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How to SURVIVE— and thrive— IN HEALTHCARE TODAY

PLUS
REDUCING PAPERWORK BURDENS

AND
MANAGING THIRD-PARTY INTERFERENCE
No matter the pressure applied, independent physicians will survive

When I first started covering healthcare, I spoke to a doctor at my first medical conference for a story on the imminent death of independent practices.

The doctor, an 80-year-old family physician, looked at me, cocked his head and asked: “Do you think private practices are doomed?” I replied that the data indicated more mergers and acquisitions by hospitals and health systems, so at this current rate, the future looked bleak.

The doctor politely put his hand on my shoulder, leaned in and said the following: “Son, private practices are like coal. They are sometimes rough, sometimes a little dirty, and often used to fuel ‘the machine,’ but when you apply pressure, they turn into a diamond and shine. We aren’t going anywhere.” He then walked away, having clearly been offended by my naïve observations.

Since then, I’ve come to better understand and appreciate the resiliency of independent physicians. And as you all know, mine was not the last “end of private practice” story ever to grace a publication.

But like that doctor said, they haven’t gone anywhere and continue to shine despite an enormous amount of pressure.

A new report by consultancy Avalere Health and the nonprofit Physician Advocacy Institute (PAI) indicates that hospital acquisition of these practices continues to rise (5,000 practices acquired between July 2015 and July 2016 marking a fourth consecutive growth year) as does physician employment by hospitals (an 11 percent increase over the same time period).

Robert Seligson, the PAI’s president, noted the difficulty in remaining independent.

“Payment policies mandated by insurers and government heavily favor health systems, creating a competitive advantage that stacks the deck against independent physicians,” he said in a statement.

He’s right. Look no further than various attempts by CMS to “group” physicians in its value-based payment initiatives and encourage strength in numbers to make data collection and reporting easier.

And I won’t get into the myriad challenges independent physicians— all physicians, really—face with less time to see patients, more time needed in front of a keyboard than in an exam room, and the onerous obstacles imposed by payers. To say it is not easy to be a physician today is a gross understatement.

But I think of that doctor, the man who looked me straight in the eye and that had likely seen thousands of patients over the years and his resiliency. He didn’t care about data. He didn’t care about what some young man thought was going to happen in the future. He cared about his patients and his business and that was his singular focus.

No, independent practices aren’t going anywhere, despite the data and the reimbursement and technological environment. Through the long hours in an office, the added hours at home, and the extra hours on the phone to explain treatment rationales to a payer.

Despite it all, independent practices will continue to shine.

Keith L. Martin is editorial director of Medical Economics. What do you see as the future of independent practice? Tell us at medec@ubm.com.
Paying for prescription drugs around the world:

WHY IS THE U.S. AN OUTLIER?

National trends in per-person pharmaceutical spending, 1980-2015

WHERE THE U.S. RANKS

Of the 10 countries in the survey, the United States ranks:

1st in per capita costs
$1,000 per person, $200 more than Switzerland, which has the second highest per capita cost

1st in patients skipping prescriptions because of cost
More than 30 percent of uninsured U.S. patients and 15 percent of insured patients surveyed said they skipped treatments because of cost

2nd in share of generics available in the market
Generics make up an 80 percent share of drugs in U.S. pharmaceutical markets, second behind only the United Kingdom

5th in costs as percent of national health spending
The United States spends 10 percent of its total health expenditures on prescription drugs

Source: Commonwealth Fund

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33 The future of health IT
From blockchain to AI, these are the innovations to watch for
I admire Paul Teirstein, MD, and his commitment to starting an alternative to the American Board of Medical Specialty’s maintenance of certification (“ChangeMakers in Medicine,” February 25, 2018). I hope his new approach will eliminate the following flaws of the ABMS system.

MOC cannot measure:
- how well physicians connect with their patients on an emotional and social level. Many go the “extra mile” in advocating for them with insurers and getting their drugs.
- the efforts of doctors who make the occasional house call, hospital, or extended care facility (ECF) visit even though they no longer take care of hospital or ECF patients—and don’t charge any fee.
- how much time doctors spend being good citizens of medicine by participating in state and local medical society meetings or writing letters to the editor of local newspapers defending patients and physicians against the intrusions of insurers.
- the efforts that doctors spend trying to move tort reform forward by participating in the advocacy efforts of their medical societies.
- how much doctors participate in the activities of their hospital medical staffs and committee meetings.
- if doctors consult specialists in a timely fashion.
- how well doctors collaborate with their consultants.
- if doctors report the findings of CAT scans and lab tests in a timely manner.
- how quickly doctors answer their phone calls.
- how long patients have to wait for an office visit.

Edward Volpintesta, MD
BETHEL, CONN.

In response to: “ChangeMakers in Medicine”:

Congratulations @LisaLarkinMD for being named a “ChangeMaker in Medicine” by @MedEconomics.
Lisa Larkin MD & Asc
@LARKINDPC

“The world needs more Lisa Larkins—couldn’t have been awarded to a more deserving + pioneering MD #womenshealth #advocate”

Cindy Whitehead
@CINDYPINKCEO
+
bit.ly/ChangeMaker-Larkin
Don’t dare tell me not to dwell on Obamacare

What expert genius really feels we should not “dwell” on ACA exchanges (“Top 2018 Challenges,” Dec. 25, 2017)?

I am watching all my independently employed patients leave our small internal medicine practice because the only things available in Georgia now that ACA (which had some terrible issues) has been gutted is an expensive Ambetter policy which is essentially run by Medicaid or an HMO with Kaiser.

I have lost some patients who have been with us for nearly 30 years. I am transferring records every day because people think they cannot pay cash for our services and instead are getting third-world care at Kaiser or they took Ambetter and cannot find a doctor or a hospital to accept them.

I lost our medical assistant because we could not, as a small group of three, find insurance for her that was affordable. Both the doctor and I are now on Medicare and my wonderful hard-working MA left for a big practice. And we should not fuss about ACA? Any clue what it costs to hire someone through an agency? It would be several thousand dollars.

We lucked out and re-hired a former employee, who happens to be on Medicare, and cut the days we see patients to four, so I do not have to pay her for 40 hours a week. I, the office manager, have taken on more of the paperwork that the MA used to do. It is 6 p.m. on Friday night and I am nowhere ready to leave. I take work home.

But I should not dwell on ACA? Those idiots in D.C. with their fancy cars and fancy lobbyist-paid dinners are killing small business. We get patients with HSAs who pay bills on those credit cards which cost us 2.5 percent of our discounted fees to run, we deal with those pesky deductibles which patients do not want to pay (thousands of dollars to collection keeps rising every year), and we do not perform fancy procedures in primary care ($17 for an EKG and the clerks at the carriers tell patients that the doctor should not have done one because it is not needed at a physical exam.).

Mrs. M is in her late 50s but retired and now has Kaiser. Mr. H is a fragile diabetic and left for Kaiser. Mr. W, who came to us in the past two years and is finally under control, is now leaving. Mr. L has been a patient for 25 years; he is self-employed. Mr. R has Medicare but his wife is younger.

I could give you 100 names of our self-employed patients who managed to pay their bills in 2017 and did not leave us stuck with their deductibles. Our cash prices are not bad but everyone who is wasting money on insurance feels they need to use the insurance.

We should not dwell on ACA. What planet are you all living on?

Sandie Berger
MARIETTA, GA.
Medical school enrollment has traditionally been dominated by men—until now. The number of women enrolling in med school surpassed men for the first time last year, according to the Association of American Medical Colleges.

Women represented 50.7 percent of the 21,338 med school enrollees in 2017. Female matriculants increased by 3.2 percent, while male matriculants declined by 0.3 percent. The overall number of U.S. med school matriculants rose 1.5 percent with total enrollment at 89,904 students.

What does this mean for women in medicine?

“It’s important because women have been underrepresented in medicine for a long time, and we really strive to have a workforce that reflects the general working population,” says Alison Whelan, MD, chief medical education officer at the Association of American Medical Colleges. Overall, a workplace that reflects a 50-50 balance is reasonable, so we should continue the effort to maintain this balance, and make sure it’s not just a onetime blip and then goes back down again,” says Whelan.

For the rest of the story, visit bit.ly/women-medschool.
89th ANNUAL PHYSICIAN REPORT

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he opioid epidemic and the fate of Obamacare occupy most of the public’s attention but outside the media spotlight many primary care practices face the more basic challenge of staying afloat financially.

In fact, 79 percent of primary care physicians (internists, family doctors, pediatricians, and obstetricians/gynecologists) surveyed by Medical Economics about the financial condition of their practices said it was worse or about the same compared with the previous year. Among those who said they were worse off, two of the top reasons cited were higher overhead costs (64 percent) and lower payer reimbursements (54 percent).

Closely related to these was the growing quantity of time spent on tasks for which they are not compensated, a problem cited by 69 percent of primary care doctors. The findings are part of the exclusive 89th annual Medical Economics Physician Report.

In follow-up interviews, survey participants say they are using a variety of strategies to bridge the widening gap between practice revenue and expenses. On the revenue side, they are seeing more patients and seeking out new sources of income, such as taking on additional employment or adding ancillary services to their practices.

On the expense side, they are reducing staffing and/or asking existing employees to take on additional tasks, and in some cases making adjustments to their lifestyles.

“You start saying, ‘I’m not going to buy that new car, or I’ll skip the ski trip,’” says Howard Mandel, MD, a Los Angeles-based OB/GYN in his 34th year of practice. “I’m comfortable with making less money today than I used to. I don’t think it’s fair, but then I ask, ‘What’s my alternative?’ And there really isn’t one.”

As for what keeps them going in the face of mounting frustrations and often-declining incomes, physicians who spoke with Medical Economics are virtually unanimous in their response: relationships with patients.

MACRA IMPACT STILL UNCERTAIN
Doctors’ concerns over reimbursements, expenses, and uncompensated tasks all jibe with what Ken Hertz, FACMPE, a long-time practice consultant and principal with the Medical Group Management Association, sees among his clients. Exacerbating physicians’ worries, Hertz says, are uncertainties over the impact of Medicare’s Quality Payment Program, which took effect last year.

“They’re worried what reform means in terms of how they have to see patients, how they have to check boxes in order to be compliant,” Hertz says. Moreover, many practices are struggling to meet the growing complexity of documentation and coding...
required by payers and the introduction of the ICD-10 coding set. "We've got practices that are not documenting and coding as effectively as they could and so are leaving money on the table," he says.

As an example, Hertz cites a February, 2018 study in Health Affairs showing that as of 2015 more than half of medical practices were not taking advantage of Medicare's Annual Wellness Visit, despite its higher reimbursements compared with problem-based visits. The study's authors attribute the reluctance to use these visits in part to their "complex and sometimes confusing requirements."

Lauri Miro, MBA, RN, vice president of consulting services for the Halley Consulting Group in Westerville, Ohio, notes that MACRA is part of the broader shift away from fee-for-service reimbursement and toward rewarding providers based on patient outcomes—a trend that frequently leads to higher overhead for practices in the forms of additional staff and/or technology.

"The increases in expenses practices are having to incur to take advantage of value-based reimbursement and increased tracking and reporting of quality metrics is increasing expenses at a faster rate than reimbursements are increasing," Miro says.

That dynamic has played out to some extent in the practice of Leroy Fleischer, MD, an internist in Broomall, Pa., who practices in a multi-site primary care group. "Reimbursements haven't been declining per se, it's more that they haven't kept pace with what it takes to operate a practice," he says. "And it's not always direct costs like for more employees as much as maybe having to spend more time on things like data entry. There's an opportunity cost to that."

Now in his 26th year of practice, Fleischer has seen a significant increase in time spent charting since he began using EHRs, in part
because of the quantity of data the systems require for each patient.

"It used to be that if a patient had, say, a stress test, we filed the results in the paper chart, and I didn't perceive I had to have them at my fingertips," he says. "Now, I have to make sure I document the negative stress test that the cardiologist did and that he changed their Metoprolol from 25 to 50 milligrams. It's a lot more time and it's uncompensated."

**GROWTH OF UNCOMPENSATED TASKS**

For Ann Pollock, MD, a partner in a two-physician internal medicine practice in Frankfort, Ky., the likely impact of Medicare payment reform will be her retirement in the next year or so, which is earlier than she expected. "I've got to do a lot more data mining and reporting for which I'm not getting compensated, but they're telling me I've got to do this just to keep my reimbursements where they are now," she says.

Pollock explains that her EHR system isn't able to report data required by the Merit-based Incentive Payment System, and the necessary upgrades would cost around $10,000. "I'm 62 and already close to retirement, so why would I want to do that? I think MACRA is set up against doctors, and it's going to end up causing a lot of us to retire," she says.

Pollock says her experience with uncompensated tasks mirrors the experience of other physicians who complain they're having to spend more time with EHRs than they are with patients.

"I try to give patients my attention, but it means I end up taking home a couple hours of chart work each night," she says. Partly as a result of this added time burden, Pollock has stopped making hospital rounds for her patients. Moreover, the hospitals themselves are putting increasing time demands on physicians.

"They're wanting us to do things a certain way and follow a bunch of time-consuming rules, so I just decided I'd eliminate my night call," she says. "In some ways it's been nice, but I don't think it's good patient care."

In the meantime, Pollock's practice has sought ways to reduce operating expenses and boost revenue. It has achieved the former mainly by cutting back on vaccinations for shingles and influenza, since the cost for both have increased dramatically in recent years, says Annalisa Davis, the practice's long-time office manager.

"We used to have a flu clinic where we'd give 300 to 400 shots a day, but we don't carry nearly as much vaccine now because if we don't use it we can't return it," Davis says. Instead, the practice now refers patients to local pharmacies for flu shots.

The practice has captured additional revenue by participating in a program offered by Humana aimed at improving patient outcomes, for which Humana sends the program monthly bonuses. But doing so requires reporting data not always captured in a chart, such as results of a diabetic patient's eye examination.

"Much as we try to remind them, the patient isn't always going to remember to tell their eye doctor to send us that information," Davis says. As a result, she has to spend time following up with the patient's eye doctor to get the results.

Internist Ajith Purush, MD, who practices in Prescott, Ariz., says reimbursements from

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"I've got to do a lot more data mining and reporting for which I'm not getting compensated, but they're telling me I've got to do this just to keep my reimbursements where they are now."

—ANN POLLOCK, MD, INTERNIST, FRANKFORT, KY.

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**Read more to find out how to explore new revenue sources for your practice.**

*Continued on page 46*
**Coding Insights**

**Understand the role of associated signs and symptoms**

**Q.** When assessing the associated signs and symptoms during a patient’s history of present illness (HPI), how do negative answers affect the documentation?

**A.** Negative responses can count toward the history of present illness (HPI) just as they do toward Review of System (ROS) questions.

Credit is given for the gathering of HPI information, not the patient's responses(s). So the patient's answers, whether positive or negative for particular signs and symptoms, help provide the puzzle pieces that direct what ROS, exam, and/or diagnostic test(s) will be medically relevant to determine the patient's diagnosis(es).

A clinician's impressions formed during the beginning of a patient visit may lead to questioning about additional signs or feelings. A provider may ask patients directly about “pertinent positives and negatives,” such as diaphoresis (marked sweating) associated with indigestion or chest pain; weakness and hunger in patients with diabetes; or blurring vision accompanying a headache. Generalized symptoms, such as chills or fever (and the degree) or overall weakness are often relevant to many conditions.

The blend of this information obtained helps a provider understand a clear picture of the patient’s self-described problem(s).

For even the highest level of Evaluation and Management (E/M) code, an extended HPI, which requires four elements, is all that is needed to support the code level. Therefore, if additional elements are documented in the HPI, credit can be given in the ROS.

Many times in these cases, the associated sign(s) or symptom(s) are credited in the ROS because they can be associated with specific systems of the body.

**Q.** Can you please tell us about the new policy for student documentation? Does the physician still need to re-document the student’s work in order to use it to bill?

**A.** According to MLN Matters (number MM10412) implemented on March 5, 2018, CMS is revising the Medicare Claims Processing Manual to update policy on E/M documentation for teaching physicians. Teaching physicians will be allowed to simply verify the student medical record documentation utilized toward the level of E/M services, rather than re-documenting the work.

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making.

According to MLN Matters, the teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work. This cuts down on the teaching physician’s time documenting.

**Renee Dowling** is a billing and coding consultant with VEI Consulting in Indianapolis, Ind. Send your coding questions to medec@ubm.com.
We’re in this together.

Regardless of the pressures your practice may face, ISMIE is looking out for you. Our complete medical protective liability coverage includes proprietary Risk Management programs and physician-led claims management. Learn why nearly 10,000 policyholders choose ISMIE at ismie.com/growth.
Physicians are riding the digital health wave, investing in startup companies long before they reach the public stock markets as technology and regulation disrupt the healthcare industry. Some physicians see the deals as financial investments, others see them as potential future careers, but all of them should keep the significant risks of early-stage companies in mind before jumping in, experts say.

Investors as a whole poured $2.5 billion into digital health startups in the first quarter of 2017, according to StartUp Health LLC, which invests in early-stage companies and promotes technological advances in health. These companies make software, data applications, and other tools for a huge variety of healthcare goals, from tracking health and patient outcomes and improving EHR to mining big data to pinpoint the causes of disease.

Among StartUp Health’s investments are Arpeggi, a gene sequencing company, and Avado, a patient relationship management platform that was acquired by WebMD.

It’s easy to understand the caution: Startups funded by angel investors had a 70 percent failure rate, according to a 2016 industry report sponsored in part by the Ewing Marion Kauffman Foundation. Angel investments are funds that invest in startups in exchange for equity or debt.

While the Kauffman study looked at deals across several industries, healthcare startups face specific challenges, often including the need to be adopted by large hospital networks, experts say.

Tobin Arthur, chief executive officer of Seattle-based crowd-funding platform angelMD, aims to improve investors’ success rate by connecting accredited investors (those with $200,000 in annual income or net worth of $1 million), to digital health startups. Most investors using the platform are physicians who are also asked to share their practice experience with startups seeking funding, though that’s not required, he says.

Fostering relationships with healthcare players, including physicians, he believes, helps lift the companies’ prospects for survival while potentially rewarding investors.

Given their incomes, physicians often are asked by family members or friends to invest in all sorts of business ventures outside their medical expertise, he says, a process that can end badly. “When people invest in what they know, the batting average goes up,” Arthur says.

Physicians thinking of exploring healthcare startups need to understand the risks, explore potential legal issues, and be realistic about the time it will take to realize any gains, experts say.

ASSessing the Risk
Not surprisingly, financial advisers urge physicians to exercise extreme caution when considering investing in startups.
New York financial adviser Alina Parizianu, MBA, CFP, says clients have different capacities and tolerance for risky investments, but as a general rule she suggests keeping startups below 5 percent of an investor’s portfolio. “You see more and more brilliant ideas these days, but which one is going to be the profitable one? No one knows,” she says.

The difference between capacity for risk and risk tolerance? A young, very wealthy individual might have significant financial resources and a long time horizon to weather periodic losses. That person might have a high capacity, or ability to take risks. But if the person has a fundamental fear of risky assets, advisers say their risk tolerance is low.

Physicians’ incomes—typically high enough to qualify as accredited investors but not so high that they are involved in venture capital financing—position them for more of the “friends and family” and angel investor networks.

Wayne Chen, MD, a geriatrician, invested in a friend’s startup, a static resistance device geared to seniors, more than two years ago and serves as an adviser to the company. “For me, the operational experience is a big part of the value,” he says, referring to new career opportunities outside traditional medical practices that the ventures can present.

“My wife and I talked it over extensively to make sure we weren’t investing more than what we could comfortably lose and that it wouldn’t impact our yearly budget. From there, I looked at it as a learning process as much as I did an investment,” he says.

WHERE TO LOOK
Finding early-stage digital health startups is fairly easy today. Many cities have startup incubators and there are several networks of angel investors specializing in healthcare online. Some angel networks now market startups to university alumni networks, and some medical societies are starting to explore partnerships with investment networks.

AngelMD, Arthur’s crowdfunding platform, matches investors (mostly physicians) with healthcare startups. An unrelated group of more than two dozen physicians have formed an angel-investing network in Chicago called MDAngels. Founder Jay Joshi, MD, MBA, launched the network with his own startup, Output Medical, a device for improving urine output measurement for patients with kidney disease. Joshi also runs a solo primary care practice in Muncie, Ind.

The MDAngels investor group meets quarterly in Chicago and thus far has invested an average of $85,000 in a handful of startups. Joshi’s advice: Physicians should think like entrepreneurs, not investors, and get involved in operations so they can positively impact the success of the company. “I’m actively involved in these companies, referring them to hospitals and nursing homes that I know and networking with other physicians,” he says.

VETTING IDEAS
Whether physicians envision setting a new career course by working with a startup, plan to use the product in their practices or just want to diversify a portfolio, experts say robust due diligence is in order. When Chen was approached by a friend to invest in the device company, the friend also asked by a large firm.

In the wake of the 2007-2008 financial crisis, legislation aimed at boosting startups’ ability to raise capital has created another funding platform known as equity crowdfunding (crowdfunding that offers stakes in startups as opposed to product discounts or other considerations.) With crowdfunding, as of May 2016, both accredited and non-accredited investors can invest small amounts (they vary depending on the assets of the investor) in startups. One noted equity crowdfunding platform is wefunder.com.

“It’s still very early in the game for crowdfunding,” says Ethan Mollick, Ph.D., MBA, a professor at the Wharton School of the University of Pennsylvania who studies the market. “Right now, the deal flow is small. Ultimately you want crowdfunding to surface deals that can’t get done through angel investment and private equity, but right now it is mostly deals that have been turned down by those investors,” he says.

DID YOU KNOW?

Ah-ha moment

About three years ago, mid-career internist Jennifer Meller, MD, MBA, entered an executive MBA program at the Wharton School at the University of Pennsylvania with the vague notion that perhaps being a healthcare consultant would provide an alternative to joining the ranks of doctors moving to employed positions.

“I was also watching the whole digital health world and felt it was on the verge of exploding,” says Meller, a solo physician and founder of medical practice Park Avenue Medicine in New York. Frequent Uber rides gave Meller the idea that would shape her next career phase. She envisioned patients sitting in doctors’ waiting rooms as riders waiting for available drivers.

“I wondered why we have all these people sitting in waiting rooms when we have the technology that would let them virtually peer into the room and see if a doctor is running late,” she says. She hired an intern to sit in her own waiting room and that of a few colleagues, texting a heads-up to patients when backups started to occur.

“Patients loved it, staff felt less pressured and I loved it because patients walked into the exam room smiling because we valued their time so they weren’t sitting in the waiting room for a long time,” she says.

Recently, she completed a round of “friends and family” financing for her resulting software product, Navimize (“Navigate care, minimize waits”), which connects with practice management systems to track patient flow and send text alerts to patients’ phones when delays occur. The software was recently piloted at a Boston hospital.

“Then the plan is to get more early adopters and start selling,” she says of the venture, in which she has invested personally.

She hopes to build Navimize into a sustainable company, while keeping a small practice on the side.

“I’m taking a bit of a risk, but this won’t ruin my future” if it doesn’t pan out, Meller says. “It wasn’t easy cash to part with, but this is a solid idea and I have my proof of concept. I don’t think a lot of physicians realize they own depth of knowledge and their ability to poke the right holes” in ideas that can help startups get better and investors make better choices.

to help with product development, marketing, and company operations. He asked the company’s two founders detailed questions about the data in their slide presentation pitch to investors, but didn’t pick up on some underlying disagreements between them. The original partners have split up and Chen, still an adviser, is re-negotiating equity terms of the partnership.

Ask startup founders how they will accomplish the day-to-day operations and bring the product to market, particularly if they are involved in companies in addition to the current venture, Chen recommends.

And even if the product is in a physician’s own specialty area, Chen says it’s important to run it by colleagues. For the portable resistance device, he validated the idea with physical therapists who work with seniors.

Internist Jennifer Meller, MD, MBA, who recently founded her own startup venture, agrees. “Just a great idea isn’t enough,” she says. “You have to evaluate whether these are people who can execute an idea.”

PATIENCE IS KEY

Physicians ready to explore startup investing further should be realistic, patient, and diligent about the details. Experts advise the following:

SET EXPECTATIONS

Private investors, even if they are silent partners, need to set out their expectations for how frequently the founders will report on product development, operations, and marketing issues, Chen says.

Investors also need to embrace realistic guidelines for any potential payoff. Just 30 percent of startups in the Kauffman study logged positive returns for investors. Among those, about 5 percent saw significant gains, returning more than 10 times their original investments.

“Sometimes original investors barely make anything,” says Carrie Coghill, CFP, AIF, president of Coghill Investment Strategies in Pittsburgh, an investment firm with several physician clients.

BE READY TO WAIT

Chen also recommends setting a much longer time frame for product development than founders typically envision. “Our timeline was three years, but we ran into production issues overseas so that is maybe five years now,” he says.

Angel investments in the Kauffman study averaged 4.5 years from initial funding to exit, either through a purchase or an initial public offering, though industry experts say the timeframe can exceed seven years.

CURB ENTHUSIASM

Even if the investment represents a very small portion of an investor’s total assets, experts often recommend scaling back the initial outlay. Parizianu cites a physician client who was asked to invest $50,000 in a friend’s startup. She felt the company was a little unrealistic about growth prospects, so she recommended investing half that amount until some benchmarks were reached.
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“Just a great idea isn’t enough. You have to evaluate whether these are people who can execute an idea.”

—JENNIFER MELLER, MD, MBA, INTERNIST, STARTUP FOUNDER

### DEAL WITH LEGAL QUESTIONS

Hire an attorney to review any contracts associated with the deal, Parizianu says. It’s critical to understand the subordination agreements that govern priority standing among investors, she says, because they spell out how initial investors will get paid once the company is sold or goes public. If the investments involve debt instead of equity, creditors need to know where they will stand in line for possible repayment in the event of bankruptcy.

Beyond the specifics of ownership in the investment are a host of legal and ethical considerations, says Reesa Handelsman, JD, a partner with law firm Wachler & Associates in Royal Oak, Mich. She typically recommends consulting tax and securities attorneys, as well as healthcare attorneys familiar with federal and state referral and anti-kickback statutes.

Even if the investment is an early-stage startup with no direct connection to patients yet, it’s important to think about how it will look in the future to anticipate possible conflicts of interest down the road, she says.

Any prospectus or documents a startup provides should highlight potential legal risks to discuss with an investor’s own attorney, she says. Will physician investors be personally referring patients or getting involved in other ways to generate business? If so, physicians need to consider their payer mix and whether their contracts prohibit that kind of activity.

As a rule of thumb, she adds, physicians should be sure they are paying fair market value for their investments to avoid the appearance of being given a stake in exchange for referrals.

From an ethical standpoint, she says, consider if the venture raises any concerns about over-utilization of health services or creates an incentive for unnecessary services on the part of the physician.

### STUDY THE COMPETITION

Another common trap for investors is assuming they are the only ones thinking about their business opportunity, Coghill says. “They get really excited about an opportunity without realizing someone with much deeper pockets might come along.”

Finally, consider the personal credibility of anyone involved in the deal, says Chris Chen, CFP, chief executive of Insight Financial Strategists in Waltham, Mass.

“Financials always look good because they are contrived to look good,” he says. In other words, treat any future projections with skepticism. “Beyond that, look at whether the principals are properly motivated and have credibility from doing this work before.”

Physicians should trust their own industry knowledge says Meller. “They bring a different perspective to the table,” she says. “They’re going to poke holes and key in on what they think is interesting about an idea,” which may be completely different than what a founder thinks.

### 3 questions to ask before investing in startups

**1. Can I afford this?** Are retirement and college-savings accounts fully funded? If not, financial advisers strongly urge investors to shore those up first.

**2. Where do I fit?** Investors need to know where they stand in the hierarchy of debt and equity holders because it can dramatically affect the time it takes to profit from an investment. If the company is sold or goes public, how are both early and later-stage investors compensated?

**3. Regardless of the quality of the business idea, can this team handle the operational issues involved?** What is their track record? Do they have operational experience on the team?
How to properly fire a practice employee

No one likes to fire an employee, but if someone is dragging down the practice, it’s time to make a change

Editor’s Note  Readers often ask for help with various human resource issues at their practices. As a response, we present “Workplace,” monthly advice from experts for physicians and staff. If there’s an issue you’d like us to address, let us know at medec@ubm.com.

1/ Go by the book
Compile an employee handbook that details practice policies and includes a termination section. Consider it both great communication and great protection. Before it’s written, get input from an employment attorney. “An hour spent doing that, and then again for a review when you have finished it, can save you thousands of dollars later on,” Halley says.

Make sure each employee receives the handbook and understands it. Ask if they have any questions. Check out basics on handbooks from the National Federation of Independent Business (bit.ly/NFIB-handbook) or a primer from the Medical Group Management Association (bit.ly/MGMA-handbook).

“Lay out employee expectations from the beginning,” says Ivery. “Then there’s no confusion. I was guilty of not doing this in the beginning and it cost me.”

2/ Follow your gut
Ivery adds that if you think a new staff member may not be the right fit long-term, you are likely correct. “People can’t fake being a good employee,” she says. “If a person is four to five weeks into their 90-day probationary period, and they’re not performing, don’t expect it to get better. Understand you have a problem on your hands and do something about it.”

Remember that an employee cannot file for unemployment benefits unless they have met the requirement for time worked or wages paid, Halley says. Each state has different rules, and as an employer practices are charged a tax to help pay for unemployment insurance (UI).

“Your UI tax rate depends on how many of your former employees qualify for benefits. Your probationary period for new employees should be shorter than the minimum time worked requirement for your state if you want to minimize your UI tax,” Halley advises.

3/ Grade them
Following the theories of organizational psycholo-
Workplace

gist Bradford Smart, Halley reminds practitioners what happens when they drag along “C”- and “D”-grade employees.

“If you fail to terminate poor performers, you drive the ‘A’ and ‘B’ players away,” he says. “They get frustrated, harbor resentments, and leave, because they can find jobs anywhere they want. They are hard to come by, but mediocre employees are a dime a dozen.”

4/ Put the practice first
If an employee starts slacking because “they have non-work obligations” that require more time and attention, that’s not the practice owner’s problem, Halley says. “They had these obligations when you hired them, and it doesn’t matter if you knew that— they still signed on to do a job for you.”

“Ask them to leave their problems at home or in the parking lot,” says Ivery. “If their kids need to go to the dentist, I recommend they do that on an administrative day—when no patient appointments are scheduled—so as not to impact patient care.”

Ivery reminds employees that if she can’t see patients due to low staffing levels, then the practice won’t make money either—and that affects employee salaries.

5/ Understand the limits
Practices with fewer than 15 employees are exempt from some federal employment regulations, Halley says. “Make sure you understand the basic employment laws in your state. Your attorney will help you know if you are considered an ‘at-will’ employer.”

An at-will practice owner can fire anyone for any reason in almost any state, and of course, the employee can quit, he says. Additional federal laws must be considered after 15 workers are hired; specifically, laws dealing with discrimination, harassment, and the Americans with Disabilities Act.

Another threshold occurs at the 20-employee level, where age discrimination laws start to apply, and another at 50 that adds the Family Medical Leave Act and Affordable Care Act, among others.

6/ Don’t surprise them
“I tell my clients that an employee should never be totally surprised they’re being terminated,” says Halley. “A good employer provides effective feedback to employees along the way, regardless of the number in the practice.”

This can be done with a performance improvement plan, so the employee fully understands what is expected of him or her, he says. “They should already know what the deficits are, and whether they are meeting the expectations that have been set for improvement when they’re brought in for a termination discussion.”

7/ Have a witness
Never fire an employee without a witness. “We have a litigious society, and an employer should also never broadcast—on social media or otherwise—why they terminate an employee,” Halley says.

“Remember, anything you say can be used against you,” he adds. “However unfair it may seem, the former employee gets to say whatever they want, but we should never retaliate or air our complaints about the former employee.”

A witness to the termination will make notes about the exchange and remains a credible back-up in case the terminated employee sues.

8/ Don’t phone it in
Halley says that as a matter of ethics, he advises never terminating an employee over the phone if it can be avoided.

“It’s just bad form. Besides you’re better off face-to-face so you can have that witness,” he says.

Stephanie Stephens is a California-based freelance digital journalist, producer, and host.
Healthcare technology’s future

Five tools physicians should be aware of in the coming years

by DONNA MARBURY  Contributing author

In the next decade, many of the concepts aiming to streamline the healthcare industry could be reality. Technology such as artificial intelligence, blockchain, and virtual reality will make interoperability and automation possible, as tech giants and startups partner with hospitals and health systems to prevent medical episodes and lower costs.

“We are entering an era of massive innovation in healthcare to combat the rising costs of the last decade,” says Jay Samit, independent vice chair of digital reality for Deloitte’s consulting firm. He says that as patients begin to get more involved in their healthcare, providers will have more data, allowing them to make better decisions.

“Right now, we use smartphones to track our vitals and our steps, but when artificial intelligence is tied into the phone, it could tell you that you might have a heart attack in 30 days. You would take that seriously,” Samit says. “Healthcare currently happens after the event, and new technology will make it more preventive.”

Here are five technologies that experts say will be commonplace in the next decade:

1/ BLOCKCHAIN TECHNOLOGY

Finding secure and reliable ways to transmit sensitive data among stakeholders has been an issue in healthcare for years. But many experts are confident that blockchain technology applied to clinical and claims data will result in huge cost savings in the next decade.

“Everyone talks about big data, but there needs to be a longitudinal view of the data that sits in different silos. Blockchain enables that,” says Shahram Ebadollahi, chief science officer for IBM Watson Health technology solution firm.

In a blockchain, patient health records could include clinical, behavioral health, and payer information, and can be reviewed, stored, and exchanged in a peer-to-peer transaction ledger. Because information is stored in blocks rather than one file, information can be used in clinical decision making or population health management.

Patients can give permission to use portions of the data, and past information can be stored without being changed. This also allows patient information to be used more widely for clinical trials without researchers having to get multiple layers of permission.

Many big players in healthcare technology have been making headway in blockchain. IBM Watson Health is working with the CDC to identify uses for it and barriers to adoption. Their goal is to exchange different

The highlights mention:

- Though artificial intelligence is used in administrative and clinical functions, experts see the technology taking a more direct role in clinical decision making.
- Increased automation could be on the horizon. Streamlining claims and administrative processes would be a game changer to the industry.

What is blockchain?

It is a digital ledger that allows for data to be stored in chronological order. The data can be interconnected, but cannot be changed once entered into the ledger. Key information can be stored without identifiable factors that can be a security risk. The technology is promising for healthcare because it allows for less paperwork and easier methods of capturing permissions to use across healthcare silos, says Shahram Ebadollahi, chief science officer for IBM Watson Health.
types of information including clinical trial data, genomic data, and patient-generated data, making it available to several stakeholders in a secure way.

Consulting firm Deloitte has submitted a whitepaper to the Office of the National Coordinator for Health Information Technology detailing how blockchain can be used to make health information exchanges more secure and interoperable. Gem, a startup blockchain provider, has also partnered with the CDC to explore population health solutions.

Ebadollahi says the various uses for blockchain technology would impact supply chain sectors of healthcare, clinical trials, business, and clinical fields.

“We see an increase in the number of risk-shared, gain-shared contracts and there are penalties for those that don’t make their outcomes. There are different outcomes produced by various players, and blockchain is a way to keep track of the outcomes of various players. It will be a huge cost savings once it is adopted on a wide scale,” Ebadollahi says.

2/ INTELLIGENT INTEROPERABILITY

The industry is focusing on improving interoperability in efforts to use technology to break down silos among payers, providers, and patients. But in the next five to 10 years, the concept of interoperability could become less about the transmission of data and more about how actionable it is.

Dave Lareau, CEO of Medcomp Systems, a medical information technology company, says “intelligent” interoperability will help identify and interpret disorganized and complex data from multiple sources. High-value information can then be filtered as part of a provider’s workflow to support clinical decision making in the exam room.

“With intelligent interoperability, providers don’t just have data, but actionable information that is structured and organized in a way that facilitates viewing across clinical settings and domains,” Lareau says. “Clinicians can access the precise information they need when they need it, during patient encounters and within their normal work flows across the continuum of care.”

The large amount of data generated by EHR systems is often disorganized, redundant, in multiple formats, and therefore unusable, Lareau says. “To achieve intelligent interoperability, providers need solutions that sift through this wealth of data, eliminate all the other clinical static, and make the right information available at the right time in the care process,” he says. “Unless organizations have the ability to contextually filter data, physicians will struggle to identify the precise information that is relevant to each specific patient and their known or suspected clinical issues.”

Lareau predicts healthcare organizations will not have to replace their current EHR systems to achieve intelligent interoperability. Instead, interoperability standards including Fast Health Interoperability Resources and Clinical Document Architecture will require more seamless data exchange.

“For example, data that comes from another provider must be coded to a usable standard. One way to achieve this is by leveraging technology that intelligently identifies, interprets, and links medical concepts and maps them to standard nomenclature, such as ICD-10, SNOMED, RxNorm, or LOINC,” he says. “The data can then be easily merged with existing information and made actionable at the point of care.

Who is using it?

47% of healthcare organizations are “trailblazers,” meaning they expect to begin investments and usage of blockchain technology in 2017, but only 8% of North American healthcare organizations fall into this category.

56% of healthcare organizations are “mass adopters,” meaning they plan on investing in blockchain between 2018 and 2020.

29% of healthcare organizations are “followers,” meaning they are waiting to see what problems and roadblocks may be involved in adopting blockchain. They plan to invest in the technology after 2020.

60% of trailblazers anticipate blockchains will help them access new markets, and new and trusted information they can keep secure.

70% of trailblazers expect the greatest blockchain benefits to be in clinical trial records, regulatory compliance, and medical/health records.

56% of healthcare organizations expect to encounter inaccurate, misleading, or incomplete information when first adopting blockchain technology.

Source: 2017 IBM survey of 200 healthcare payer and provider executives in 16 countries on the adoption of blockchain technology
In addition, when clinicians create new data through the documentation process, they need tools that facilitate the capture of high quality data in structured formats that are easily exchanged and interpreted with minimal manual intervention.”

3/ ARTIFICIAL INTELLIGENCE

Though artificial intelligence (AI) is being used in administrative and clinical functions, experts believe that the next decade could see the technology taking a more direct role in clinical decision making.

The use of AI to design treatment plans, manage medications, assist with repetitive administrative tasks, and promote predictive medicine could grow the AI technology market to more than $10 billion by 2024, according to a report by the consulting firm Accenture.

AI’s growth in the next decade could also ease workforce shortages. Projected physician shortages have many healthcare organizations beefing up care teams with physician assistants and nurses, and AI could help those care teams with decision making.

Technology that enables AI can also make genomics more accessible to care teams, and assist with chronic care management, Ebadollahi says. “The role of artificial intelligence is to help practitioners sift through knowledge, publications, and hard-to-analyze data,” he notes.

Ebadollahi adds that AI already has differing adoption rates depending on the healthcare sector, but in the next five years the technology will be more common in the hands of physicians and nurses as they diagnose patients and create treatment plans.

The use of more AI, and data in general, will also lead to new roles, says Ebadollahi. “On a healthcare team of physicians, nurses, and physician assistants, it won’t be a remote idea to have a data scientist as a part of the team.”

4/ INCREASED AUTOMATION

Streamlining claims and administrative processes would be a game changer to the industry. Billing and insurance-related administrative expenses total more than $375 billion, accounting for about 15% of healthcare costs in the United States, according to a 2015 report by BMC Health Services Research. A simplified billing system would save money and push the industry toward being more in step with other automated consumer experiences.

Craig Kasten, cofounder of Skygen USA, a claims management technology and outsourcing consulting firm, says in the next decade healthcare organizations that aren’t able to process claims and authorizations in the same day will be obsolete.

“During the next five to 10 years, healthcare payers will either adopt new technologies and automated processes, or they will be replaced by competitors with lower costs that offer innovative services and deliver a much better experience for both providers and patients,” Kasten says.

Health plans need technology solutions built with electronic communications and process automation as the foundation of the architectural design, rather than technology centered on paper forms and manual processes, according to Kasten.

“Many hospitals and health systems in particular are making investments in revenue cycle management technology in an effort to create greater efficiencies, reduce waste, and improve the member/provider experience,” says Kasten. “Incorporating automated claims submission, remittance advice, payments, etc., into those technologies will greatly increase the value of those investments and help them manage their cash flow more effectively—an important consideration given the challenges that come with the transition to value-based care coupled with ever-shrinking margins.”

Kasten says that real-time automated determinations and claims adjudication will result in more accurate and reliable claims payment, reduced accounts receivables, more consistent revenue streams with faster and easier daily reconciliation, and less reliance on collection agencies to pursue unpaid bills and unpaid claims from insurers.

Health plans will benefit from significantly fewer calls from providers seeking claims status and payment information, fewer duplicate claims submissions, fewer denied and resubmitted claims, higher provider satisfaction, a better experience for patients, greater productivity, and lower administrative costs, Kasten says. He notes that same-day accounting and reimbursement encourages providers to abandon paper and engage in electronic relationships.

“Clinicians can access the precise information they need when they need it.”

Craig Kasten, Skygen USA

Money Matters

Billing and insurance-related administrative expenses cost more than $375 billion annually, accounting for about 15% of total healthcare costs in the United States.

Source: BMC Health Services Research.
"To achieve the best outcomes with the lowest costs, health plans must invest in modern technologies that seamlessly automate routine administrative functions, while streamlining processes that require human judgement, such as instantly providing a full, online view into patient treatment history, allowing clinicians to make medical necessity determinations efficiently and accurately."

5/ VIRTUAL REALITY

The daily use of virtual and augmented reality with practitioners is coming within the next 10 years, says Samit. "If the engine is artificial intelligence and blockchain, augmented and virtual reality are the interfaces that make the technology accessible."

So what will this look like? He predicts physicians will use virtual reality by, for example, wearing glasses that capture a patient encounter and ensure compliance, record keeping, and patient privacy. "Augmented reality glasses can be worn by doctors and someone can listen in on their meetings and take notes," Samit says. "At the end of their rounds, everything is typed up, medications are noted, conflicts have been researched, questions have been answered. Everyone on the care team will have the latest and greatest knowledge, and it helps the doctor be more educated."

Augmented and virtual reality technology can also be used in operations where the surgeon is in a remote location guiding robotics to perform surgeries. It can also be used in the operating room as surgeons wear headgear and glasses that can show 3D images of a patient’s tumor to be removed, says Samit. "Today we are seeing great imaging, but it is useless to see 2-dimensional images when you can see 3-dimensional images hovering above your patient in the operating room."

Another use for virtual reality: combatting the opioid epidemic. Samit calls this "mechanized medication," citing studies showing that patients who are distracted from their pain using virtual reality leave hospitals sooner and have less use for pain medication. A 2016 study conducted at Cedars-Sinai Medical Center in Los Angeles found that patients experience 24% less pain within 10 minutes of viewing virtual reality experiences including ocean exploration, Cirque du Soleil performances, and tours of Iceland.

Samit predicts that virtual reality glasses and holographic technology will flood the healthcare market in the next two years, due to their efficiency and the better health outcomes they produce.

Editor’s note: This article was first published in our partner publication, Managed Healthcare Executive.

"During the next five to 10 years, healthcare payers will either adopt new technologies and automated processes, or they will be replaced by competitors."

CRAIG KASTEN, SKYGEN USA

$18 BILLION

The savings expected to be realized by 2026 if the healthcare industry uses artificial intelligence to assist with administrative tasks.

19%

The percentage of healthcare organizations who say their most pressing Health IT problem is exchanging claims/patient data with other entities.

36%

The percentage of healthcare organizations who employ a data scientist whose sole job is to analyze and interpret data, spot trends, and provide feedback.

Source: Managed Care Technology Survey, 2018.
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The nation's largest physician-owned insurer is now expanding in New York.
continued from page 23

**Docs tackle revenue challenges**

his payers have trailed his expenses practically since he established his solo practice in 2011.

"Even private insurances are paying terrible," he says. "We had to terminate our contract with United HealthCare because they were paying us close to 30 percent less than Medicare and weren't willing to go up at all."

How does he bridge the gap between reimbursement and practice expenses? "Working longer hours," he says. "Putting in a lot of 12-to-14 hour days." But a considerable chunk of that time is spent entering data into his EHR, a task that leaves him feeling like "a glorified clerk for an insurance company," he says.

Contributing to Purush’s frustration is the inability of EHR systems to communicate with one another, forcing doctors to employ time-consuming workarounds when they want to exchange patient data with each other or send it to government agencies—time that could otherwise be spent treating patients.

"If the government really wants us to give them data, they should have developed a unified system so this problem of interoperability wouldn’t exist," he says.

In Purush’s view, EHR manufacturers take advantage of the situation by making it expensive and disruptive for practices to switch systems. "We are trying to mix an altruistic service with business and that never goes well," he says.

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**EXPLORING NEW REVENUE SOURCES**

Mandel, the Los Angeles OB/GYN, faces dual reimbursement challenges, both related to his decision not to participate in insurance networks while retaining a fee-for-service practice model.

Reimbursements to nearby practices that are in networks have been stagnant or declining, he says, which means those practices aren’t raising their rates. "So even though I’m out of network, I can’t push my rates when the competition isn’t," he says.

In addition, payers have been scaling back or eliminating payments for out-of-network coverage. "I get patients saying, ‘My insurance used to pay 70 percent of my bill but now they’re only paying 50 percent, so I’ll need a discount or I’ll have to leave you’," he says.

Mandel makes up for the lost revenue by looking for other sources of income and cutting costs. For the former, he is taking on legal and forensic consulting work, much of which actually pays more per hour than his medical practice.

To reduce expenses, he no longer purchases educational materials to give to patients, and laid off a staff member at the beginning of the year. But the biggest expense reduction has been in his own take-home pay. Not counting for inflation, "I made three times as much money in 1988 as I make today.

"Luckily, I’m 61-and-a-half years old and I worked my a-- off for the last 35 years and didn’t live above my means," he says. "But if I were five or 10 years younger or had younger kids who still needed to be put through college, it would be a bigger issue."

**DRAWING STRENGTH FROM RELATIONSHIPS**

Physician Report participants acknowledge that the ongoing struggle to find the time and money to properly care for patients sometimes dampens their enthusiasm for medicine. What keeps them going, many of
them say, is the relationships they’ve established with patients over decades in practice. “Because I’m out of network, I know that my patients come here because they really want to see me,” says Mandel, adding that not being in an insurance network gives him the luxury of spending as much time with each patient as he thinks necessary.

“If I were in network, the only way to survive would be to churn through patients quickly, and the docs I know who are spending six minutes per patient are all miserable,” he says.

Like Mandel, Fleischer draws energy from his ties to patients. “I really value my relationships with my patients, maybe because being in a practice where I’ve taken care of some families for three generations allows me to build a strong bond [with them],” he says.

In addition, Fleischer sits on the board of directors of an ACO. “It gives me the semi-delusional and probably misguided notion that maybe I’m at the forefront of changing healthcare for the better,” he says.

Purush remains inspired by recalling what drew him to medical practice. “When you’re young, you’re altruistic, before you get jaded by the business end of medicine, was a time when you wanted to make a difference in people’s lives,” he explains. “So if you keep going back to that place, it gives you the encouragement to stay with it.”

For Pollock, continued enjoyment in practicing medicine comes from fulfillment of the basics. “I love seeing my patients, and I like the staff I work with,” she says. “I have a beautiful office that’s about five minutes from my home. So for as long as I can make it last, it’s a pretty sweet gig.”

Average salary comparison for both employed physicians and practice owners

2017 Median income = $212,000

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The top 9 issues facing primary care in 2017

1. Burden of paperwork/quality metrics
2. Third-party interference (e.g., prior authorizations, etc.)
3. Inadequate reimbursement
4. Physician burnout
5. EHR systems don’t work as they should
6. Primary care is undervalued compared to other specialties
7. Malpractice/need for tort reform
8. Competition from retail clinics
9. Patients getting health information online
The biggest problem plaguing primary care is the paperwork burden, according to Medical Economics’ 89th Physician Report, with 79 percent of respondents ranking it as their top challenge.

"Payers and CMS with their reporting requirements are trying to do the right thing and reward quality care, but the process and metrics we have today are adding to the burden with little substantive evidence it is helping quality," says David Gans, MHA, senior fellow of industry affairs for the Medical Group Management Association.

With quality metrics becoming more common and the quantity of forms and data reporting increasing, experts say physicians need to take steps to keep their paperwork to manageable levels.

**START WITH THE EHR**

While large organizations typically have dedicated staff members to help with quality reporting requirements and the technology needed to make it minimally intrusive, small practices will have to invest time to save time, says Gans. He suggests starting with the EHR.

"Physicians can work with their EHR vendor to look at ways to automate data reporting, such as having the right prompts appear during a visit that address quality metrics," Gans says. For example, if a patient has diabetes, it might prompt about foot or eye exams, document it, and report it to the practice’s contracted payers.

Jennifer Caudle, DO, a primary care physician and associate professor at Rowan University School of Osteopathic Medicine, says that physicians don’t always realize all the help that may be available through their EHR. "Sometimes taking a refresher course can be helpful in reminding us of tips and tricks to more efficiently use the program," she says. "Doctors might be surprised at how many reminders and alerts can be set up in the EHR."

Because of the number of patients covered by Medicare, most EHRs should offer some help reporting to CMS. But Gans points out that this assistance may be built-in or an add-on capability. Software modules designed for private payers are rarer because insurers reporting requirements can vary by state or region, making it expensive for EHR vendors to design custom software for each area of the country for each payer.

Physicians should also review how their EHR desktop view is set up and how information is organized there, then customize it to reflect their workflow, she adds. To save time, she structures her view to show tasks and what her day looks like and what reports need to get done.

"Having a strategy for the EHR is very important," says Caudle. "The small things should not be underestimated."
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In their own words

Doctors discuss what they see as the biggest issue facing primary care

Medical Economics asked the participants in our 89th Annual Physician Report what they believe is the biggest challenge facing primary care. Some of these physicians told us in their own words:

“The challenge of finding physicians who want to practice primary care.”

“The complexity of patients and cumbersome EHRs equal low reimbursement, high stress, and less time for eye contact.”

“The expectations that all outcomes will be perfect.”

“Hospital consolidation/acquisition of primary care practices.”

“Hospital takeovers, no new independent practices starting up.”

“Lack of doctors. Too many patients seen by physician assistants and nurse practitioners, resulting in too many referrals to specialists.”

“I do think it’s important that physicians don’t get caught up in the faxing, scanning, and calling. If you are able to ask someone to do this and it is within their responsibilities and skill level, that will free up physician time for more appropriate tasks,” says Caudle.

She adds that sometimes it’s a matter of delegating tasks and working only at the top of a license. “Physicians need to recognize that and work with their team,” she says. “They need to ask themselves, ‘What is the best and most appropriate use of time?’”

Gans says that even though CMS is reviewing reporting requirements, physicians should not assume that value-based care—and the reporting that goes with it—is going away, and recent announcements from the agency have reaffirmed that.

“In the long run, value-based reporting is going to be a requirement from all payers,” he says. “Doctors need to build systems into their normal practice workflow while taking advantage of the capabilities that may be available from their EHR. They need to know what their systems can do to record information, how they can report data and make sure they understand all the requirements and deadlines.”

“Payers exert too much control. Medicine belongs to patients and doctors.”

“I’m tired of specialists not realizing that we know something also. We get patted on the head and told to go and play.”

“The lack of universal health insurance.”

“The loss of autonomy and physician control.”

“The over-reliance on commercialized pharmaceuticals.”

“The lack of realization that quality primary care takes time.”

In their own words

Doctors discuss what they see as the biggest issue facing primary care

Medical Economics asked the participants in our 89th Annual Physician Report what they believe is the biggest challenge facing primary care. Some of these physicians told us in their own words:

“The challenge of finding physicians who want to practice primary care.”

“The complexity of patients and cumbersome EHRs equal low reimbursement, high stress, and less time for eye contact.”

“The expectations that all outcomes will be perfect.”

“Hospital consolidation/acquisition of primary care practices.”

“Hospital takeovers, no new independent practices starting up.”

“Lack of doctors. Too many patients seen by physician assistants and nurse practitioners, resulting in too many referrals to specialists.”

“I do think it’s important that physicians don’t get caught up in the faxing, scanning, and calling. If you are able to ask someone to do this and it is within their responsibilities and skill level, that will free up physician time for more appropriate tasks,” says Caudle.

She adds that sometimes it’s a matter of delegating tasks and working only at the top of a license. “Physicians need to recognize that and work with their team,” she says. “They need to ask themselves, ‘What is the best and most appropriate use of time?’”

Gans says that even though CMS is reviewing reporting requirements, physicians should not assume that value-based care—and the reporting that goes with it—is going away, and recent announcements from the agency have reaffirmed that.

“In the long run, value-based reporting is going to be a requirement from all payers,” he says. “Doctors need to build systems into their normal practice workflow while taking advantage of the capabilities that may be available from their EHR. They need to know what their systems can do to record information, how they can report data and make sure they understand all the requirements and deadlines.”

“Payers exert too much control. Medicine belongs to patients and doctors.”

“I’m tired of specialists not realizing that we know something also. We get patted on the head and told to go and play.”

“The lack of universal health insurance.”

“The loss of autonomy and physician control.”

“The over-reliance on commercialized pharmaceuticals.”

“The lack of realization that quality primary care takes time.”
Keeping payers, other third parties from interfering with patient care

by CHRIS MAZZOLINI Content manager

Primary care physicians say they find their practices increasingly beset by outside interference that gets in the way of effective patient treatment.

When asked about the main problem facing primary care today, 70 percent of physicians tagged “third-party interference” as the biggest challenge, according to the Medical Economics 89th Annual Physician Report.

Most physicians in the study pointed to prior authorizations as the most common type of interference they experience. But that is only the beginning, says Ripley Hollister, MD, a primary care physician who operates Hollister Healthcare Team in Boulder, Colo.

After thinking about the various sources of interference physicians deal with Hollister came up with an extensive list: prior authorizations and narrow networks from private payers; government mandates, regulations, and attestation requirements; quality metric and certification obligations; hospitals; EHR vendors; and physician advocacy groups. The list goes on.

“Third-party interference is burning doctors out because we want to take care of patients,” says Hollister, who also serves as a board member for the Physicians Foundation, an advocacy group for practicing physicians. “Doctors enjoy the intellectual challenge, the compassion, the relationships; that’s why we went into medicine. And all of these things get in the way.”

“It has nothing to do with medical care,” adds Kenneth Kubitschek, MD, an internist in Asheville, N.C. “It’s all about saving money and putting people through the hassle so they get tired of the hassle.”

Physicians interviewed by Medical Economics say there are ways to minimize the pain and take a stand, however. They range from small workflow tweaks to more drastic changes such as dropping a payer or switching to a practice model such as direct primary care that cuts insurance companies out completely.

**WORKFLOW CHANGES**

Prior authorization for prescription drugs is the most common form of third-party interference practices experience, physicians say.

At Ravenna Family Practice in Ravenna, Mich., Nicholas Beechnau, DO, and his father, Timothy Beechnau, DO, have a small staff so they try to stay on top of what their major payers require to avoid unnecessary call-backs. “You start to learn what they require for the next test,” says Nicholas. “The problem with all the different payers is that they all have different hoops.”

**HIGHLIGHTS**

- One option for dealing with prior authorizations is to put the initial onus on patients to call their insurance company.
- An even more radical step is to stop taking third-party payments entirely. Among the most common ways practices are doing this is by adopting the direct primary care model.
That can quickly get complicated. Requirements and formularies are constantly changing. There is rarely, if ever, any notice when these changes occur. Doctors typically learn about a change only when coverage is denied. “It’s never steady ground you’re standing on; it’s always a moveable world,” Kubitschek says.

Kubitschek’s 17-provider practice has a staff person dedicated to handling prior authorizations and learning the “hoops they need to jump through,” Kubitschek says. The key is having someone who can monitor the most important payer contracts, track denials and pre-approval requests, and communicate changes to the physicians and providers as they come up, he adds.

Another option is to put the onus on patients to call the insurance company for authorizations, Kubitschek says. While his practice will complete any forms the patient needs to send to their insurance company for approval, staff members will not make the calls. “We put it back on the patient,” he says. “You can’t take on everything when they [the insurance companies] are putting up barriers more and more. If patients don’t feel that pain with us, the insurance company will say, ‘Why not put up more barriers?’ We have to let the patients know that their insurance companies are being unreasonable.”

It’s important to explain to patients the reason for this policy, Kubitschek says. His practice has a script that employees can use to make sure they explain the issue thoroughly, answer questions and address any complaints.

There have been some changes for the better, Kubitschek says. His practice’s EHR recently acquired the ability to do e-authorizations, which has the potential to streamline the approval process somewhat. “We’re excited about it,” he says. “It fills out part of the form for you, the demographics of the patient. We just started using it and I think it’s going to be a big plus for us.”

**FIGHTING BACK**

But sometimes a payer’s requirements, denials, and authorization demands become so onerous there’s only one option: Stop working with that payer.

Kubitschek’s practice recently jettisoned a payer that had become too difficult to work with. He advises that it’s not a decision to make lightly, as it will affect patients and could impact the practice’s bottom line. But practices shouldn’t be afraid to make it under the right circumstances.

“Know your payer mix, and know when you need to fish or cut bait,” he says.

An even more radical step is to stop taking third-party payments entirely. Among the most common ways practices do this is to adopt the direct primary care model, in which patients pay a monthly fee that covers all their routine medical care.

Hollister, with the Physicians Foundation, says direct primary care offers a route to a kind of freedom that puts patient care first. “We want to take care of the patient, but we’re taking care of the insurance company,” he says. “One of the solutions is to do whatever you can to get rid of intrusions, and that’s what direct primary care looks like. Doctors want to care for patients, patients want to receive care from the physicians. That’s the equation that works.”

“It has nothing to do with medical care. It’s all about saving money and putting people through the hassle so they get tired of the hassle.”

—KENNETH KUBITSCHEK, MD, INTERNIST, ASHEVILLE, N.C.
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Michelle Fenoughty, MD, MBA’16
Chief Medical Officer, Hendricks Regional Health

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Salary
How much do physicians earn?

Average income by...

**GENDER**

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>$253,000</td>
<td>$257,000</td>
<td>$266,000</td>
<td>$270,000</td>
<td>$268,000</td>
</tr>
<tr>
<td>Women</td>
<td>$186,000</td>
<td>$190,000</td>
<td>$191,000</td>
<td>$204,000</td>
<td>$207,000</td>
</tr>
<tr>
<td>Difference</td>
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<td>$67,000</td>
<td>$75,000</td>
<td>$66,000</td>
<td>$61,000</td>
</tr>
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</table>

**PRIMARY CARE SPECIALTY**

<table>
<thead>
<tr>
<th>Specialty</th>
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<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
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<td>Internal medicine</td>
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<td>$203,000</td>
<td>$211,000</td>
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<td>$230,000</td>
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<td>$198,000</td>
<td>$202,000</td>
<td>$205,000</td>
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<tr>
<td>Cardiology</td>
<td>$381,000</td>
<td>$376,000</td>
<td>$401,000</td>
<td>$460,000</td>
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<tr>
<td>Pediatrics</td>
<td>$195,000</td>
<td>$203,000</td>
<td>$214,000</td>
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<td>$205,000</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>$263,000</td>
<td>$260,000</td>
<td>$262,000</td>
<td>$264,000</td>
<td>$271,000</td>
</tr>
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Average income by...

<table>
<thead>
<tr>
<th>COMMUNITY</th>
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<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner city</td>
<td>$212,000</td>
<td>$211,000</td>
<td>$232,000</td>
<td>$231,000</td>
<td>$247,000</td>
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<tr>
<td>Urban</td>
<td>$228,000</td>
<td>$247,000</td>
<td>$236,000</td>
<td>$254,000</td>
<td>$253,000</td>
</tr>
<tr>
<td>Suburban</td>
<td>$236,000</td>
<td>$235,000</td>
<td>$248,000</td>
<td>$257,000</td>
<td>$249,000</td>
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<tr>
<td>Rural</td>
<td>$232,000</td>
<td>$223,000</td>
<td>$232,000</td>
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<td>$230,000</td>
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<table>
<thead>
<tr>
<th>REGION</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>$231,000</td>
<td>$229,000</td>
<td>$228,000</td>
<td>$262,000</td>
<td>$245,000</td>
</tr>
<tr>
<td>Midwest</td>
<td>$230,000</td>
<td>$237,000</td>
<td>$233,000</td>
<td>$256,000</td>
<td>$245,000</td>
</tr>
<tr>
<td>South</td>
<td>$236,000</td>
<td>$233,000</td>
<td>$252,000</td>
<td>$256,000</td>
<td>$249,000</td>
</tr>
<tr>
<td>West</td>
<td>$228,000</td>
<td>$241,000</td>
<td>$237,000</td>
<td>$237,000</td>
<td>$252,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRACTICE OWNERSHIP, 2017</th>
<th>Owner</th>
<th>$252,000</th>
<th>Non-owner</th>
<th>$241,000</th>
</tr>
</thead>
</table>

| PRACTICE MODEL, 2017 | Traditional fee-for-service (FFS) | $251,000 | Combo (FFS & value-based pay) | $258,000 | Direct pay | $172,000 | Concierge | $251,000 | Hybrid | $225,000 |

$7,000
The difference in average annual income between physicians who received value-based pay in 2017 and physicians who accepted only fee-for-service reimbursement.

Productivity

Average number of patient visits per week

Average number of patient visits for all physicians = 80

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family practice</td>
<td>99</td>
<td>89</td>
<td>90</td>
<td>85</td>
</tr>
<tr>
<td>Internists</td>
<td>93</td>
<td>85</td>
<td>87</td>
<td>76</td>
</tr>
</tbody>
</table>

Median number of hours worked per week

Average number of hours for all physicians = 52

<table>
<thead>
<tr>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family practice</td>
</tr>
<tr>
<td>Internists</td>
</tr>
</tbody>
</table>

Average number of patients seen per week, by practice ownership, 2017

(Numbers of patients per week)

<table>
<thead>
<tr>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
</tr>
<tr>
<td>Hospital-owned practice</td>
</tr>
<tr>
<td>Nonprofit</td>
</tr>
<tr>
<td>Hospital in-patient</td>
</tr>
</tbody>
</table>

Where physicians saw patients in 2017

<table>
<thead>
<tr>
<th>65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Senior residence/nursing home</td>
</tr>
<tr>
<td>Telemedicine</td>
</tr>
<tr>
<td>Patient homes</td>
</tr>
<tr>
<td>Other locations</td>
</tr>
</tbody>
</table>
Malpractice rates
Median annual premiums...

<table>
<thead>
<tr>
<th>for primary care physicians</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family practice</td>
<td>$11,900</td>
<td>$11,100</td>
<td>$10,900</td>
<td>$10,700</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>$12,200</td>
<td>$12,700</td>
<td>$12,600</td>
<td>$12,100</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$20,600</td>
<td>$18,700</td>
<td>$18,700</td>
<td>$16,700</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>by geographic region</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>$16,800</td>
<td>$18,400</td>
<td>$15,700</td>
<td>$16,900</td>
</tr>
<tr>
<td>South</td>
<td>$12,600</td>
<td>$12,200</td>
<td>$12,200</td>
<td>$11,500</td>
</tr>
<tr>
<td>Midwest</td>
<td>$13,600</td>
<td>$13,700</td>
<td>$13,600</td>
<td>$13,200</td>
</tr>
<tr>
<td>West</td>
<td>$13,800</td>
<td>$12,700</td>
<td>$11,500</td>
<td>$12,400</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>by years in practice</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 or less</td>
<td>N/A</td>
<td>$5,600</td>
<td>$13,100</td>
<td>$15,000</td>
</tr>
<tr>
<td>6 to 10</td>
<td>$14,100</td>
<td>$14,000</td>
<td>$13,700</td>
<td>$13,500</td>
</tr>
<tr>
<td>11 to 20</td>
<td>$14,500</td>
<td>$14,300</td>
<td>$13,800</td>
<td>$14,100</td>
</tr>
<tr>
<td>21 to 30</td>
<td>$14,300</td>
<td>$14,300</td>
<td>$13,800</td>
<td>$12,900</td>
</tr>
<tr>
<td>more than 30</td>
<td>$12,400</td>
<td>$12,300</td>
<td>$11,800</td>
<td>$11,900</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>by practice size</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>$12,600</td>
<td>$12,400</td>
<td>$12,800</td>
<td>$12,000</td>
</tr>
<tr>
<td>2 physicians</td>
<td>$14,900</td>
<td>$16,000</td>
<td>$13,300</td>
<td>$10,400</td>
</tr>
<tr>
<td>3 to 10 physicians</td>
<td>$15,000</td>
<td>$14,600</td>
<td>$13,300</td>
<td>$14,600</td>
</tr>
<tr>
<td>11 to 25 physicians</td>
<td>$12,900</td>
<td>$12,500</td>
<td>$10,000</td>
<td>$11,900</td>
</tr>
<tr>
<td>26 to 50 physicians</td>
<td>$17,900</td>
<td>$15,400</td>
<td>$15,000</td>
<td>$14,600</td>
</tr>
<tr>
<td>More than 50 physicians</td>
<td>$15,900</td>
<td>$13,900</td>
<td>$15,000</td>
<td>$13,900</td>
</tr>
</tbody>
</table>

ANCILLARY SERVICES

Most popular ancillary services in internal medicine/family practice
1. ECG
2. Lab services
3. Spirometry
4. Nutritional/weight loss counseling
5. Radiology/imaging services
6. Implantable contraceptives
7. Stress tests

Percentage of revenue from ancillary services for primary care in 2017 (Average)

- Internal medicine: 10%
- Family practice: 10%
- Pediatrics: 8%
- Cardiology: 24%
- OB/GYN: 10%

Change in malpractice premiums for 2017, compared with 2016
- Increased: 11%
- Decreased: 4%
- Stayed the same: 49%
- Don’t know: 36%

CYBERSECURITY
Did your practice have a data breach in 2017?
- Yes: 85%
- No: 3%
- Not sure: 12%

Continued on page 58
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- Courses to Build, Market and Grow Aesthetic Practices

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SECONDARY INCOME

Did you earn income from an employment source outside of your practice?

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32%</td>
<td>30%</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>No</td>
<td>67%</td>
<td>69%</td>
<td>66%</td>
<td>69%</td>
</tr>
<tr>
<td>No answer</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Amount of secondary income (Average)

<table>
<thead>
<tr>
<th>Internal Medicine</th>
<th>$64,900</th>
</tr>
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<tbody>
<tr>
<td>Family Practice</td>
<td>$51,800</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$42,000</td>
</tr>
</tbody>
</table>

PRESCRIBING

About how many prescriptions do you write during an average week?

<table>
<thead>
<tr>
<th>Internal Medicine</th>
<th>114</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>126</td>
</tr>
<tr>
<td>Cardiology</td>
<td>76</td>
</tr>
</tbody>
</table>

Do you e-prescribe?

86% YES

No, but I plan to at some point: 6%

No answer: 1%

Do you e-prescribe controlled substances?

21% YES

No: 60%

No answer: 1%

32% YES

No: 67%
About the respondents

**Years in practice**
- Median = 26 years in practice

**Physician age**
- Median = 57 years old

**Physician gender**
- 65% Male
- 35% Female

**Continuing Medical Education**
- 64 HOURS
- The average amount of time primary care physicians spent on CME in 2017

**Practice ownership**

<table>
<thead>
<tr>
<th>Practice ownership</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>55%</td>
</tr>
<tr>
<td>Hospital-owned practice</td>
<td>16%</td>
</tr>
<tr>
<td>Academic center/hospital/practice</td>
<td>10%</td>
</tr>
<tr>
<td>Nonprofit organization</td>
<td>4%</td>
</tr>
<tr>
<td>Hospital</td>
<td>4%</td>
</tr>
<tr>
<td>Government</td>
<td>2%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Primary field of practice**

<table>
<thead>
<tr>
<th>Primary field of practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family practice</td>
<td>23%</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>18%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>18%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>14%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4%</td>
</tr>
<tr>
<td>Urology</td>
<td>4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>4%</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>2%</td>
</tr>
<tr>
<td>Surgical specialty</td>
<td>2%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>2%</td>
</tr>
<tr>
<td>Other specialties</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Practice size**

<table>
<thead>
<tr>
<th>Practice size</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo practice</td>
<td>28%</td>
</tr>
<tr>
<td>2 physicians</td>
<td>8%</td>
</tr>
<tr>
<td>3-6 physicians</td>
<td>22%</td>
</tr>
<tr>
<td>7-10 physicians</td>
<td>8%</td>
</tr>
<tr>
<td>11-25 physicians</td>
<td>12%</td>
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<tr>
<td>26-50 physicians</td>
<td>4%</td>
</tr>
<tr>
<td>More than 50 physicians</td>
<td>17%</td>
</tr>
</tbody>
</table>

**Do you have an ownership interest in your practice?**
- No: 51%
- Yes: 49%

**About the respondents**

**Physician gender**
- Male: 65%
- Female: 35%

**Practice ownership**
- Private practice: 55%
- Hospital-owned practice: 16%
- Academic center/hospital/practice: 10%
- Nonprofit organization: 4%
- Hospital: 4%
- Government: 2%
- Urgent care: 1%
- Other: 8%

**Continuing Medical Education**
- 64 HOURS
- The average amount of time primary care physicians spent on CME in 2017

**Primary field of practice**
- Family practice: 23%
- Internal medicine: 18%
- Pediatrics: 18%
- OB/GYN: 14%
- Cardiology: 4%
- Urology: 4%
- Dermatology: 4%
- Hospitalist: 2%
- Surgical specialty: 2%
- Urgent care: 2%
- Other specialties: 9%

**Practice size**
- Solo practice: 28%
- 2 physicians: 8%
- 3-6 physicians: 22%
- 7-10 physicians: 8%
- 11-25 physicians: 12%
- 26-50 physicians: 4%
- More than 50 physicians: 17%
t has been more than a year since Donald Trump ascended to the presidency, promising the very best of everything. I was among a small minority in healthcare that cheered the arrival of a different administration because it brought with it the hope of a new direction. Suffice it to say, my problems with the direction the prior administration took were legion.

Without re-litigating the myriad issues that arose in the last eight years, most can comfortably agree that at the end of the era of enlightened planning from the center, healthcare is more expensive, more regulated, and more inefficient.

It is the fashion of late to not just disagree with Trump, his cabinet, and his policies, but to find them all immoral people who hate (in no particular order): children, poor people, women, and any persons of color. I find it striking that most of these characters were relative unknowns toiling away in their former lives who garnered no special attention prior to joining the Trump team, and finally being outed as Voldemort-worshipping death eaters.

The members of the #RESISTANCE need not, therefore, have to worry their heads about actual policy positions, but I will attempt to summarize the stance of these apostles of Satan.

TOM PRICE: C
Tom Price, MD, a former orthopedic surgeon, was brought in as head of the Department of Health and Human Services. The move was applauded by most rank-and-file physicians because he spoke the language of physicians suffering under the weight of the prior administration's good intentions.

In his Senate confirmation hearing, Price bemoaned the rules and regulations related to Meaningful Use that had pushed physicians into retirement, but did nothing to increase value to patients. He signaled a lighter touch may be on the horizon when it came to EHRs by noting that the role of the federal government was to ensure interoperability rather than micromanaging the collection of useless data points from data entry clerks formerly known as doctors.

Unfortunately, the former congressman was gone before he could effect any change, felled by the stellar journalists at Politico who uncovered evidence of travel via a charter plane for personal matters.

Unfortunately, the former congressman was gone before he could effect any change, felled by the stellar journalists at Politico who uncovered evidence of travel via a charter plane for personal matters.

I must profess to being incredibly annoyed at the development. The penalty seemed entirely too great given how hopeful I was at having a physician voice speaking to physician concerns at the head of the policy making table. Regardless, the reign of Price was an ineffectual one.

SEEMA VERMA: B-
Appointing Seema Verma to head the Centers for Medicare and Medicaid Services was another move applauded by many in the trenches. Little known to most, she had garnered attention in Indiana with an innovative approach to the state’s Medicaid program. She seemed to understand that poor access in Medicaid patients was driven in large part by inordinately poor reimbursement for a population that can be very complex to manage.

A key component to Indiana Medicaid was using tobacco tax dollars to raise Medicaid reimbursement rates to at least equal Medicare rates—a move that made her popular among physicians whose charge it was to take care of these patients.

Unfortunately, it is the charge of the director of CMS to administer, rather than make, laws. There has been little of substance to report from Verma other than some nice words about putting patients before paperwork. She has also been remarkably ineffective in making a case for what she believes in publicly.

Those of us who believe that solutions in healthcare lie with physician-patient partnerships that make a wide
berth around third-party payers, need an effective and vocal salesperson. While there are glimmers of what could be as a recent fiery address at the HIMSS conference attests to, Verma has unfortunately mostly relegated herself to staid positions that inch the ball forward.

Evidence of this can be seen in her approach to the framework of value-based care that is mostly indistinguishable from its predecessors. There are some more exclusions for low-volume providers, but the meaningless system that transfers healthcare dollars from those unable to comply with regulations to those that can comply remains largely in place. It is still early, but a lack of bold action has marked the Verma reign so far.

SCOTT GOTTLIEB: A

The man appointed as commissioner of the FDA has been a bright spot that has drawn applause from many corners of the political spectrum. A conservative approach to the high price of drugs dictates using markets to lower prices, and in that vein, the FDA commissioner approved a record number of generics in 2017. The FDA also announced an expedited review of generic drugs for which there are fewer than three existing generic competitors.

In addition, Gottlieb has launched a pilot program for orphan drug requests to ensure the world would create no more Martin Shkreli.

Gottlieb also maintains an active and mature presence on Twitter, in stark contrast to the other members of the Trump healthcare team. If he could only manage the President’s Twitter account as well, world peace may well be within our reach.

HEALTHCARE POLICY: B

Healthcare turned out to be very complicated. Who knew? The solutions to what ails us remain comfortably far from reach after one year. There are those like me who believe the path to the best healthcare system courses through physician-led practices beholden to patients rather than systems. A mostly non-practicing class of healthcare busybodies made up of administrators, economists, public health officials, and MBAs think the opposite.

To this group, the physician is an interchangeable widget. Pushing back against this monolith is a slow process that began with the election of an outsider. The people appointed by Trump have not disappointed in changing the overall conversation in healthcare.

The individual mandate is a good example. What was a good idea to ensure everyone paid their fair share turned into a $300 to $500 per month boondoggle for a 40-year-old who just wanted financial protection from a catastrophic event. Little surprise that there were few tears shed here when this non-working mandate was repealed with the recent tax bill.

The administration has also hearteningly attempted to rein in spending for a Medicaid program that has largely been working poorly for patients, because low reimbursement rates have meant poor access to primary care physicians.

The reimbursement rates are particularly befuddling given the fact that the United States gave about $500 billion to insurance companies in 2015 alone to manage Medicaid patients. One hopes that the nation’s vast wealth may be deployed in a manner that serves patients, rather than their insurance companies.

Overall, there is ample evidence that new management has brought a different approach.

Change, though, continues to be frustratingly slow. Value-based pay-for-performance care that doesn’t actually relate to value remains the law of the land, and its implementation continues to leave much to be desired. Vertically integrated networks, once formed, seem difficult to displace.

A word of advice for the appointees facing some very tall tasks in the three years to come: Fly economy.

Anish Koka, MD, is a cardiologist in private practice in Philadelphia. Do you agree with his assessment of the Trump administration? Tell us at medec@ubm.com.
**“If I was not a physician, I’d be...”**

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“a photographer.”

“I wouldn’t want to be anything else.”

“an engineer or a very poor musician.”

“a detective.”

“a teacher or bioengineering researcher.”

“a university professor.”

“a counselor.”

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“I’m comfortable with making less money today than I used to. I don’t think it’s fair but then I ask, ‘What’s my alternative?’ And there really isn’t any.”

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The annual pay gap between male and female physicians

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