related to implementation.

The Medical Economics EHR Best Practices Study allows physicians time to gain experience and knowledge by working with an EHR system over 2 years. As the study moves into its second year, all of the participating physicians have implemented systems, and many already have attested to meaningful use.

The ultimate goal of the study is to gather real-world data and identify strategies to help solo and small office-based doctors in their quest to implement and use EHR systems. To accomplish this goal, the study has been segmented into four stages of an EHR implementation: pre-implementation, implementation, post-implementation, and EHR functionality. Study participants are asked to report on everything from vendor selection, data migration, connectivity, and assessing a practice’s integration capabilities to developing a workflow and preparing for the unanticipated costs. Participants are reporting key benchmarks to ease implementation in their practice and identify creative ways to keep pace with changing economic trends.

Examine your revenue cycle to keep pace with changing economic trends

New ways of paying for healthcare call for adjustments to billing, collections processes

by GEORGE G. ELLIS JR., MD

REVENUE CYCLE MANAGEMENT (RCM) tools can drive healthcare reimbursement to higher levels. And tools to actively and accurately monitor your revenue cycle are becoming rapidly available in the form of robust electronic health record (EHR) systems that are consolidating functions to streamline the way revenue is we collect and process revenue.

Consider that RCM refers to an entire billing process. The cycle begins when a patient books an appointment, and it ends when remittance is received from the payer and the patient. It also includes multiple steps along the way, including eligibility checks (verifying insurance); capturing, entering, editing, or scrubbing a claim, collecting accurate information needed to create a medical billing claim to a third-party payer, Medicare, Medicaid, and so on.

And the revenue cycle is taking on greater significance because of a variety of financial trends affecting primary care physicians. A white paper published by Triple Tree Consulting says that the inefficiencies of redundant data collection, manual process, and repetitive rwork of claims submissions are “all contributing to a diminishing bottom line.” Sound familiar? And as the trend pushes payers (and many other businesses influencing our revenue cycle) to reduce healthcare costs, we physicians will need to become much more efficient in the way we manage and operate our practices.

Some of those efficiencies range from how we handle eligibility checks to the processes we have in place to scrub claims or investigate the reason for a denial. And there are just as many reasons to conduct a thorough examination of your revenue cycle.

Why? Not only are insurance deductibles increasing, so is the use of flexible spending accounts. More and more of our patients will be tied to costs associated with their healthcare. This trend has been called “consumer-driven health,” and Triple Tree Consulting suggests that it will be the greatest driver to healthcare since the rise of managed care. It will have a direct effect on how we organize and collect for our services for patients and payers.

We also are seeing consolidation of services that traditionally have helped us manage this revenue cycle—from billers and coders, to billing processing companies, to payer adjudication, to a wholesale integration of all of these functions within some of these EHR systems. The trend will help us manage our practices more effectively and efficiently, and it ultimately will simplify a very complex billing process and make entering and tracking reimbursements, claim denials, collections, and financial analytics that much easier.

When we examined my practice’s internal systems and ways to improve our revenue cycle, our cash flow improved.

My suggestions? Start by examining the capabilities of your EHR system. For the past year, I have been working with athenahealth’s practice management system and noted a decrease in claims denials secondary to coding errors, lack of modifiers, or incorrect insurance. In fact, in being part of the 2-year Medical Economics EHR Best Practices Study, which is working with multiple EHR vendors, I...
have been exposed to many systems in the market that can help you advance in a variety of ways to improve and streamline your practice’s revenue cycle.

Next, look at your revenue cycle processes as they relate to the pre-encounter, patient-doctor encounter, and back-office operation. We sought to improve our efficiency in the pre-encounter phase. In fact, we wanted to streamline the processes of our front-office staff as patients enter the practice.

Typically, at this point, the patient’s demographics are obtained, and his or her insurance information is acquired and verified before the encounter. The patient’s eligibility is verified prior to the office visit at 2 weeks, again at 24 hours, and on the day of service. Not only does insurance verification at the time of the visit help us manage and collect copays before the encounter, it also can substantially reduce denials on the back end.

Because of changing reimbursement models, more and more patients will have out-of-pocket deductibles. Therefore, collecting copays and deductibles at the time of the encounter is going to take on even greater significance to a practice’s financial health.

Once these steps have been completed, the patient is ready to see the physician, where a note is completed. The amount of information obtained during the exam, the complexity of the exam, the amount of documentation, and the complexity of decision making will all determine the evaluation and management (E/M) level of care and International Classification of Diseases, Ninth Revision, (ICD9) codes used during the encounter. The ICD codes and E/M level of care will provide the necessary information for charge entry, another critically important step.

As physicians, we not only drive patient care, we also generate most of the revenue for the practice. We clearly are the most valuable asset of the practice. Realizing this role, I have taken on the responsibility of charge capture and submitting claims for submission to payers as well. Why? RCM has enabled me to enter charges at the end of the day, and my doing so results in fewer lost charges (or omission of charges). Reviewing ancillary services performed during visits enables me to capture charges omitted by nursing or medical assistants.

With declining reimbursements, it is critical to capture all charges and submit them in a timely fashion with proper coding. If you have a bad claim, tools such as Code Checker guide you to use correct modifiers or choose a more specific diagnosis.

Ultimately, better managing your revenue cycle will improve your financial performance. And as the healthcare marketplace shifts to reducing costs overall, we need to look at every management strategy available to help us remain economically viable so we can continue to offer high quality care to the asset we care about most: our patients.


USING SINGLE HIT VENDOR HAS BENEFITS, DRAWBACKS

by LYLE MELICK

Newer federal laws and regulations related to using electronic health record systems and safeguarding patient information under changes to the Health Insurance Portability and Accountability Act may have your medical practice taking a closer look at its technology-related needs.

Physicians and their practice managers are starting to see that complying with these laws and mandates will require a greater use of information technology and are exploring the pluses and minuses of using a single vendor versus multiple vendors for their HIT needs.

**PROS**

The advantages of using one vendor:

- **One point of contact.** To start with, you have only one point of contact for all your HIT needs. You don’t have to partially troubleshoot a problem to decide which vendor to call or mediate between vendors if the practice management software vendor says the Internet service provider is causing the problem.
- **More resources.** Core HIT vendors usually have a larger staff to pull into large projects as well as access to all the equipment and software required to fully troubleshoot and solve any problems you may experience.

**CONS**

On the other hand, the disadvantages of using a single vendor:

- **Expense.** Larger vendors will have more overhead than smaller, niche vendors and can be more expensive. So although the vendor may only assign one technician and the help desk to your account full-time, the costs of all its other technicians, sales staff, and office staff will factor into the pricing of its services.
- **Potential delays.** Core vendors may try to solve all your problems in-house, delaying escalation to equipment and software vendors. Although they are less likely to encounter a problem requiring vendor intervention than is a smaller, niche vendor, delays in seeking additional support could affect your practice.

**WHAT TO LOOK FOR**

Base your decision on a provider on three factors:

- **Experience.** An experienced HIT vendor will have standard policies for dealing with equipment failures and Internet outages. It should be able to monitor your equipment and software around the clock for signs of impending problems and undertake proactive maintenance to help prevent failures. It should have the capability to monitor and routinely test your data backups to ensure that your data are protected, possibly including some form of off-site archival.
- **Connections.** Check client references for your potential new HIT vendor. Ask about the problem that has taken the longest to resolve and about any surprises they may have encountered after signing with the vendor. Ask how long they have been a client and what vendor staff turnover has been like. Good HIT service companies pride themselves on attracting and keeping good talent.
- **Leadership.** Ask your potential HIT vendor about the company’s approach to customer service. Look for a company that acts more like a partner and finds creative ways to meet your technology needs.

Hiring a single HIT vendor to address your hardware, software, and networking needs can seem expensive, but doing so may be more economical for your practice in the long run. Having one number to call to solve a technology problem can get you back in action quicker because you avoid vendor squabbles.

Look for a vendor that can meet your needs, matches your service philosophy, and wants to support your business so that you can spend more time caring for your patients.
NEW TELEMEDICINE KIT ENABLES VIDEO CONFERENCING

VoIP Supply’s Telemedicine Kit—built from LifeSize Video Conferencing, a division of Logitech—provides physicians with remote patient monitoring and distance medical services to conduct quick visual check-ups for reviewing medical history, performing basic physical exams, or manage chronic diseases such as diabetes or asthma in patients.

The Health Insurance Portability and Accountability Act-compliant kits are designed to help a practice start video conferencing. Patients need a home computer and Web camera to participate and also should sign a consent form to be treated via telemedicine.

Telemedicine carts may increase productivity for doctors, providing opportunities for more billable hours and the provision of more direct services. Another potential benefit is that patients may not have to wait an extended period of time to see a physician.

AMPHIO HEALTH SYSTEM ALLOWS YOU TO REMOTELY MONITOR PATIENTS’ HEALTH CONDITIONS

Ambio Health’s Remote Health Monitoring System, a wireless health-monitoring product, is now available for purchase online.

The system has a “plug-and-play” set-up with no Bluetooth or Wi-Fi configuration, and it automatically sends readings from anywhere in a patient’s house. Patients can use meters and send readings without having to possess a wireless gateway hub, connect a cable, or start a personal computer or smartphone application. Ambio automatically logs readings, which can be viewed in a secure, Web-based portal and can be printed or emailed as needed. Users can be notified when their test strip supplies are low and need to be reordered.

A single device costs $49.97 and includes a glucose meter with wireless connectivity as well as an annual subscription costing about $4.99 per month. Wireless blood pressure meters and weight scales are sold separately.

The system has been named one of eWeek’s “10 health and fitness tools to track exercise, chronic conditions.”

VoIP Supply    (800) 398-8647    www.voipsupply.com/telemedicine-kit

Ambio Health    (203) 612-5600    www.ambiohealth.com

Work Stations Are Wall-Mounted or AC-Powered

Midmark Corp. has introduced wall-mounted and AC-powered options to its line of Care Exchange Workstations, which are designed to enable physicians to integrate technology into their practices.

The wall-mounted workstations are devised for environments where a mobile technology platform is not an option. Offering various adjustable-height monitors and keyboards, these workstations also feature a keyboard tray that rotates up and out of the way or extends an additional 4 inches.

The AC-powered workstations last up to 12 hours before requiring a recharge. Traditional sealed lead acid and lithium ion phosphate battery options are available. The compact base aims to be easily maneuverable.

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Doctors: Patients should be able to update but not view full records

Patients should be able to update their electronic health records but should not be able to have full access to them, according to physician participants in a survey by Accenture.

Eighty-two percent of U.S. respondents said they want patients to actively take part in their own healthcare by updating their records. Only a third of physicians (31%), however, believe that patients should have full access to their records; 66% believe that patients should have limited access, and 4% say they should have no access.

Most U.S. doctors said that patients should be able to update some or all standard information in their records, including demographics (95%), family medical history (88%), medications (87%), and allergies (85%). Also, most doctors (81%) believe patients should be able to add clinical updates such as new symptoms or self-measured metrics.

Nearly half (49%) of respondents said patient access to records is crucial to providing effective care, but only 21% currently allow patients to have online access to their medical summaries or patient charts.

More than half (53%) believe that electronic records have improved care quality, and most (84%) say they are somewhat or strongly committed to promoting electronic records in their clinical practice. Most (77%) also believe the right investments in adopting electronic records are being made, and 83% believe they will become integral to effective patient care in the next 2 years.
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