Exclusive side-by-side analysis

THE ELECTION’S IMPACT ON PHYSICIANS

Care coordination
How small practices can succeed

Financial adviser checklist
5 questions to ask

Data security
Get the right tools
Dear President-elect:

First, congratulations on your historic victory and new job as the 45th President of the United States. Second, I feel compelled to write to you about a pretty big section of your citizenry largely overlooked during the major party conventions as well as the heated debate season: physicians.

While the closest we got to healthcare during the campaign was the fate of the Affordable Care Act—and perhaps your own personal health—physicians (nearly one million strong at last count) are facing a number of serious issues as you prepare to take the oath and move into the White House.

First is Obamacare itself. I’m hopeful you can do something to make the program work more effectively and truly affordably for patients. In addition to thousands seeking new coverage as payers flee the marketplace, many of the remaining plans are accompanied by high deductibles and copays out of reach for your average American. Unfortunately, they don’t call you or their representatives in Congress to complain, they complain to their doctor … who has no control over the issue.

And while you are addressing the ACA, perhaps take a look at those constantly narrowing provider networks.

“While you are addressing the ACA, perhaps take a look at those constantly narrowing provider networks.”

Additionally, if it’s not too much trouble, could you take a look at another national behemoth that is troubling docs: the rising costs of drug prices? You and your opponent were pretty vocal in promising to rein in skyrocketing price tags with the help of Congress, so I’m hoping you can deliver on that promise, and fairly quickly. Physicians — and patients — would really appreciate it and for many, it’s becoming a life-and-death issue.

Another issue you may want to look at is MACRA. Don’t worry if you don’t know what that means, a lot of U.S. physicians are in the same boat. Your friends in the Senate and House reformed Medicare’s payment programs in a way that is really going to hurt solo and small-practice physicians. The road paved with good intentions … Am I right?

Finally, if you could also take a peek at these additional issues in your free time, I’m sure physicians would appreciate it: interoperability of electronic health records, the proliferation of direct-to-consumer drug ads, the opioid crisis, preserving autonomy for independent physicians, the clear conflict between HIPAA and the need to share patient information, something called “maintenance of certification” (Google it), and oh yes, how physicians can actually treat their patients and improve their well-being on a regular basis.

I know you have a lot on your plate and you might only have this job for four years, but there are nearly a million reasons why these things are important. So please make them an important part of your administration.

Keith L. Martin is content channel director for Medical Economics. As a physician, what would you like to see the next president tackle upon taking office? Tell us at medec@ubm.
Divided Congress unites to fight opioid epidemic
Will new funding to counter opioid addiction help physicians and patients deal with this problem?

PAGE 50

IN EVERY ISSUE
10 Interactive
11 Your Voice
17 Vitals
64 Advertiser index
65 Funny bones

D. C. CORNER

Trump vs. Clinton
An exclusive side-by-side comparison of the election’s impact on physician

PAGE 18

22 Decrease patient wait times
5 ways to move patients more efficiently through your practice

40 The ethics of telemedicine
How to preserve medical thoroughness during remote consultations

24 Make care coordination work
Coordinating among physicians can be challenge for small practices

45 Prevent a data breach
Many data breaches are easy to thwart. Here are some tips.

30 Evaluate your financial adviser
5 questions to ensure your money manager is the right fit

46 Return of the house call
Will a new payment model bring back an old-fashioned way to practice?

32 Don’t ignore data security
Why you need to do a risk analysis right now

52 Observation coding
When to use initial versus subsequent visit coding

38 Read the fine print
Why you shouldn’t ignore your employment contract’s boiler-plate

© 2016 UBM. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical including by photocopy, recording, or information storage and retrieval without permission in writing from the publisher. Authorization to photocopy items for internal educational or personal use, or the internal educational or personal use of specific clients is granted by UBM for libraries and other users registered with the Copyright Clearance Center, 222 Rosewood Dr., Danvers, MA 01923 (p. 7101). For use beyond those listed above, please direct your written request to Permission Dept. fax 440-756-5255 or email: mcannon@advanstar.com. SMARTER BUSINESS BETTER PATIENT CARE is used pending trademark approval.

MEDICAL ECONOMICS is published semimonthly (24 times a year) by UBM Medica, 131 W. First St., Duluth, MN 55802-2065. Subscription rates: one year $95, two years $180 in the United States & Possessions, $150 for one year in Canada and Mexico, all other countries $150 for one year. Singles copies (prepaid only): $18 in US, $22 in Canada & Mexico, and $24 in all other countries; include $6.50 for U.S. shipping and handling. Periodic postage paid at Duluth, MN 55806 and at additional mailing offices. Postmaster: Send address changes to Medical Economics, PO Box 6085, Duluth, MN 55806-6085. Canadian GST Number: R-124213133RT001. Printed in the USA.

© 2016 UBM. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical including by photocopy, recording, or information storage and retrieval without permission in writing from the publisher. Authorization to photocopy items for internal educational or personal use, or the internal educational or personal use of specific clients is granted by UBM for libraries and other users registered with the Copyright Clearance Center, 222 Rosewood Dr., Danvers, MA 01923 (p. 7101). For use beyond those listed above, please direct your written request to Permission Dept. fax 440-756-5255 or email: mcannon@advanstar.com. SMARTER BUSINESS BETTER PATIENT CARE is used pending trademark approval.

UBM Medica provides certain customer contact data (such as customers’ names, addresses, phone numbers, and e-mail addresses) to third parties who wish to promote relevant products, services, and other opportunities that may be of interest to you. If you do not want UBM Medica to make your contact information available to third parties for marketing purposes, simply call toll-free 888-626-2923 between the hours of 7:30 a.m. and 5 p.m. CST and a customer service representative will assist you in removing your name from UBM Medica’s lists. Outside the U.S., please phone 218-740-6477.

Medical Economics does not verify any claims or other information appearing in any of the advertisements contained in the publication and cannot take responsibility for any losses or other damages incurred by readers in reliance of such content.

Medical Economics cannot be held responsible for the safekeeping or return of unsolicited articles, manuscripts, photographs, illustrations, or other materials.

Library Access libraries offer online access to current and back issues of Medical Economics through the EBSCOhost databases.

To subscribe, call toll-free (888) 527-7088. Outside the U.S., call 218-740-6477.
Government control: MACRA threatens independence

Paying physicians for the value and quality of care they provide may sound great in theory, but independent physicians have been burned time and time again by previous government efforts to achieve that goal. Physicians say plans for Medicare payment reform are already inspiring ripples of dread.

bit.ly/MACRAcontrol

HIPAA resource center

The latest on how to keep your practice compliant with federal privacy and security rules

MedicalEconomics.com/tag/hipaa-resource-center

TOP HEADLINES NOW

Quality metrics
Why doctors, not data, must drive the future of healthcare
bit.ly/morethanmetrics

The opioid crisis
How physicians can become part of the solution to prescription drug abuse
bit.ly/MEopioidcrisis

Obamacare scorecard
Physicians give the Affordable Care Act a failing grade in exclusive survey

EHRs and malpractice
How to avoid a lawsuit related to your electronic health record system

HIPAA AUDITS
Here’s our 7 best tips for doctors to prepare for the 2016 HIPAA audits:
http://buff.ly/1Luizii

LEADERSHIP
How can doctors take on leadership positions in today’s challenging healthcare environment?
http://ow.ly/ULtJE

CODING
#coding can make or break your medical practice. Follow these steps to hire the right person.
http://ow.ly/NSt1q

HIGH DEDUCTIBLES
Why physicians must adjust how they practice
http://buff.ly/1QJWgun

HEALTH IT
Silicon Valley’s vision to transform healthcare #google #technology
http://buff.ly/1muKs6J

MOC
MOC, recertifications are ‘cancers’ doctors should rally against via
http://buff.ly/1QAaCkE
any years ago, I wrote a letter to the editor of JAMA following their article condemning doctors for accepting gifts, dinners, etc. I am in complete agreement with Dr. Ellis (“JAMA study a slap in the face to physicians,” August 10, 2016)) that it is an insult to the integrity of physicians that others believe our prescribing habits are influenced by a donut.

In my letter, I pointed out that they were complaining in a journal that physicians were receiving for free courtesy of the pharmaceutical companies. Should we therefore assume that everything in JAMA is biased because it is a pharmaceutical gift?

The same could be said of Medical Economics since we receive it at no cost. I would ask you if I should question the veracity of your articles because of pharmaceutical subsidies. I practiced as a solo doctor for many years and attended numerous pharmaceutical dinners. Most of them were very informative and given by very reputable speakers.

I also think I was smart enough to tell the wheat from the chaff. What is interesting is when I joined a large group whose policy was that physicians should not accept samples or attend pharmaceutical sponsored dinners, I found that the bright, young doctors I worked with didn’t have a clue about the new medicines that were available.

The only response I ever received from my patients when I handed them some free samples was a thanks. I realize perception is important, but the only folks who seem to have a problem with this is the government and our own industry—not the patients.

Isn’t it time to give physicians some credit for having a brain and allow each physician to decide for him/herself as to what type of relationship they want to have with the pharmaceutical industry?

Steven Howard MD
BELMONT, CALIFORNIA

Prescribing decisions dictated by payers

Dr. Kohil wrote an interesting article about doctors needing to be aware of medication costs when making prescribing decisions (The last word, August 10, 2016) but her essay ignored a few realities of practice today.

Prescribing decisions are dictated by insurance company formularies, not doctor or patient preference. The patient might want Eliquis and you might agree that it is the best option, but if the insurance company only covers warfarin, that’s what the patient is going to get.

Perhaps you have the staff and time to appeal a denial and obtain prior authorization for the preferred drug, but even then you may find that the copay is cost prohibitive for your patient.

It is impossible for us to know what any particular drug costs since the cost and coverage can vary dramatically from plan to plan. Also, the cost and coverage often changes on January 1.

Steven Gitler, DO
CAMDEN, NEW JERSEY

Physician burnout

Every year we lose about 400 physicians to suicide, roughly one a day. This deserves a thoughtful read. #ZeroSuicide

Roxanne Moore BFA MS
@MOOREROXANNE

Physicians abused, ignored and silenced no more
buff.ly/2bK4iZr

Medical Economics
@MEDICALECONOMICS

Retail’s fall & doc impact

I just wonder how many docs and/or practice managers are listening.

Michael Hein
@HEINDOC

Top 3 warnings to medical providers from the fall of retail buff.ly/2biXY4

Medical Economics
@MEDICALECONOMICS
I read with interest the various report cards on the different challenges medicine is currently facing. As a general internal medicine physician, the primary care incentive pay article was particularly interesting. I think it is important to understand that this bonus was simply a lifeline to primary care practices that had heavy exposure to Medicare patients.

In a busy and mature internal medicine practice, Medicare is frequently well over 50% of the practice. In my case, the bonus amounted to an additional one-half month of revenue. This is certainly a significant amount of money for any practice. I don’t think there is any real expectation from CMS that this incentive pay would change behaviors. It was simply an attempt to help maintain financial stability for these practices.

Unfortunately, our leaders in organized medicine were focused solely on getting rid of the SGR. During their rush to make a deal on this, they basically gave away too much. They have saddled primary care with additional burdens under MIPS. Eventually, specialists will have some of these burdens as well. However, primary care will remain the most heavily burdened with these programs. In addition to having more bureaucratic burdens, we gave up the money from the primary care incentive program. I don’t think there was anything similar that was given up by the specialist community.

John S Matlock, MD
SAN ANTONIO, TEXAS

PQRS is insulting to the integrity of physicians

I am very upset about losing my appeal with the CMS Physician Quality Reporting System (PQRS).

Because of an unfair and arbitrary process, my practice will lose thousands of dollars this year. We made a perfectly valid appeal and were harshly denied: “This decision is final.”

I run a solo practice of internal medicine in a small town. My wife, an RN, is my office manager and she worked diligently in 2014 to fulfill the “quality” inputs. Three measures were performed, as we were supposed to do. Two, we did perfectly well and passed (hundreds of patient encounters and data entries). The third was denied because the CMS “denominator” was misunderstood and/or inappropriately determined.

For example, it included patients who died, lived elsewhere, or changed to a new doctor, so it was impossible to reconcile their medications after a hospitalization. Also, the wording of the policy is confusing.

So, CMS said we were five patients short on Measure 46 and they did not show any understanding or sympathy on our appeal – the space for which on the online form was very limited.

We then get NO credit, only penalization, for all our many hours of efforts over the whole year. We did 99% right, spending a ton of resources on this “quality” project, and get worse than zero for all our efforts! This is unfair and insulting to our integrity and professionalism.

This sort of governmental arbitrariness embitters well-meaning physicians trying to make a living, particularly those of us without the resources of big groups.

Physicians should be spared this major frustration. Practicing medicine is difficult enough.

J. Gary Grant, MD
PACIFIC GROVE, CALIFORNIA

Agree on tort reform’s role in solving defensive medicine

In “Tort reform necessary to solve defensive medicine” (Your voice, June 25, 2016) Calvin S. Ennis, MD, was right to express his frustration with the way our tort system deals with medical malpractice.

Making plaintiffs’ attorneys (if they lose their case) pay the defense attorneys’ fees as he suggests would probably go a long way to cutting down on frivolous law suits.

But special health courts presided over by judges with special training in medical malpractice should also be considered as a solution. They have the potential to resolve cases quickly, and cut down on administrative costs and excessive payouts.

Both patients and doctors would be treated in a reasonable way, reducing the fierce hostility and adversarialism that now prevail. And defensive medicine, though it would not disappear, entirely would be lessened significantly.

Edward Volpintesta MD
BETHEL, CONNECTICUT

CMS saddling primary care with too many burdens

I read with interest the various report cards on the different challenges medicine is currently facing.

As a general internal medicine physician, the primary care incentive pay article was particularly interesting. I think it is important to understand that this bonus was simply a lifeline to primary care practices that had heavy exposure to Medicare patients.

In a busy and mature internal medicine practice, Medicare is frequently well over 50% of the practice. In my case, the bonus amounted to an additional one-half month of revenue. This is certainly a significant amount of money for any practice. I don’t think there is any real expectation from CMS that this incentive pay would change behaviors. It was simply an attempt to help maintain financial stability for these practices.

Unfortunately, our leaders in organized medicine were focused solely on getting rid of the SGR. During their rush to make a deal on this, they basically gave away too much. They have saddled primary care with additional burdens under MIPS. Eventually, specialists will have some of these burdens as well.

However, primary care will remain the most heavily burdened with these programs. In addition to having more bureaucratic burdens, we gave up the money from the primary care incentive program. I don’t think there was anything similar that was given up by the specialist community.

John S Matlock, MD
SAN ANTONIO, TEXAS
For decades, there have been few new developments in flu shot manufacturing.¹ Now, there’s a vaccine made using a modern process that could help transform flu protection for your patients. FLUCELVAX QUADRIVALENT is made using cell culture technology, which does not require eggs for manufacturing and has the potential for rapidly increased production of flu shots in times of need.¹ ² It’s also antibiotic, preservative, and latex free, and it helps protect against 4 strains of the flu in people aged 4 years and older.²

In clinical studies, FLUCELVAX QUADRIVALENT was immunogenic against the flu, and in adults, it produced stronger antibody responses to the B strain, which was not contained in the trivalent comparator flu vaccine.³ FLUCELVAX QUADRIVALENT was also shown to be well tolerated.³ This flu season, consider a flu shot that’s on the cutting edge of flu protection. Choose FLUCELVAX QUADRIVALENT.

Introducing a flu shot that could help transform flu protection

3 Ways to Purchase

www.flu.seqirus.com
855-358-8966 or cs.flu@seqirus.com
Contact your SEQUIRUS account manager

Indication and Usage for FLUCELVAX QUADRIVALENT® (Influenza Vaccine)

FLUCELVAX QUADRIVALENT® is an inactivated vaccine indicated for active immunization for the prevention of influenza disease caused by influenza virus subtypes A and type B contained in the vaccine. FLUCELVAX QUADRIVALENT is approved for use in persons 4 years of age and older.

IMPORTANT SAFETY INFORMATION

Contraindication

• Do not administer FLUCELVAX QUADRIVALENT to anyone with a history of severe allergic reaction (e.g. anaphylaxis) to any component of the vaccine.

Warnings & Precautions

• Guillain-Barré Syndrome (GBS): If GBS has occurred within 6 weeks of receipt of a prior influenza vaccine, the decision to give FLUCELVAX QUADRIVALENT should be based on careful consideration of the potential benefits and risks.

• Preventing and Managing Allergic Reactions: Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of the vaccine.

• Syncope: Syncope (fainting) can occur in association with administration of injectable vaccines, including FLUCELVAX QUADRIVALENT. Syncope can be accompanied by transient neurological signs such as visual disturbance, paresthesia, and tonic-clonic limb movements. Procedures should be in place to avoid falling injury and to restore cerebral perfusion following syncope by maintaining a supine or Trendelenburg position.

• Altered Immunocompetence: After vaccination with FLUCELVAX QUADRIVALENT, immunocompromised individuals, including those receiving immunosuppressive therapy, may have a reduced immune response.

• Limitations of Vaccine Effectiveness: Vaccination with FLUCELVAX QUADRIVALENT may not protect all vaccine recipients against influenza disease.

Most Common Adverse Reactions

• The most common (≥10%) local and systemic reactions in adults 18-64 years of age were injection site pain (45.4%), headache (18.7%), fatigue (17.8%) and myalgia (15.4%), injection site erythema (13.4%), and induration (11.6%).

• The most common (≥10%) local and systemic reactions in adults ≥65 years of age were injection site pain (21.6%) and injection site erythema (11.9%).

• The most common (≥10%) local and systemic reactions in children 4 to <6 years of age were tenderness at the injection site (46%), injection site erythema (18%), sleepiness (19%), irritability (16%), injection site induration (13%), change in eating habits (10%).

• The most common (≥10%) local and systemic reactions in children 6 through 8 years of age were pain at the injection site (54%), injection site erythema (22%), injection site induration (16%), headache (14%), fatigue (13%), and myalgia (12%).

• The most common (≥10%) local and systemic reactions in children and adolescents 9 through 17 years of age were pain at the injection site (58%), headache (22%), injection site erythema (19%), fatigue (18%) myalgia (16%), and injection site induration (15%).

Please see Brief Summary of Prescribing Information for FLUCELVAX QUADRIVALENT adjacent to this ad.
FLUCELVAX QUADRIVALENT (influenza vaccine)
Suspension for Intramuscular Injection
2016-2017 Formula
Initial U.S. Approval: May 23, 2016
BRIEF SUMMARY:
See package insert for full Prescribing Information.

1 INDICATIONS AND USAGE
FLUCELVAX QUADRIVALENT® is an inactivated vaccine indicated for active immunization for the prevention of influenza disease caused by influenza virus subtypes A and type B contained in the vaccine. FLUCELVAX QUADRIVALENT is approved for use in persons 4 years of age and older. For children and adolescents 4 through 17 years of age, approval is based on the immune response elicited by FLUCELVAX QUADRIVALENT. Data demonstrating a decrease in influenza disease after vaccination of this age group with FLUCELVAX QUADRIVALENT are not available. [see Clinical Studies (14)]

4 CONTRAINDICATIONS
Do not administer FLUCELVAX QUADRIVALENT to anyone with a history of severe allergic reaction (e.g. anaphylaxis) to any component of the vaccine [see Description (11)].

5 WARNINGS AND PRECAUTIONS

5.1 Guillain-Barré Syndrome
The 1976 swine influenza vaccine was associated with an elevated risk of Guillain-Barré syndrome (GBS). Evidence for a causal relation of GBS with other influenza vaccines is inconclusive; if an excess risk exists, it is probably slightly more than 1 additional case per 1 million persons vaccinated. If GBS has occurred after receipt of a prior influenza vaccine, the decision to give FLUCELVAX QUADRIVALENT should be based on careful consideration of the potential benefits and risks.

5.2 Preventing and Managing Allergic Reactions
Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of the vaccine.

5.3 Syncope
Syncope (fainting) can occur in association with administration of injectable vaccines, including Flucelvax. Syncope can be accompanied by transient neurological signs such as visual disturbance, paresthesia, and tonic-clonic limb movements. Procedures should be in place to avoid falling injury and to restore cerebral perfusion following syncope by maintaining a supine or Trendelenburg position.

5.4 Altered Immunocompetence
After vaccination with FLUCELVAX QUADRIVALENT, immunocompromised individuals, including those receiving immunosuppressive therapy, may have a reduced immune response.

5.5 Limitations of Vaccine Effectiveness
Vaccination with FLUCELVAX QUADRIVALENT may not protect all vaccine recipients against influenza disease.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience
The most common (≥10%) local and systemic reactions in adults 18-64 years of age were injection site pain (45.4%), headache (18.7%), fatigue (17.8%) and myalgia (15.4%), injection site erythema (13.4%), and induration (11.6%). The most common (≥10%) local and systemic reactions in adults ≥65 years of age were injection site pain (21.6%), and injection site erythema (11.9%).

The most common (≥10%) local and systemic reactions in children 4 to <6 years of age after first dose of vaccine were tenderness at the injection site (46%), injection site erythema (18%), sleepiness (19%), irritability (16%), injection site induration (13%) and change in eating habits (10%).

The most common (≥10%) local and systemic reactions in children 6 through 8 years of age after first dose of vaccine were pain at the injection site (54%), injection site erythema (22%), injection site induration (16%), headache (14%), fatigue (13%) and myalgia (12%).

The most common (≥10%) local and systemic reactions in children and adolescents 9 through 17 years of age were pain at the injection site (58%), headache (22%), injection site erythema (19%), fatigue (18%) myalgia (16%), and injection site induration (15%).

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a vaccine cannot be directly compared to rates in clinical studies of another vaccine, and may not reflect rates observed in clinical practice.

Adults 18 years of age and older:
The safety of FLUCELVAX QUADRIVALENT in adults was evaluated in a randomized, double-blind, controlled study conducted in the US (Study 1). The safety population included a total of 2680 adults 18 years of age and older; 1340 adults 18 through 64 years of age and 1340 adults 65 years of age and older.

In this study, subjects received FLUCELVAX QUADRIVALENT or one of the two formulations of comparator trivalent influenza vaccine (FLUCELVAX QUADRIVALENT (N=1335), TIV1c, N=676 or TIV2c N= 669). The mean age of subjects who received FLUCELVAX QUADRIVALENT was 57.4 years of age; 54.8% of subjects were female and 75.6% were Caucasian, 13.4% were Black, 9.1% were Hispanics, 0.7% were American Indian and 0.3%, 0.1% and 0.7% were Asian, Native Hawaiian and others, respectively. The safety data observed are summarized in Table 2.

In this study, solicited local injection site and systemic adverse reactions were collected from subjects who completed a symptom diary card for 7 days following vaccination.

Solicited adverse reactions for FLUCELVAX QUADRIVALENT and comparator are summarized in Table 2.

Table 2: Incidence of Solicited Adverse Reactions in the Safety Population1 Reported Within 7 Days of Vaccination (Study 1)

<table>
<thead>
<tr>
<th>Reaction</th>
<th>FLUCELVAX QUADRIVALENT (N=663)</th>
<th>Trivalent Influenza Vaccine (N=327)</th>
<th>FLUCELVAX QUADRIVALENT (N=656)</th>
<th>Trivalent Influenza Vaccine (N=336)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection site induration</td>
<td>11.6 (0.0)</td>
<td>9.7 (0.3)</td>
<td>10.4 (0.0)</td>
<td>8.7 (0.0)</td>
</tr>
<tr>
<td>Injection site erythema</td>
<td>13.4 (0.0)</td>
<td>13.3 (0.0)</td>
<td>10.1 (0.0)</td>
<td>11.9 (0.0)</td>
</tr>
<tr>
<td>Injection site ecchymosis</td>
<td>3.8 (0.0)</td>
<td>3.3 (0.0)</td>
<td>5.2 (0.0)</td>
<td>4.7 (0.0)</td>
</tr>
<tr>
<td>Injection site pain</td>
<td>45.4 (0.0)</td>
<td>37.0 (0.0)</td>
<td>40.7 (0.0)</td>
<td>21.6 (0.0)</td>
</tr>
</tbody>
</table>

Local Adverse Reactions

Systemic Adverse Reactions

Chills | 6.2 (0.0) | 6.4 (0.6) | 6.4 (0.0) | 4.4 (0.3) | 4.1 (0.3) | 4.5 (0.6) |
Nausea | 9.7 (0.3) | 7.3 (0.9) | 8.9 (1.2) | 3.8 (0.2) | 4.1 (0.0) | 4.2 (0.3) |
Myalgia | 15.4 (0.8) | 14.5 (0.9) | 15.0 (1.2) | 8.2 (0.2) | 9.4 (0.3) | 8.3 (0.6) |
Arthralgia | 8.1 (0.5) | 8.2 (0.0) | 9.5 (0.9) | 5.5 (0.5) | 5.0 (0.3) | 6.8 (0.9) |
Headache | 18.7 (0.9) | 18.5 (0.9) | 18.7 (0.6) | 9.3 (0.3) | 8.5 (0.6) | 8.3 (0.6) |
Fatigue | 17.8 (0.6) | 22.1 (0.3) | 15.6 (1.5) | 9.1 (0.8) | 10.6 (0.3) | 8.9 (0.6) |
Vomiting | 2.6 (0.0) | 1.5 (0.3) | 0.9 (0.0) | 0.9 (0.2) | 0.3 (0.0) | 0.6 (0.0) |
Diarhoea | 7.4 (0.6) | 7.6 (0.0) | 7.6 (0.6) | 4.3 (0.5) | 5.0 (0.9) | 5.1 (0.3) |
Loss of appetite | 8.3 (0.3) | 8.5 (0.3) | 8.3 (0.9) | 4.0 (0.2) | 5.0 (0.0) | 3.6 (0.3) |
Fever: ≥38.0°C (≥100°F) | 0.8 (0.0) | 0.6 (0.0) | 0.3 (0.0) | 0.3 (0.0) | 0.9 (0.0) | 0.6 (0.0) |

1 Safety population: all subjects in the exposed population who provided post-vaccination safety data
2 Percentage of severe adverse reactions are presented in parenthesis Study 1: NCT01992094

Children and Adolescents 4 through 17 years of age:
The safety of FLUCELVAX QUADRIVALENT in children was evaluated in a randomized, double-blind, controlled study conducted in the US (Study 1). The safety population included a total of 2332 children 4 through 17 years of age; 1161 children 4 through 8 years of age and 1171 children 9 through 17 years of age.
In this study, subjects received FLUCELVAX QUADRIVALENT or one of the two formulations of comparator trivalent influenza vaccine: (FLUCELVAX QUADRIVALENT (N=1159), TIV1c, N=593 or TIV2c N= 580). Children 9 through 17 years of age received a single dose of FLUCELVAX QUADRIVALENT or comparator vaccine.

Children 4 through 8 years of age received one or two doses (separated by 4 weeks) of FLUCELVAX QUADRIVALENT or comparator vaccine based on determination of the subject’s prior influenza vaccination history. The mean age of subjects who received FLUCELVAX QUADRIVALENT was 9.6 years of age; 48% of subjects were female and 53% were Caucasian. The safety data observed are summarized in Table 3 and Table 4.

### Table 3: Incidence of Solicited Adverse Reactions in the Safety Population1 (4 through 5 years of age) Reported Within 7 Days of the First Dose of Vaccination (Study 2)

<table>
<thead>
<tr>
<th>Reaction</th>
<th>FLUCELVAX QUADRIVALENT (N=182)</th>
<th>Trivalent Influenza Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=371-372</td>
<td>TIV1c N=91</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TIV2c N=93</td>
</tr>
<tr>
<td><strong>Local Adverse Reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection site induration</td>
<td>13 (1)</td>
<td>20 (2)</td>
</tr>
<tr>
<td>Injection site erythema</td>
<td>18 (1)</td>
<td>23 (1)</td>
</tr>
<tr>
<td>Injection site ecchymosis</td>
<td>9 (0)</td>
<td>11 (0)</td>
</tr>
<tr>
<td>Injection site tenderness</td>
<td>46 (1)</td>
<td>45 (1)</td>
</tr>
<tr>
<td><strong>Systemic Adverse Reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in eating habits</td>
<td>10 (1)</td>
<td>7</td>
</tr>
<tr>
<td>Sleepiness</td>
<td>19 (1)</td>
<td>12 (3)</td>
</tr>
<tr>
<td>Irritability</td>
<td>16 (2)</td>
<td>10 (2)</td>
</tr>
<tr>
<td>Chills</td>
<td>5 (1)</td>
<td>2 (0)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>4 (0)</td>
<td>2 (0)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>4 (0)</td>
<td>2 (0)</td>
</tr>
<tr>
<td>Fever: ≥38°C ≥40.0°C)</td>
<td>4 (0)</td>
<td>4 (0)</td>
</tr>
</tbody>
</table>

1 Safety population: all subjects in the exposed population who provided post-vaccination safety data.

### Table 4: Incidence of Solicited Adverse Reactions in the Safety Population1 (6 through 17 years of age) Reported Within 7 Days of Vaccination (Study 2)

<table>
<thead>
<tr>
<th>Reaction</th>
<th>FLUCELVAX QUADRIVALENT (N=271-372)</th>
<th>Trivalent Influenza vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=185</td>
<td>TIV1c N=185</td>
</tr>
<tr>
<td></td>
<td>N=186</td>
<td>TIV2c N=186</td>
</tr>
<tr>
<td><strong>Local Adverse Reactions</strong></td>
<td>16 (0)</td>
<td>19 (1)</td>
</tr>
<tr>
<td>Injection site induration</td>
<td>22 (0)</td>
<td>23 (1)</td>
</tr>
<tr>
<td>Injection site erythema</td>
<td>9 (0)</td>
<td>9 (0)</td>
</tr>
<tr>
<td>Injection site ecchymosis</td>
<td>54 (1)</td>
<td>57 (1)</td>
</tr>
<tr>
<td>Injection site pain</td>
<td>4 (1)</td>
<td>3 (0)</td>
</tr>
</tbody>
</table>

1 Safety population: all subjects in the exposed population who provided post-vaccination safety data.

2 Percentage of subjects with severe adverse reactions are presented in parenthesis.

Study 2: NCT01992107

In children who received a second dose of FLUCELVAX QUADRIVALENT, TIV1c, or TIV2c, the incidence of adverse reactions following the second dose of vaccine were similar to those observed with the first dose.

Unsolicited adverse events, including serious adverse events, were collected for 21 days after last vaccination. In children 4 through 17 years of age, unsolicited adverse events were reported in 24.3% of subjects who received FLUCELVAX QUADRIVALENT within 3 weeks after last vaccination.

In children 4 through 17 years of age, serious adverse events (SAEs) were collected throughout the study duration (until 6 months after last vaccination) and were reported by 0.5%, of the subjects who received FLUCELVAX QUADRIVALENT. None of the SAEs were assessed as being related to study vaccine.

### 6.2 Postmarketing Experience

The safety experience with FLUCELVAX (trivalent influenza vaccine) is relevant to FLUCELVAX QUADRIVALENT, because both vaccines are manufactured using the same process and have overlapping compositions.

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

**Immune system disorders:** Anaphylactic reaction, angioedema.

**Skin and subcutaneous tissue disorders:** Generalized skin reactions including pruritus, urticaria or non-specific rash.

**Nervous systems disorders:** Syncope, Presyncope.

**General disorders and administration site conditions:** Extensive swelling of injected limb.

### 7 DRUG INTERACTIONS

#### 7.1 Concomitant Use With Other Vaccines

No data are available to assess the concomitant administration of FLUCELVAX QUADRIVALENT with other vaccines.

### 8 USE IN SPECIFIC POPULATIONS

#### 8.1 Pregnancy

Pregnancy Category B: The developmental and reproductive toxicity study performed with the trivalent formulation of Fluclavex is relevant to Fluclavex Quadrivalent because both vaccines share the same manufacturing process and route of administration. A reproductive and developmental toxicity study has been performed in rabbits with Fluclavex, with a dose level that was approximately 11 times the human dose based on body weight. The study revealed no evidence of impaired female fertility or harm to the fetus. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this vaccine should be used during pregnancy only if clearly needed.

In a reproductive and developmental toxicity study, the effect of Fluclavex containing 45 mcg HA/dose on embryo-fetal and post-natal development was evaluated in pregnant rabbits. Animals were administered vaccine by intramuscular injection 3 times prior to gestation, during the period of organogenesis (gestation day 7) and later in pregnancy (gestation day 20), 0.5 mL/rabbit/occasion (approximately 11-fold excess relative to the projected human dose on a body weight basis). No adverse
THE QUESTION is: Do physicians have the right tools to deliver value-based care?

A recent study suggests the answer is no. Commissioned by Quest Diagnostics and Inovalon, “Finding a Faster Path to Value-Based Care” found that fewer than half of all respondents (47%) agreed that it’s clear to physicians which quality measures apply to their individual patients under value-based care models. Seventy-nine percent of the physicians surveyed said they do not know the quality metrics that apply to individual patients that would allow their practice to qualify for financial incentives under value-based care models.

Value-based care models require physicians to have this information at the point of care so they can align care with quality, outcomes and other measures on which financial incentives are based. Imagine how much financial leakage occurs that could be stemmed if physicians had ready access to this information so as to align care with quality measures during the patient consult.

Of course, some patient information, such as medical history, can and does come from electronic health records (EHRs). But today’s EHRs do not contain the information necessary to meet multiple and highly complex quality requirements specific to each patient.

New technologies are emerging that may help. The key is making sure physicians are aware of the solutions available to them.
The Vitals

Patients look for tech-savvy physicians and practices

By baby boomers are more likely to use digital healthcare tools than millennials, according to recent data compiled to give medical groups insights into the evolving patient experience.

The Patient Experience Index (PXI)—created by electronic health record (EHR) vendor CareCloud—also found that EHRs and other health information are having a profound, and largely positive, impact on patient behavior.

“This survey of the patient experience only reinforces the importance of technology in modern medicine,” said Ken Comée, CareCloud’s chief executive officer, in a press release.

“The patient experience is dramatically transforming. Not only are one-third of patients reporting a positive impact of technology on their care, but patients of all ages are actually embracing digital online patient engagement tools, from scheduling appointments to accessing their medical records and making online payments.”

About 1,400 participants across the United States shared their perspectives as part of an interactive online survey for the study.

The PXI asked patients who had seen an outpatient provider in the past 12 months about their entire experience—from initial selection of a provider through post-visit engagement.

Respondents were equally distributed across four age demographics: millennials (18-35), Gen X (36-50), Boomers (51-65), and Matures (66+).
Exclusive side-by-side analysis

THE ELECTION’S IMPACT ON PHYSICIANS

by JORDAN ROSENFELD and LIZ SEEGERT Contributing authors

IN DEPTH Policy

HEALTHCARE IN THE UNITED STATES IS TRULY AT A CROSSROADS with practice overhead costs rising, physician compensation falling and many independent practices pondering their futures amid multiplying mandates.

And physicians are left wondering who is best to lead them forward regarding healthcare in the U.S.: a Washington insider who seeks to build on the existing healthcare framework, or a New York outsider pledging to knock it down at all costs?

Former Secretary of State Hillary Clinton pledges to advance Obamacare initiatives while also addressing issues such as rising drug prices and healthcare for immigrants. Real estate magnate Donald Trump has focused on easing access to imported medications and selling health insurance plans across state lines. (See sidebar on page 56 indicating the stated healthcare policy positions of both candidates).

With less than a month to go until Election Day, the candidates are working overtime to convince the American public that they are the best for the job. But who is best for physicians?

We sought out the experts to examine four issues important to physicians. Both Trump’s and Clinton’s camps declined requests for interviews to answer our questions directly.

INSIDE
Fate of the Affordable Care Act
Page 19
Prescription drug prices
Page 54
Rising out-of-pocket costs/high deductibles
Page 55
Physician compensation
Page 57
Fate of the Affordable Care Act

CLINTON
Much of the broader Clinton health policy hinges on what can be accomplished through modifications to the Affordable Care Act (ACA), which can be a boon to physicians.

Clinton wants more Americans covered by the ACA. While about 20 million people gained health insurance through the exchanges or Medicaid expansion, approximately 10% of Americans still lack any coverage. A national public option was cut from the original law, but Clinton says she will work with every governor to enact state-based public option insurance plans, an approach that will not require Congressional approval. She wants to hire more patient navigators and conduct more outreach to encourage enrollment.

A public option is especially important in areas where the marketplaces are not providing sufficient competition among insurers, leaving people with little choice, according to Judy Feder, Ph.D., professor at Georgetown University’s McCourt School of Public Policy. “If you have only one insurer, there’s a concern that there is not enough competition to keep premiums affordable. Having a public plan would ensure that there is a viable competitor in every marketplace,” she explains.

A public option could be good for physicians, according to Robert Doherty, senior vice president for governmental affairs and public policy with the American College of Physicians (ACP). It all depends on reimbursement rates. Payment that is at least on par with Medicare or some private plans would encourage more physician participation, Doherty notes.

Clinton also wants to expand Medicare by allowing people to buy into the program starting at age 55. A recent study by Washington, D.C.-based healthcare consultancy Avalere found that nearly 13 million Americans over age 50 who are currently uninsured or have individual coverage purchased through the private market may be eligible to buy into Medicare under Clinton’s plan.

Specific details have yet to be worked out, but Feder points out that if Medicare becomes available to more people, it will have advantages over other insurance in the marketplace because of its negotiating power. Overall, she believes it would benefit physicians even if reimbursements are lower than those of commercial plans, because it will allow more people to get care and generate more revenue for practices, assuming payment rates are at least on par with current Medicare levels.

A Medicare buy-in may not be a better choice than a private plan, however. There are problems with making Medicare available in the exchanges because the Medicare benefit package is less generous than what the ACA requires. Details on what coverage would be included are still vague.

In addition, Clinton proposes to double

TRUMP
Repeal the healthcare reform law and open up the sale of health plans across state lines.

CLINTON
Preserve and expand Obamacare, including the addition of a public option and expanding Medicare coverage.

"I think there’s no question that Obamacare is in trouble.”
—SALLY PIPES, FORMER HEALTH ADVISER TO RUDY GIULIANI
funding for primary care over the next 10 years by expanding the system of Federally Qualified Health Centers (FQHCs), safety-net outpatient clinics in medically underserved urban and rural communities. She would extend current FQHC funding under the Affordable Care Act and expand it by $40 billion over the next decade.

Overall, Feder thinks Clinton's ideas will benefit physicians. "Independent of the public plan, expanding coverage in the marketplaces is only good for physicians because it's enabling people who are now uninsured to be insured. It's more paying customers, more people getting care, and that's a good thing," she says.

TRUMP

One of the tent poles of Trump's healthcare plan is rhetoric that accuses President Obama, the Democrats and the Supreme Court of "raising economic uncertainty," and hinges upon his promise to repeal and replace the ACA in favor of "free-market reforms." He would do away with the mandate that everyone have healthcare insurance, and allow insurers to sell products across state lines. Analysts disagree as to whether complete repeal is a necessary step to correcting frustrating flaws in Obamacare.

David Bowen, PhD, global lead in health for Hill+Knowlton in New York, feels that repealing the ACA will hurt the poorest and sickest Americans. "Removing [the ACA] and replacing it with vague promises where the numbers don't add up would be catastrophic for Americans coast to coast," he says. He cites the non-partisan fiscal analysis group The Committee for a Responsible Federal Budget's assessment of Trump's seven-point healthcare plan, which found that the plan would cost $550 billion over a decade.

Gerald Kominski, PhD, professor of health policy and management at the UCLA Fielding School of Public Health, also worries that repeal would leave the country with a host of problems. "It means we roll back the clock to a marketplace where people could be denied insurance, where insurers could offer a whole variety of products and weren't held to any real standards," he says. He fears that many of the 20 million people who receive coverage under the ACA would "rejoin the ranks of the uninsured." This doesn't bode well for physicians, either, he says, since they "would now be dealing with patients who were newly uninsured," and who may struggle to pay for their care.

Stephen Parente, PhD, professor of health and economics at the University of Minnesota Carlson School of Manage-
Get an in-depth look at practice performance.

When you improve physician engagement and satisfaction, you see better clinical and financial outcomes for your organization. It’s not just our opinion. It’s what we learned by analyzing thousands of providers on the athenahealth® network.
Practical Matters

Decrease patient wait times in 5 steps

These tips for operating more efficiently and increasing physician capacity can help reduce the time patients spend in your waiting room

Study provider schedules
Analyze provider schedules to determine if they are truly working to full capacity. Does the amount of time providers spend each week on direct patient care match contract requirements? Is too much time blocked for overbooking? Over time, it’s easy for inefficiencies to creep into schedules.

Look for large chunks of time where providers do not see patients—including unused overbooking time—to find places where appointment slots could be added. If there is more availability, add hours gradually. Make an effort every quarter, for example, to add one hour of direct patient care to the daily schedule. Don’t try to zoom to top capacity all at once; rather, chip away at access issues steadily.

Anticipate pushback on scheduling changes. One common complaint is that use of electronic health records creates documentation inefficiencies. If this is an issue, practices can look for solutions that help physicians to chart more quickly.

Analyze wait times and schedules
Practices should study the average wait time for the third—not first—available appointment. Studying the wait time for the first available appointment is not a reliable metric due to the frequent cancellations and no-shows that occur at practices, which makes the “first available appointment” wait appear artificially brief.

Work ahead
Complete the benefits-eligibility verification process and any authorizations before each appointment. The goal is for patients to arrive at the practice, check in and quickly confirm their insurance information. Long lines at the front desk greatly annoy patients, especially if they also waited months for the appointment.

Cutting down on overbookings also has a positive effect on the front office. These same-day slots should be reserved for emergency cases. Otherwise, staff must hurriedly verify eligibility for these new patients, instead of serving the patients already in the practice.

Ditch the front-desk phone
Front-desk staffers should focus on greeting patients and answering their questions and messages to clinical staff. Too often, these staff members must interrupt conversations with patients to answer the telephone. Alleviate the problem by moving phones to a separate office. Dedicate one or two employees to focus on phone service.

FIND A PHYSICIAN CHAMPION

Find a physician leader who wants to drive change and understands how patient access influences care quality and financial performance. Any scheduling or workflow change designed to improve efficiency or capacity is likely to receive a warmer reception from a clinical colleague aligned with the practice manager.

Johanna Epstein is vice president of management consulting services for Culbert Healthcare Solutions. This article originally ran in our partner publication, Physicians Practice.
It’s your name on the door.

Introducing the best way to keep it there.

Kareo introduces the first and only technology platform built specifically to help your independent practice succeed.

Kareo is purpose-built to enable your success in managing a medical practice and delivering outstanding patient care. Designed to serve the unique needs of your independent practice, Kareo helps you find more patients, manage patients with a fully certified and easy-to-use EHR, and get you paid quickly— all in one complete, cloud-based and integrated platform. With Kareo, you’ll run a more efficient, profitable practice and keep your name on the door for a long time to come.

To learn more, call (888) 255-5696 or download our free guide at kareo.com/mydoor2
Independent practices seek care coordination strategies

Physician collaboration is difficult for small practices under today’s payment models, but its importance is growing

by NICOLE LEWIS Contributing author

HIGHLIGHTS

For care coordination to work, healthcare facilities must collaborate more effectively on the planning, execution and management of patient care through integrated systems.

The biggest barrier to meeting performance targets is the financial toll that comes from monitoring patients and documenting their care.

SMALL PHYSICIAN practices are struggling with the burden of implementing care coordination strategies that they say stretch their finances, strains their workload and impedes their ability to deliver quality healthcare.

Designed to improve collaboration among care teams spanning the continuum of care, care coordination efforts at small practices have had the opposite effect.

Just ask internist Michael Soppet, MD, who signed up for a three-year pilot program that began in 2010 to establish a patient-centered medical home (PCMH), a model of care that relies on increasing the extent and effectiveness of care coordination for chronically ill patients.

“Care coordination was one of our major difficulties because of the interoperability problem,” Soppet says. “Sharing information between providers has not been made any better by our electronic capabilities. That’s still something we have to do by hand.”

Doctors are inundated with data entry chores to meet regulatory requirements and are disappointed that after substantial investments in electronic health records (EHRs) they can’t exchange patient data with outside hospitals or other providers using different EHRs.

Typically, care teams working closely together can improve patient outcomes, prevent hospitalizations and improve healthcare overall. Yet for small, independent practices, the goal of developing an effective care coordination plan is unachievable.

The problem, physicians say, boils down to limited resources, the lack of interoperable health IT systems and payment plans that don’t offer enough money to cover care coordination costs.

PHYSICIANS STRUGGLE WITH CARE COORDINATION

While care coordination isn’t possible today, it could be. The federal government has outlined an interoperable health IT infrastructure plan, and notes that by 2024 the healthcare system will have an array of interoperable health IT products and services that will support transparency and provide access to real-time patient data.

This coincides with healthcare policymakers’ focus on care coordination that aims to replace a fragmented system of care with a more cohesive model. For care coordination to work, healthcare facilities must collaborate better on the planning, execution and management of patient care through integrated systems and processes that prevent bottlenecks during the course of the patient’s treatment.

The promise of care coordination was one feature of the PCMH that attracted Soppet to signing up for this model of care.

Soppet, who until last January was one of seven physicians in a group practice in Dothan, Alabama, says care coordination
required him to develop a closer working relationship with other physicians as well as nurses, social workers and other caregivers, and he expected clinical teamwork to be a forceful driver in the effort to improve quality measures for patients.

During the pilot program, which ran from 2010 to 2013, there were improved quality performance metrics for patients with diabetes in several areas including hemoglobin A1c monitoring, low-density lipoprotein (LDL) cholesterol monitoring, nephropathy screening and treatment, and retinal exam rates.

Additionally, colon cancer screening rates for patients exceeded 70%, and immunization rates improved for pneumococcal vaccinations to over 80%, Soppet says.

While patients were seeing improvements under the PCMH model, the attempt to redesign the practice to support care coordination goals was financially burdensome, physically exhausting and deeply frustrating to Soppet and his staff.

For a start, care coordination was hamstrung by the lack of interoperability among different EHR systems. The inability of Soppet’s EHR to interact with those used at hospitals, specialists’ offices and pharmacies slowed the practice’s systems and increased the manual tasks its staff members were required to perform.

“To exchange data with other physician offices we had to print and fax pages to their offices to facilitate care,” Soppet says. “The promise of EHRs simply evaporated as soon as they had to perform.”

Added to this, the need for seamless bi-directional communications between pharmacy systems and the EHR at Soppet’s practice, which was crucial to care coordination, didn’t occur.

Soppet says while he could authorize refills and new prescriptions with the click of a button, he couldn’t electronically cancel a medication that he wanted a patient to stop taking. To do this someone had to call the pharmacy or send a note by fax.

As the PCMH program evolved, Soppet’s practice implemented staffing changes to accommodate the growing workload. For instance, the receptionist took on the responsibility of ordering immunizations and vaccines and making sure the office had enough of these to meet patient demand.

The practice hired seven new full-time employees to support care coordination efforts, including a receptionist, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.

Soppet says that for the practice’s efforts, Blue Cross Blue Shield of Alabama paid $5,750 for practice transformation to PCMH in the first year, and for performance improvements the practice received $11,000 and $20,000 for the second and third years respectively. These didn’t come close to covering the added costs of running the practice, however. Staff salary and benefits (excluding physician salary and benefits) increased from $810,000 in 2010 before adopting the PCMH model to $1.2 million in 2015.

According to Soppet, the effort to coordinate care as a PCMH increased almost every cost of running the practice.

Like many other small practices that have embarked on care coordination, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.

Soppet says that for the practice’s efforts, Blue Cross Blue Shield of Alabama paid $5,750 for practice transformation to PCMH in the first year, and for performance improvements the practice received $11,000 and $20,000 for the second and third years respectively. These didn’t come close to covering the added costs of running the practice, however. Staff salary and benefits (excluding physician salary and benefits) increased from $810,000 in 2010 before adopting the PCMH model to $1.2 million in 2015.

According to Soppet, the effort to coordinate care as a PCMH increased almost every cost of running the practice.

Like many other small practices that have embarked on care coordination, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.

Soppet says that for the practice’s efforts, Blue Cross Blue Shield of Alabama paid $5,750 for practice transformation to PCMH in the first year, and for performance improvements the practice received $11,000 and $20,000 for the second and third years respectively. These didn’t come close to covering the added costs of running the practice, however. Staff salary and benefits (excluding physician salary and benefits) increased from $810,000 in 2010 before adopting the PCMH model to $1.2 million in 2015.

According to Soppet, the effort to coordinate care as a PCMH increased almost every cost of running the practice.

Like many other small practices that have embarked on care coordination, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.

Soppet says that for the practice’s efforts, Blue Cross Blue Shield of Alabama paid $5,750 for practice transformation to PCMH in the first year, and for performance improvements the practice received $11,000 and $20,000 for the second and third years respectively. These didn’t come close to covering the added costs of running the practice, however. Staff salary and benefits (excluding physician salary and benefits) increased from $810,000 in 2010 before adopting the PCMH model to $1.2 million in 2015.

According to Soppet, the effort to coordinate care as a PCMH increased almost every cost of running the practice.

Like many other small practices that have embarked on care coordination, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.

Soppet says that for the practice’s efforts, Blue Cross Blue Shield of Alabama paid $5,750 for practice transformation to PCMH in the first year, and for performance improvements the practice received $11,000 and $20,000 for the second and third years respectively. These didn’t come close to covering the added costs of running the practice, however. Staff salary and benefits (excluding physician salary and benefits) increased from $810,000 in 2010 before adopting the PCMH model to $1.2 million in 2015.

According to Soppet, the effort to coordinate care as a PCMH increased almost every cost of running the practice.

Like many other small practices that have embarked on care coordination, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.

Soppet says that for the practice’s efforts, Blue Cross Blue Shield of Alabama paid $5,750 for practice transformation to PCMH in the first year, and for performance improvements the practice received $11,000 and $20,000 for the second and third years respectively. These didn’t come close to covering the added costs of running the practice, however. Staff salary and benefits (excluding physician salary and benefits) increased from $810,000 in 2010 before adopting the PCMH model to $1.2 million in 2015.

According to Soppet, the effort to coordinate care as a PCMH increased almost every cost of running the practice.

Like many other small practices that have embarked on care coordination, a person to oversee medical records, two nurse practitioners, a nurse for each nurse practitioner, and an IT professional.
“...Physicians are being forced into hospital employment and can no longer be the kind of advocate for a patient that they could be.”

— OSCAR LOVELACE, MD, PROSPERITY, SOUTH CAROLINA

25 initiatives that depend on care teams to manage patient care, Soppet says, his practice was exposed to increased risk. That’s because the care coordination model comes with higher operational costs and less income to offset those expenses.

COLLABORATION REQUIREMENTS
As physicians increasingly transition to models of care that rely on care coordination—such as accountable care organizations (ACOs), bundled payment programs and population health initiatives, in addition to PCMHs—they will need four key elements to successfully coordinate care, says Peter Cunningham, PhD, professor in the department of health behavior and policy at Virginia Commonwealth University in Richmond, Virginia.

“First, there needs to be an integrated delivery system that spans across all the different sectors—primary care, inpatient care, specialty care and even rehabilitative services,” Cunningham says.

He adds that each member of the care team must be connected to a single EHR and must be able to access and exchange data with full interoperability with all other members of the care team.

Second, the system needs non-clinicians to support care coordination. These include social workers, case managers and others who will follow up with patients before, during and after hospitalization.

For example, when a patient is discharged from the hospital the social worker needs to ask questions such as does the patient have a place to go? Do they have transportation to take them to their medical appointments? And are they going some where family members can follow up with tasks like taking their medications on-time?

“It’s important to track the minute details of the care being delivered within the system to the patient,” Cunningham says.

Third, small-practice physicians need financial incentives that can cover the additional costs of care coordination. Finally, they need a higher level of patient engagement through communication via email, mobile apps, web portals and other technologies that can help patients better manage their health.

“A lot more attention needs to be paid to using technology as a tool to teach patients how to manage their health conditions to enhance preventative care and reduce hospital readmissions,” Cunningham says.

Unfortunately, small practices face many barriers to implementing effective care coordination measures. For one, Cunningham says, many small group practices don’t have enough patients to enable economies of scale, and therefore can’t afford care coordination services.

Furthermore, many large hospital systems are purchasing small physician practices, thus controlling the entire continuum of care and excluding independent practices, Cunningham says.

As hospitals contribute to a realignment in healthcare that changes where care is delivered, and who will provide it, small practice physicians are also facing more stringent guidelines from the Centers for Medicare & Medicaid (CMS).

The passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), places an even greater focus on tying clinical performance to quality metrics.

For example, under the coming Merit-based Incentive Payment System’s composite performance score, practices failing to meet quality measures could see a 4% drop in their Medicare payments in 2019 and as much as a 9% cut by 2022.

Cunningham points to the agency’s growing requirements for practices to document performance metrics, as another reason why many small group practices are finding it harder to survive.

“Most solo and small group practices won’t be able to sustain themselves in the future, and a lot of them are willing to sell their practice because it’s just too hard to stay independent,” Cunningham says.

SMALL PRACTICES ARE CRITICAL
In the meantime, small practices are having a big impact on one of healthcare reform’s primary goals: keeping patients healthy and out of the hospital.

“I’m concerned that many private practices are being forced into hospital employment ...”
Tirelessly defending the practice of GOOD MEDICINE.

We're taking the mal out of malpractice insurance.
By constantly looking ahead, we help our members anticipate issues before they can become problems. And should frivolous claims ever threaten their good name, we fight to win—both in and out of the courtroom. It's a strategy made for your success that delivers malpractice insurance without the mal. See how at thedoctors.com
5 questions every physician must ask their financial adviser

Odds are your current adviser is doing good work, but are they doing the best work for you?

Are you a fiduciary 100% of the time?

Unlike most professionals, financial advisers have a choice of operating under one of two professional standards: suitability or fiduciary. The fiduciary standard requires advisers to act in their client’s best interests, whereas the suitability standard does not.

Advisers fall into one of three camps: fiduciary all the time, suitability all the time or both. Those that do both “wear two hats” by switching back and forth between suitability and fiduciary standards.

Don’t settle for the part-time fiduciary. It’s best to verify they’re acting as a fiduciary all the time.

How many physicians do you work with?

Cutting-edge advisory firms are building niches to stay relevant and provide the best possible value to their clients. Industry experts say firms should target between 50 and 150 clients per adviser depending upon the level of services provided. If they’re dedicated to a specific niche, at least 50% of those clients should be within it. The more specific their niche, the better. Ideally your adviser has a manageable number of clients with a very high percentage consisting of physicians just like you.

How does your firm’s revenue percentage breakdown?

Today, most financial advisers are proudly beating the financial planning drum. Some firms offer “free” financial planning and use it as a back door sales tool to sell more financial products. Others bundle it with investment management services and consider it a value-add. And then some firms charge for stand-alone financial planning services only or in combination with other services.

If you’re uncomfortable asking the question, or the answer is ambiguous, a quick ADV search can give you an idea of how much financial planning they’re doing. Visit bit.ly/IAPD-search, enter your adviser’s firm and click on “View Latest Form ADV filed.” Scan down to Item 5 and you’ll see a good bit of information on the firm’s advisers and clientele.

Are you fee-only or fee-based?

Fee-only advisers can only accept fees directly from clients. They’re not permitted to accept any referral fees, commissions, or kickbacks from third parties. Fee-based advisers accept client fees and commissions or other types of compensation. Understand your adviser’s fee structure, and you’ll be well equipped to identify conflicts.

How much am I exactly paying you for this service?

As uncomfortable as this question is, it’s legitimate. Financial advisers traditionally haven’t done a good job of explaining how their compensation and services work. Nonetheless, you have a right to know. As a client, how can you possibly measure the cost/benefit of working together if you’re not clear on services and costs?

Ask the Tough Questions

At the end of the day, these are all necessary and legitimate questions. The answers will help determine if your adviser is keeping up with the changes and continuing to act in your best interest.
Florajen unites high potency with affordability.

**Beneficial Bacteria**

<table>
<thead>
<tr>
<th>Product</th>
<th>Live Cells per Bottle</th>
<th>Cost Per Month at Recommended Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florajen</td>
<td>600 billion</td>
<td>$60.00</td>
</tr>
<tr>
<td>Florajen3</td>
<td>450 billion</td>
<td>$33.20</td>
</tr>
<tr>
<td>Culturelle</td>
<td>300 billion</td>
<td>$24.99</td>
</tr>
<tr>
<td>Align</td>
<td>28 billion</td>
<td>$15.95</td>
</tr>
<tr>
<td>Florastor</td>
<td>None*</td>
<td>$13.95</td>
</tr>
</tbody>
</table>

*No beneficial bacteria—only Saccharomyces, a yeast

Florajen contains more live probiotic bile-tolerant cells per dollar spent than any competitor.

Florajen is formulated with proven safe and effective strains. Its higher cell count delivers a level of potency with real and significant health benefits. Unlike the leading competitors, Florajen is refrigerated for freshness and quality and it is affordable for all your patients.

**For Free Sample Packs to get your patients started, call 800-257-5433 or visit florajensamples.com!**

---

**Florajen High Potency Probiotics**

www.florajen.com

Statements have not been evaluated by the Food and Drug Administration. This product is not medicinal and is not intended to diagnose, treat, cure or prevent any disease.
ONE OF THE knottiest challenges facing medical practices today is protecting the security of electronic patient information. For both operational and regulatory compliance reasons, practices must perform security risk assessments to find out where they are vulnerable so they can plug the holes. If they don’t, they are much more likely to suffer a security breach that compromises patient data or locks them out of access to their vital records. They could also be fined for not complying with government regulations.

For a security risk assessment, practices don’t necessarily have to hire a security consultant. They can learn much of what they need to know by downloading publicly-available security risk assessment tools. Read on to find out how to do that and how to use these tools.

Security risk assessments are required by the security rule of the Health Insurance Portability and Accountability Act (HIPAA). In addition, the federal electronic health records (EHR) incentive program, popularly known as “Meaningful Use,” mandates them, as does the successor to meaningful use, the Advancing Care Information category of the Merit-based Incentive Payment System (MIPS).

Despite these requirements and the increasing threat of cyber attacks, many small practices have “huge gaps” in their security procedures, notes Lee Kim, JD, director of privacy and security for the Health Information Management and Systems Society (HIMSS). Some doctors and practice managers believe that if their system has a firewall and is password-protected, they’re secure, she says.

Kim and other experts doubt that small practices can do adequate security risk assessments on their own, even with the help of online risk assessment tools available from HIMSS and the Office of the National Coordinator for Health IT (ONC).

“They can try to tackle it themselves, but there’s so much to sort through,” says Nathan Gibson, director of IT operations and privacy officer for WVMQ Quality Insights, based in Charleston, West Virginia.

Gibson and Kim both recommend small practices enlist the help of security consultants. But they recognize it’s expensive: hiring a consultant for a security risk assessment can easily cost several thousand dollars, Kim notes. And that doesn’t include the cost of repeat assessments—which should be done at least once a year—or the cost of mitigating security problems.

Gibson says that a large group’s IT staff can handle security risk assessments on its own. That approach has proven successful for some groups. For example, Susan Har-
Kim disagrees. “We’ve had small providers who’ve been affected, but not everyone has heard of it or been afflicted by it. That awareness needs to rise.”

Security is always a work in progress. Harrington’s annual security plan updates, for example, explain what the practice has done to improve its security and what remains to be done. The security risk assessments, she says, help her measure that progress.

“It’s not going to come out perfect, but you do need to know what work needs to be done, and it helps you to prioritize and start on the work, and every year chip away at what needs to be done,” she says.

Citing the ever-changing nature of the threat, Stulsky says a security risk assessment “is an ongoing situation” that constantly requires new tactics to counter potential attacks. For example, Emerald is now using intrusion protection software that would immediately alert the practice if its firewall were breached or if an unauthorized person tried to log on to the network.

No matter how intensive the security procedures are, Gold believes that determined hackers can find ways to circumvent them.

“Security is one of the biggest challenges facing physician practices,” he observes. “You can do everything right—everything you could possibly do—and somebody will hack your system somewhere along the way.”

01/ Risk assessment tools
The HIMSS and ONC tools provide a good starting point for practices to get a grip on security risk assessments, Kim says. The HIMSS Risk Assessment Toolkit, she points out, is mainly a compliance guide. While it lacks technical details, it does give practices a big-picture look at how they’re protecting and maintaining the integrity of patient information.

02/ Security controls
Practices should make sure that the security controls in their EHR software are turned on, the experts point out, but they should not rely on these controls alone for security. In a 2015 survey, HIMSS found that most groups still depended on old security technology such as firewalls and antivirus...
Software, Kim notes. These measures won't necessarily stop hackers, regardless of what vendor sales people may tell physicians, she emphasizes.

Gibson agrees. This is why practices need to do "technical vulnerability assessments to help determine the functionality and effectiveness of the security controls," he says. He recommends also that practices encrypt all their data, including data on workstation computers, laptops, and backup tapes.

Small practices could do some encryption work on their own, Gibson says. For example, they could use BitLocker for certain versions of Windows, and they could enable encryption within an EHR and within backup software. But some aspects of encryption—such as recovery procedures if a desktop or laptop won't boot and testing encrypted backups—would require internal expertise or assistance from a consultant, he says.

Some practices believe that their system is secure if it is not directly connected to the Internet. But virtually every practice has some Internet connectivity, if only to send its claims to clearinghouses or to request referral authorizations online. "If the staff can access the EHR and also access the Internet, there are risks that need to be mitigated," Gibson notes.

An EHR with robust security features can block attacks from sites known to originate viruses, and practices can install spam filters to segregate some dangerous emails. In addition, the groups we interviewed all block employees' access to some websites.

03/ Governance and access
Security risk assessments address many other areas, including how data is governed, who has access to it, and how those individuals are authenticated.

The governance structure is crucial, because it determines who is in charge of security. At Emerald Physicians, for instance, only Harrington and Stulsky can make changes in the system's settings.

Both Emerald and Old Hook use role-based access to limit the access of individuals to the system. This is important not only for privacy—Old Hook's employee records, for example, can be viewed only by management—but to prevent a hacker from viewing or stealing all of the group's data.

Most groups still use only a log-on and a password for user authentication. Two-factor authentication using biometric devices, tokens, smart cards, and other factors has not caught on widely.

Emerald and Old Hook use security mechanisms such as complex passwords, timeouts, automatic lockouts, and regular password resets.

04/ Employee training
No matter what a practice does to limit access and fend off intruders, its efforts will not be effective if staff members fall for phishing attacks or if hackers obtain their passwords. Encryption is useless, Gibson points out, if somebody leaves a Post-it note containing their password attached to their computer.

It is essential to train physicians and employees in security procedures. Emerald's security training includes pamphlets and a video, Harrington says. The video, which features PowerPoint slides and a voiceover by an employee, uses examples from the practice. "It's effective because it's pertinent and it covers all parts of security," she says.

Some cyber-attacks are inside jobs, so practices should do background checks on potential employees, Kim advises. All of the groups cited in this article do that. Old Hook even hires private detectives in some cases, Gold says.

05/ Remote access
From a security standpoint, Kim says, it would be best if a practice did not allow remote access to its network. However, she admits, doctors may need to connect to the office network from home or from other work locations. In that case, they should use secure connections such as virtual private networks (VPNs), she says.

Old Hook not only uses VPNs for remote access, but for connecting personal iPads to the network when physicians use them at work, Gold says. Escondido, California-based Graybill Medical Group, a 70-doctor practice, uses a VPN and a secure portal to protect its system from any malware that may lurk on home computers, notes Troy Stokes, director of IT for SmartCare MD Practice Management, which manages Graybill.

06/ Mobile devices
The use of mobile devices, including iPads and smartphones,
Technology

Security risk assessments

34 Technology

Security risk assessments has become increasingly common in clinical care, and they should be included in a security risk assessment, Kim emphasizes. The assessment should ask whether there’s a “bring your own device” policy in place, and when it was last updated. It should also ask what applications are being used on each device and whether it can access the EHR, Gibson says.

Most practices don’t allow patient data to be stored on mobile devices. But clinicians in some groups have figured out how to download data onto their devices or using portable media such as thumb drives.

Kim and Gibson stress the importance of placing mobile device management software on all devices. These apps can remotely wipe data if a device is lost or stolen.

Graybill purchases and encrypts laptops for physicians to use at work, Stokes says. If they want to access corporate email on their smartphones (iPads are not supported), they have to sign a document that explains the group’s policy, which includes encryption of Android phones and the use of PINs with iPhones.

Business associates

HIPAA requires practices to sign business associate agreements with all outside parties with which they share protected health information (PHI). These agreements oblige the business associates to safeguard the PHI. Covered entities do not have to evaluate the security procedures of their business associates, Gibson says. But he recommends that the security practices of business associates be part of the risk assessment.

“The business associate has that responsibility without the covered entity verifying it,” he says. “But it really needs to be part of the security risk assessment to at least ask how they protect the information that’s being shared with them.”

Physical security

Physical security, a basic part of any risk assessment, includes access to a practice’s servers, workstations and mobile devices. It may be as simple as making sure that an office’s back door and windows are locked. In addition, notes Emerald CIO Roland Stulsky, servers should be in an area that only authorized people can access. Security cameras and alarms may be installed in that area.

Data backup

The security risk assessment should look at how a practice backs up its data and how it prepares for natural disasters, power outages, and other unforeseen events. Practices should also have a disaster recovery plan that allows them to restore as much of their data as possible.

Among other steps, the practice should evaluate what kind of backup is being done and how often, Gibson notes. The frequency and timing of backups can determine the amount of data loss in case of a natural disaster or ransomware attack. For example, if a practice does its backup every evening, and disaster strikes late the following afternoon, all of the data entered earlier in the day may be lost.

Gibson stresses the importance of encrypting backups. “The backup includes all of the PHI in your environment, and if that’s lost or stolen, that’s worse than a missing or stolen laptop that contains a few records,” he points out.

Graybill backs up its data both onsite and offsite. The onsite backup is refreshed every night, while data is backed up at the disaster recovery site every 15 minutes. As a result, Stokes says, not much data would be lost if the system crashed late in the day and was swiftly restored. To guard against cyber-attacks, the group segments its system so that the malware, if detected early, can’t spread to the EHR or to the backup server.

Prepare for incidents

Practices must also create a security incident response protocol, Gibson notes. Such a plan would enable IT and practice managers to take a calm, methodical approach to analyzing an incident and estimating its potential impact on the practice and its patients. For example, the plan might specify that the practice’s IT staff should determine whether a lost or stolen laptop has PHI on it, whether the laptop is encrypted, and if so, whether the incident has to be reported to the U.S. Department of Health and Human Services.

Harrington is glad her practice has an incident response plan. “If you use the [ONC] tool, you have everything ready to roll,” she says. “So if some terrible event happened, and you had to go through the process of reporting it, all your letters are prepared. You just need to fill in the blanks.”
Legally Speaking

CONTRACT BOILERPLATE LANGUAGE

Why you should pay attention

The last pages of your new employment contract contain a number of provisions, typically described as “boilerplate,” that no one discusses. Here’s what that fine print covers.

by ANDREW M. KNOLL, MD, JD Contributing author

While some boilerplate provisions have less practice impact than others, physicians should pay attention to the substantive provisions that potentially have practical impact for physicians signing employment contracts.

Procedural provisions

These include sections on counterparts, waiver, entire agreement and severability. They evolved for the most part to counter the old doctrine that a defect in any way resulted in the entire contract being unenforceable. For example, the waiver provision means that should the employer waive one provision, the entire contract does not become void.

Governing law

This provision states what state law would be applied in a dispute. Typically, this provision would include the venue where the dispute would be resolved. Venue can be important. If, for example, you work in New York for a healthcare organization that’s headquartered in California, it’s probably not that significant if New York or California law applies; however, if you live in New York and get into a dispute, you would rather have the fight close to home than have to fly to California.

Assignment

This section explains whether someone else can take over the contract. Typically it says either that no one can assign the contract without the other party’s permission or the employer reserves the right to assign the contract to a successor. In the current era of mergers and acquisitions, the right of the employer to assign the contract to the company that buys it out may be important. Most contracts have termination on notice provisions that say if you don’t like your new boss, you can give notice and quit.

Offset

This provision means that the employer could take from your paycheck any money that it believes you owe the employer. Generally, state employment laws prohibit deducting payments (other than payroll taxes, such as FICA) from an employee’s paycheck without the employee’s permission. The offset provision is that permission. This can have importance if the employment relationship doesn’t end well and the employer alleges you have caused it damages.

Andrew M. Knoll, MD, JD, is a founding member of Cohen Compagni Beckman Appler & Knoll, PLLC, in Syracuse, New York. Send your legal questions to: medec@ubm.com.
and from which no appeal can be taken. In my opinion, litigating in court is preferable; but employers hardly ever remove an arbitration clause. In practice, however, it is usually not a problem because most employment disputes, in my experience, are resolved without litigation.

**Indemnification**

This provision is not in every employment agreement, but when included typically it states that you will indemnify the employer for any breaches or acts that result in the employer being sued or incurring damages. I am not so concerned when these provision are limited to egregious conduct, but they are worrisome if they include negligence or payer audits.

In the case of physicians, negligence means medical malpractice. By definition, the employer is vicariously liable for any malpractice committed by its employees and plaintiffs’ attorneys always sue the employer.

Practically, I have never seen an employer invoke this provision in a malpractice case, but there is always a first time. I try to revise the employment agreement to prevent this, but if the employer refuses it remains a potential risk.

Similarly, third-party payers audit and demand money back from medical practices all the time. Coding and billing are highly subjective and experts disagree frequently over proper codes. Provided you coded in good faith, the risk of audits and recoupments should be the employer’s cost of doing business, not yours.
IN DEPTH  Trends

Balancing telemedicine advances with ethics

Treating patients remotely requires the same diligence as face-to-face encounters, experts say

by MARY K. PRATT Contributing author

AN INCREASED number of clinicians are delivering medical care via the Internet, a shift away from traditional office visits that brings both opportunities as well as concerns. The trend has also prompted the American Medical Association and others to develop new guidelines governing how doctors should conduct these virtual exams.

More than half of all U.S. hospitals use some form of telemedicine, according to the American Telemedicine Association. Meanwhile, IHS Technology predicts that the global telehealth market will grow more than tenfold from 2013 to 2018, with the number of patients using telehealth services jumping to 7 million in 2018 from fewer than 350,000 in 2013.

Consider the situation in Wyoming. It’s the 10th largest state in the country in area, but with fewer than 600,000 residents, it’s also one of the most sparsely populated. That makes accessing doctors a challenge for the many patients who live hundreds of miles away from major medical centers and face long drives even to see primary care physicians, says James F. Bush, MD, FACP, an internist now serving as the Wyoming Medicaid medical director and chairman of the Wyoming Telehealth Consortium.

There’s no question, Bush says, that telemedicine increases access to care and decreases burdens on these patients. But he adds that telemedicine introduces new challenges to ensuring quality care with the same safeguards that exist for in-person healthcare visits.

“For example, he says a patient who visits an emergency department can be assured that the doctors there are licensed in the state where the ED is located. But that assurance doesn’t exist if the patient connects with a doctor via telemedicine. In fact, Bush says, the virtual doctor may not even be based in the United States.

“Telehealth is a huge step forward—if it’s done correctly,” he says. “We feel very strongly that there should be a single standard of care, so you don’t have a separate standard of care for telehealth than you would for in-person doctor visits.”

ALIGNING STANDARDS OF CARE

Such concerns have prompted various professional associations to act, with the latest coming from the American Medical Association (AMA). The AMA in June adopted a new policy outlining ethical rules for physicians who see patients using telemedicine technologies (see sidebar for details).

“The new AMA ethical guidance notes
that while new technologies and new models of care will continue to emerge, physicians' fundamental ethical responsibilities do not change," AMA board member Jack Resneck, MD, said in announcing the policy.

The policy includes multiple best practices for physicians engaged in telemedicine, including protecting patient privacy and confidentiality; informing patients about the limitations of the care provided virtually; and supporting communication of services with the patients' primary care physician (if the treating doctor is not the PCP).

In addition, the AMA policy sets forth guidelines aimed at governing overall telemedicine practices. It recommends that physicians delivering telemedicine services be licensed in the state where the patient receives services and requires that care delivery be consistent with that state's scope-of-practice laws.

It also says patients seeking care via telemedicine must be able to choose their physician and be aware of their cost-sharing responsibilities.

Resneck tells Medical Economics that the AMA issued the policy in response to physicians seeking guidance on how to ensure that ethical medical standards are being applied in virtual exchanges.

Resneck says delivering treatment via webcams and computers creates a different care setting than exam rooms, and that difference presents new concerns and challenges. Specifically, Resneck says the AMA is concerned that virtual doctors be qualified to treat patients and their specific ailments and that they're licensed in the state in which the patient receives services so that the patient can easily seek remedy with the state's board of medicine should any problems arise from the visit.

Moreover, he says, the AMA believes that doctors delivering care virtually should work to ensure continuity of care by obtaining medical histories and providing documentation of any care provided to the patients' primary care physician.

"It makes no sense to create a telehealth world that provides fragmented care," he notes, particularly at a time when the national healthcare system is pouring billions of dollars into electronic health record systems and interoperability to ensure continuity of care.

Resneck, who cochairs the dermatology

---

**AMA ties real-world standards to virtual care**

**After years of debate, the American Medical Association adopted a new policy regarding physicians using telemedicine at its annual meeting this year.**

**The new policy states that any physician delivering care via telemedicine must:**

- Disclose financial or other interests, specifically telemedicine applications or services; and
- Protect patient privacy and confidentiality.

**The policy also provides guidance for doctors responding to individual health queries electronically or providing clinical services via telemedicine. According to the policy, physicians should:**

- Inform patients about the limitations of the virtual relationship and the services provided
- Encourage telemedicine patients with a primary care physician to inform them about their online health consultation and also ensure details of the encounter are accessible for future episodes of care
- Recognize the limitations of technology and take "appropriate steps" to overcome them. The AMA suggests having another healthcare professional at the patient's location conduct an exam or use remote technologies to obtain vital information
- Ensure that patients have a basic understanding of how telemedicine technologies are used in their care, the limitations of the technologies and ways the information will be used after the patient encounter

**The AMA is expected to release the full guidelines and further details on its new telemedicine policy later this fall.**
department at the University of California-San Francisco, points to a study he coauthored that used researchers posing as patients to assess the performance of 62 clinical encounters at 16 direct-to-consumer teledermatology websites.

The study, published this spring online by *JAMA Dermatology*, found that patients were assigned a clinician without any choice in 68% percent of the encounters; that only 26% disclosed information about clinician licensure, with some using internationally-based physicians without California licenses; and that 23% collected the names of patients’ PCPs with just 10% offering to send records.

Nevertheless, Resneck says he still supports telemedicine—as long as it meets the same ethical standards that govern brick-and-mortar medical care.

**CONNECTING CARE**

Mia Finkelston, MD, medical director of the Online Care Group at Amwell, the direct-to-consumer telehealth platform of telemedicine software provider American Well, has been practicing medicine for more than 20 years. She worked in a large healthcare system and then in private practice in a rural region before joining American Well four years ago. She is licensed in 27 states and the District of Columbia.

To do this, Finkelston said she has to abide by each state’s medical board requirements.

“This way they can guarantee that their mission of providing care across the country is established,” Finkelston says, adding that pursuing so many licenses helps her better serve patients.

Finkelston says she started to champion telemedicine while still in private practice after seeing some of her patients struggling to get to office visits. She tried to bring a telemedicine option to her private practice, but encountered resistance from some colleagues and learned that insurance wouldn’t reimburse for visits in her primary care setting—a roadblock other doctors also say still hinders them from using it to treat their patients.

Finkelston says physicians delivering care using telemedicine technologies must have strong history-taking, observational and listening skills because they can’t rely on physical exams. They must also learn how to obtain critical data in new ways, such as instructing patients to feel certain spots and report back tenderness or pain.

In addition, they must learn to use the growing list of tools patients have, including smartphone cameras (which provide excellent views of sore throats, she notes). And they should be aware of the limits of the technology.

“We have guidelines for what makes for an appropriate visit and what doesn’t,” she explains, saying she has told virtual patients that they need to go to the emergency department for treatment or has referred them to other real-world care providers when their symptoms warranted.

Dean Bartholomew, MD, says he, too, sees the benefits of telemedicine although his use differs from Finkelston’s. Bartholomew has been in private practice in Saratoga, Wyoming, for 12 years. He
Patient complaints. Malware. Lost devices. 3rd party breaches.

What do these incidents have in common? They could happen at any time.

Most organizations think they have HIPAA covered, but find out too late they are missing important documentation.

Take our free assessment to find out if your organization is missing critical pieces of its HIPAA security compliance program.

LayerCompliance™ is the comprehensive HIPAA solution that helps you get and stay in compliance.

Visit layercompliance.com or email info@layercompliance.com to learn more.
“The provider needs to know the limitations of the services provided and know when it’s safe to complete the visit via telehealth and when it’s not and say, ‘We need to see you in person.’”

—DEAN BARTHOLOMEW, MD, SARATOGA, WYOMING

Roy Schoenberg, MD, MPH, is president and CEO of American Well, says the benefits of telemedicine “far exceed the concerns,” particularly as telemedicine helps reduce the number of patients seeking treatment for nonemergency issues in emergency departments, and in many cases provides a more efficient method for follow-up treatment.

He says he supports the AMA’s positions and that the association is providing clarity on issues for physicians who are eager for those guidelines. He says such guidelines are needed because while high standards of care should govern virtual encounters as well as face-to-face visits, telemedicine is a new care setting that requires physicians to sometimes think and act differently.

The AMA, Schoenberg points out, is just one of many organizations moving to guide doctors on how best to perform in this new care environment; the American College of Radiology, the American Academy of Dermatology Association, the American Psychological Association, the Federation of State Medical Boards and the American Telemedicine Association are among the healthcare organizations that have published standards, guidelines or statements on appropriate use of telemedicine.

Medical schools increasingly are teaching students how to deliver care effectively and ethically via telemedicine, as are professional medical associations. Schoenberg also notes that his company provides training to its doctors on this topic, in addition to including or automating certain processes to ensure specific care standards. For example, doctors ask patients at the conclusion of every virtual medical visit whether they have a PCP and if they would give American Well authorization to share clinical summaries to ensure continuity of care with that provider.

Other providers concur, saying that such education and guidelines are essential to ensuring that the same ethics govern all medical care, whether the visits are in the real world or via the Internet.

“Telehealth is a wonderful vehicle, I want doctors to not be afraid of it,” Bush says, “but we have to get in front of this, because whatever you’re doing with telehealth, you need to be held to the same standard as if you were meeting in person.”
Totally avoidable causes of data breaches

In the last six years, healthcare became the single most breached industry, according to a recent Brookings Institution report. The silver lining is that many breaches are preventable.

Secure physical devices and data
Train staff to avoid theft of mobile devices and data storage devices like backup tapes and USB flash drives. Laptops or backup tapes left in the car overnight still are among the most common causes of breaches.

Enforce clear policies for mobile devices, including personal cellphones, tablets and laptops. If staff access work data on them, they must have basic security measures in place, such as a password or PIN and automatic screen locking.

Encryption is your friend. If an unencrypted backup tape, USB flash drive, phone or laptop is lost or stolen, you need to assume it will be breached. If it’s encrypted, there’s little risk of a breach. Encryption is now a standard feature on all newer devices.

Don’t use USB flash drives. Using HIPAA-compliant cloud storage will be a safer solution.

Create access silos for staff
Disable staff and vendor accounts as soon as they leave your practice.

Avoid shared accounts. Create individual administrative level accounts for staff. If everyone is using the same administrative account, things get complicated when someone leaves or is fired.

Use the auditing functions in your electronic health record (EHR) for reviewing the alerts and reports to monitor any unusual activity.

Set up EHR accounts based on job roles: You’ll probably find you can make do with a small number of easily managed roles. This makes it clear who has access to what and also will reduce errors.

Protect against ‘oops’ events
Educate staff not to click links or open attachments in emails.

Train staff not to send any healthcare data using regular email. If you’re using Microsoft Office 365 or a patient portal, set up secure messaging and use it.

Enable installing updates automatically. Systems that haven’t been updated for months or even years are breach magnets.

Consider using a cloud-based EHR. A cloud-based EHR runs on servers secured and managed by the vendor. They also relieve you of burdensome tasks such as configuration, updates and patching.

Stephen McCallister, CPHIT, CPEHR, is a health IT consultant with over 20 years’ experience managing technology for healthcare organizations. This article originally ran in our partner publication, Physicians Practice.
New financial model may provide future for home visits

A payment model experiment could make house calls an opportunity again for primary care physicians

by JANET COLWELL Contributing author

MONICA VANDIVORT, MD, believed she had found her calling as a house call physician practicing in rural southeastern Arizona. She loved being out of the office and developing close bonds with patients. But when one of her Medicaid contractors ended its capitated payment program in late 2011, she found she could no longer make ends meet. “By the end of 2013, I was frustrated with the reimbursement structure,” says Vandivort, who previously had received a per-member-per-month stipend from Medicaid in addition to Medicare reimbursement for dually eligible homebound patients. “I was giving great care and keeping patients out of the hospital, but it was very hard under the fee-for-service model.”

House calls have the potential to reduce healthcare costs among frail, elderly or otherwise homebound patients, according to Medicare data, but most physicians don’t provide them. Although home visits are reimbursable under Medicare, the standard fee-for-service rates usually don’t fully cover physicians’ expenses.

Such conditions make it almost impossible for physicians in solo or small practices to make house calls work from a revenue standpoint without extra fees. As a result, house calls are more common in concierge and direct-pay practices that rely on membership fees as their primary income.

Ramin Rafie, MD, of Southfield, Michigan, has conducted home visits for nearly a decade through his work with the Visiting Physicians Association, the nation’s largest house call medicine provider. He says it is “possible, but difficult” for smaller practices to conduct home visits, by identifying patients closer to the office to cut travel time and adding a non-physician provider to conduct the visit and share the workload.

“If doctors in private practice want to do [house calls], they can, under the right circumstances”, Rafie says. “But they could also spin them into a concierge medicine model … as a way to make it more economically feasible.”

Change may be coming. Medicare has been reporting positive results during the third year of its Independence at Home (IAH) home visits demonstration project, raising hopes that the home care incentive program will be extended to all physicians.

First-year performance results showed savings of more than $25 million—$3,070 per beneficiary—with $11.7 million of that paid as shared savings to providers that met cost and quality targets.

Medicare officials hope the
MORE INSIGHT

helps you make the most of your practice’s revenue cycle.

KNOW YOU HAVE A DEDICATED BANKER WHO UNDERSTANDS YOUR INDUSTRY AND YOUR NEEDS.

As a healthcare professional, you want to spend more time helping patients and less time worrying about your finances. With dedicated Healthcare Business Bankers, PNC provides tools and guidance to help you get more from your practice. The PNC Advantage for Healthcare Professionals helps physicians handle a range of cash flow challenges including insurance payments, equipment purchases, and managing receivables and payables. In such a fast-moving business, PNC understands how important it is to have a trusted advisor with deep industry knowledge, dedication and a lasting commitment.

Cash Flow Optimized is a service mark of The PNC Financial Services Group, Inc. ("PNC"). Banking and lending products and services, bank deposit products, and treasury management services, including, but not limited to, services for healthcare providers and payers, are provided by PNC Bank, National Association, a wholly owned subsidiary of PNC and Member FDIC. Lending and leasing products and services, including card services and merchant services, as well as certain other banking products and services, may require credit approval. All loans and lines of credit are subject to credit approval and require automatic payment deduction from a PNC Bank business checking account. Origination and annual fees may apply. ©2015 The PNC Financial Services Group, Inc. All rights reserved. PNC Bank, National Association. Member FDIC
Money

Home visits

“I can see if their home is safe, if they have food ... and if they’re taking their medications—which is so much more information than I would get during an office visit.”

—MONICA VANDIVORT, MD, HOUSE CALL PHYSICIAN, ARIZONA

A FINANCIAL MODEL

If extended beyond the demonstration stage, IAH may convince more primary care physicians to adopt the house call model, says Jon Salisbury, MD, founder of Visiting Physician Services in Eatontown, New Jersey. The company employs six physicians and 29 physician assistants and nurse practitioners who make about 32,000 house calls per year to 3,200 active patients. Almost all of the company’s revenue comes from Medicare fees. “It’s not easy to make it financially,” he says. “You have to keep your overhead costs down and constantly look for efficiencies.”

Last year, VPS was acquired by the Visiting Nurse Association (VNA) Health Group, a nonprofit offering home health, hospice, and palliative care services throughout New Jersey. The partnership broadens VPS’ home care team to include VNA’s nurses, home health aides, therapists and social workers.

For long-term success, it’s also critical to build an extended support team that includes clinical and administrative staff, says de Jonge. “The idea is that you are trying to address all of the medical and social needs of the patient and the family caregivers,” he says, “and that’s very hard to do as a solo practitioner or small shop.”

Building a support infrastructure may be out of reach for small practices working purely within a fee-for-service environment. However, under an incentive-based payment model such as IAH, small practices can participate in house calls by partnering with other physicians, nursing agencies, councils on aging, or other health and social service providers in their communities.

IAH gives providers a financial stake in improving outcomes, and incentive payments can be substantial for participants who meet Medicare’s minimum savings requirement. For example, Visiting Physicians Association of Texas spent $4,088 per beneficiary per month—$769 lower than its spending target—and received an incentive payment of $1,727,392. First-year payouts to nine of the 17 participating practices ranged from $257,427 to $1,805,208.

The initial success of IAH has caught the attention of large health systems, many of which see a future for house call programs. For example, two years ago Vandivort signed on with Banner University Medicine at the University of Arizona in Tucson. The Banner house call practice is still too small to qualify for IAH, which requires participants to have 200 patients. However due to the success of IAH and other shared savings programs tied to home care, Banner and other health systems are investigating how such programs might fit into their population health strategies.

HOW IT WORKS

The typical home care patient is very frail or sick. Many have been recently discharged from the hospital and need help with the transition. Medicare beneficiaries can also be considered homebound and qualify for home visits if they have cognitive, psychiatric, or social issues that present significant barriers, says de Jonge, who cofounded the Medical House Call Program in Washington, D.C., an IAH site.

Once inside the home, physicians can survey the patient’s living environment, which is invaluable to managing the patient’s care effectively, says Vandivort. “I can see if their home is safe, if they have food in the refrigerator and if they’re taking their medications—which is so much more information than I would get during an office visit,” she notes.

De Jonge describes a visit to a 71-year-old blind and obese patient suffering from hypertension. During the visit, he surveyed the kitchen and noticed that the woman was eating a high-salt diet. The foods were exacerbating her hypertension and causing fluid retention in her legs and lungs—symptoms of congestive heart failure.
“The changes we made may have prevented her from eventually being admitted to the ER and being hospitalized. That’s good for her and for Medicare,” he says. House call physicians travel with a modern “black bag” containing portable diagnostic and treatment instruments, says de Jonge. Those might include an electrocardiogram machine; equipment for taking blood and urine samples and vital signs; and portable X-ray and ultrasound machines. A laptop with wireless access to patients’ electronic health records is also essential.

Vandivort stocks her car with a variety of tools, including kits for toenail care and ear irrigation; wound care and blood-drawing equipment; a nebulizer machine; IV medications, bags, and fluids; and injectable medications for infections or joint issues.

The home care team, which might include a nurse practitioner (NP) and social worker, helps patients reconcile and adjust medications and interpret care plans if they recently left the hospital. New patient visits tend to be complex, lasting one to two hours, says Salisbury, whose typical patient is between 80 and 85 years old. The physician establishes a care plan at the initial visit. Subsequent, shorter visits are handled by the group’s NPs and physician assistants and involve checking on medications, vital signs, and symptoms.

In addition to avoiding trips to the emergency department, house calls can provide a link with other levels of care when needed, says Vandivort. If a patient is very ill and not ready for hospice, she calls her colleagues at the hospital and arranges for direct admission. As a result, the patient has a smoother transition and doesn’t have to wait in the ED when he or she arrives.

MAKING IT WORK
Salisbury has spent more than 20 years refining his processes and workflow to maximize efficiency and keep overhead costs down, and today maintains a bare-bones office staff to support his care teams in the field.

Scheduling and geography play a huge role in maximizing efficiency, he says. For example, NPs are assigned to patients living within 12 miles of their homes so as to minimize travel time. Similarly, new patient visits are grouped together geographically, allowing physicians to see between six and 10 patients per day. To break even, each clinician needs to have about 30 fee-for-service encounters per week, he says.

High patient turnover is unavoidable for practices that focus on caring for sick, elderly patients, says Salisbury. VPS’ entire patient panel changes every two years, on average. However, that’s up from 16 to 18 months several years ago, he says, suggesting that earlier intervention by house call clinicians is contributing to patients living longer.

Some physicians focus on making calls to assisted living facilities where they can see several patients in a relatively short time, says Vandivort. It’s important to know frequently used billing codes so as to maximize reimbursements.

For example, Medicare now pays a separate fee for non-face-to-face chronic care management services for patients with multiple chronic conditions. Home providers may be eligible to use the code (99490) for those services if they meet certain criteria, such as creating comprehensive care plans and providing 24/7 patient access.

Medicare demo may be financial model for house calls

Earlier this year Medicare released first-year results from its home care demonstration project, Independence at Home (IAH). The numbers suggest that home care not only improves care for chronically ill patients but lowers healthcare costs overall.

Highlights from the first-year results include:

- Savings of over $25 million or $3,070 per beneficiary
- $11.7 million in incentive payments to nine of the 17 participating practices
- Improvements in quality on at least three of the six quality measures by all 17 sites, while four practices satisfied all measures
- Reductions in hospital readmissions within 30 days among all participants
Doctors groups are applauding newly-approved national legislation to fight opioid abuse while calling for more funds to implement many of the bill’s programs. The Comprehensive Addiction and Recovery Act of 2016 (CARA) passed both houses of Congress in July after Democrats backed off their demands that higher levels of funding be included in the bill.

CARA encompasses a variety of programs to deal with opioid abuse, including creation of a task force to examine how doctors can best treat pain and encouraging states to create drug monitoring programs.

Among its many provisions is one saying that if doctors or patients request only a partial fill of a Schedule II substance, pharmacists are allowed to comply. The bill also calls on Medicare to develop a safe prescribing and dispensing protocol for its beneficiaries.

Other provisions include expanding healthcare provider awareness of the risks associated with the misuse of opioids and increasing the availability of opioid overdose reversal drugs.

The American College of Physicians (ACP) called on Congress to continue its drive to assist with opioid abuse. “This legislation takes important steps to address this growing crisis and to provide patients with greater access to the care and treatment they need to deal with substance use disorders. It is critical that Congress now move ahead to ensure funding for these important advancements,” ACP President Nitin S. Damle, MD, MS, said in a statement.

Funding for opioid abuse programs became the sticking point that slowed the legislation. Republicans balked at the funding level the president requested.

The White House called for $1.1 billion in new funding for addiction-fighting programs, announced after Senate approval that the president would sign it, even though it does not contain the funding levels he wanted. The president signed the bill in late July.

Funding for opioid abuse programs became the sticking point that slowed the legislation. Republicans balked at the funding level the president requested and blocked Democratic attempts to add it to the opioid abuse bills that were simultaneously moving through both houses.

Consequently, measures passed in each chamber—CARA in the Senate and 18 opioid-related bills in the House—did not include that level of new funding.

Those differing House and Senate bills needed to be reconciled by a conference committee and then approved by both chambers before a final bill could reach the president’s desk. Conference committee work got off to a sluggish start as reports surfaced that the president was directing Democrats to go slow on the bills in hopes that public pressure would force Republicans to reconsider his funding proposal. The White House also tried to turn up the heat in mid-June by releasing a breakdown of how much money would go to each state under its funding plan.

“Congress has been voting on various pieces of legislation related to the opioid epidemic, but so far has not provided the resources needed to make treatment available to everyone who wants it,” said a June 17 post on the White House blog that included a map showing how much each state would receive in new funding.

The opioid abuse issue has come up in congressional elections across the country this fall. Democrats likely decided they did not want to be portrayed as the ones blocking government action on the issue, said Kelly Brantley, a director at Avalere Health, a healthcare consulting firm.

John Frank is a journalist with 38 years of experience. What can physicians do to halt the opioid epidemic? Tell us at medec@ubm.com.
Technology plays a vital role in my field. By treating patients with the latest innovations, I restore more than hearing; I restore hope.
**Coding Insights**

**Observation Codes**

**When to use initial vs subsequent**

We are a private practice that has several physicians who follow their patients in the hospital. There are times that the patient is in observation, and they are called to help decide whether to admit them or not. Should our physicians bill initial and subsequent observation codes for these visits?

Q: We are a private practice that has several physicians who follow their patients in the hospital. There are times that the patient is in observation, and they are called to help decide whether to admit them or not. Should our physicians bill initial and subsequent observation codes for these visits?

A: As with many scenarios in coding, the answer is: It depends. Unfortunately, the CPT and Medicare guidelines vary when it comes to billing for services provided by those physicians and non-physician providers (NPPs) who didn’t place the patient in observation status (e.g., ordering physician or NPP).

Observation care services are specifically for new or established patients who need to be observed in order to distinguish if the patient’s problem(s) will resolve and the patient can be discharged, or if the patient needs to be admitted as an inpatient.

If more than half of the visit time was spent counseling and/or coordinating care for the patient, the code can be billed based on the time instead of the history, exam and medical decision making (MDM) components. As with inpatient care codes, the time at the patient’s bedside or on the floor working for that patient can be counted.

Since observation codes are infrequently billed, we sometimes need a refresher in order to remember all of the nuances involved. As I mentioned earlier, Medicare and the CPT codebook have different instructions as to how non-ordering physicians should bill.

The CPT codebook specifically states:

“For observation encounters by other physicians, see office or other outpatient consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate.”

Additionally, “For observation care services on other than the initial or discharge date, see subsequent observation services codes (99224-99226).”

Medicare Claims Processing Manual, Chapter 12, Section 30.6.8(A)

### Subsequent Observation Care Coding

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Typical Total Time</th>
</tr>
</thead>
</table>
| 99224    | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:  
  - Problem focused interval history;  
  - Problem focused examination;  
  - Medical decision making that is straightforward/low complexity | 15 minutes         |
| 99225    | Expanded problem focused interval history;  
  - Expanded problem focused examination;  
  - Medical decision making of moderate complexity | 25 minutes         |
| 99226    | Detailed interval history;  
  - Detailed examination;  
  - Medical decision making of high complexity | 35 minutes         |

**by RENEE DOWLING**  Contributing author
states: "For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes."

So the bottom line is that consultations should be billed with outpatient consultation codes (99241-99245) for all insurance payers. However, Medicare requires office codes (99201-99215) while CPT’s instructions are to use subsequent observation care codes (99224-99226). Since each payer could adopt CPT or Medicare rules, you should check with each to ensure you are billing correctly. Also, physicians and NPPs should not be expected to remember these types of billing rules when choosing their CPT codes. So they should be educated to bill these services with one set of codes or the other, depending on a majority of their patient population. If there is an instance where the code needs to be changed, it should be done by your billing staff.

Keep in mind that observation status is considered outpatient, with Place of Service codes:

22 On Campus-Outpatient Hospital: A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization; and

19 Off Campus-Outpatient Hospital: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

---

**Renee Dowling** is a coding and billing consultant with VEI Consulting in Indianapolis, Indiana. Send your coding and billing questions to: medec@ubm.com.

---

**Unleash the Power of Your Healthcare Data!**

**AHIMA’s Data Institute:**
Making Information Meaningful

**December 8–9 | Las Vegas, NV**

*CEUs: 12 | Product #: 16DATAIN12
Price: $750 | Member Price: $650*

Join industry experts as they explore the effective management of healthcare data and examine how data permeates all aspects of the healthcare industry at AHIMA's Data Institute. You’ll gain innovative best practices for data management from real-world experiences on critical topics, industry best practices, and trends.

**A PEEK AT THE AGENDA:**

Creating a Successful Population Health Infrastructure: More than IT
Dr. Bill O’Connor; Richard Swafford, PhD; and Cheryl McKay, PhD

Implementing Predictive Analytics for Cancer Readmissions Within the EMR: Transforming Retrospective Data into Real-Time Clinical Decision Support
Kristen Johnson, MHA, and Susan White, PhD, RHIA, CHDA

Patient Matching Challenges: Identifying Underlying Causes for MPI Data Discrepancies
David Marc, PhD, MBS, CHDA; Beth Haenke Just, MBA, RHIA, FAHIMA; and Megan Munns, RHIA

Data Visualization: A Picture’s Worth a Thousand Data Points
Emily N. Graham, RHIA, and Kristen Johnson, MHA

Occupational Data for Health Is Coming! What Is It and What Do I Need to Know About it?
Genevieve Luensman, PhD

CMS Pay for Performance: Start with the Data
Catherine Gorman-Klug, RN, MSN, CPM, and Elaine King, MHS, RHIA, CHP, CHDA, CDIP, FAHIMA

**View the complete agenda and register now at ahima.org/events.**
Prescription drug prices

CLINTON

Clinton would require health insurers to cap out-of-pocket prescription drug costs at $250 per month per patient for covered drugs. The cap would apply to FDA-approved prescription medication covered by insurance. Her campaign estimates that at least one million people could benefit. Retail drug spending is up by more than 13% since 2001, according to an IMS Institute report. Much of the growth comes from new medications, specialty drugs, and price increases among brand-name drugs.

“Drug companies have been pretty relentless in extracting higher and higher prices and the government gives them a monopoly. I think she’s going to take that seriously,” says Ezekiel Emanuel, MD, Ph.D., professor of medical ethics and health policy in the Perelman School of Medicine at the University of Pennsylvania, and a key architect of the Affordable Care Act. Emanuel was an adviser to the Obama administration and is now advising the Clinton campaign.

Increased cost sharing and higher prices for medication have been shown to decrease use of effective care and increase use of inpatient and emergency department services among the chronically ill, says the ACP’s Doherty. That becomes a huge cost to the health system. “It doesn’t matter if drugs are available. They don’t do any good if they’re at a price that patients can’t afford,” he says.

To further lower U.S. drug prices, Clinton plans to allow drug re-importation from Canada and some European countries, and would permit Medicare to negotiate drug and biologic prices. This particularly impacts high-priced drugs with little or no competition. Drug re-importation could help lower the high costs to patients and get around Medicaid’s “best price” requirement, according to the libertarian-leaning Cato Institute.

Many physician groups support drug re-importation, provided regulators can reasonably assure consumer safety. ACP President and internist Nitin Damle, MD, recently told Congressional lawmakers that without action to address high prescription prices, patients will be unable to afford life-saving drugs. He argues that the cost strains on Medicare, Medicaid and other payers will force trade-offs between allocating more dollars for drug expenditures and reducing benefits for other services, as well as higher insurance premiums and higher taxes.

Physicians spend about an hour a day dealing with patient-related prescription cost issues—including conversations with patients and pharmacies about costs and cheaper alternative therapies, according to a 2014 survey from healthcare advocacy organization Community Catalyst. Half of those surveyed say discussing the cost of prescription drugs with patients is difficult. Patients admit not filling prescriptions, and skipping or cutting doses to stretch prescriptions further.

One of Clinton’s most ambitious proposals would directly take on the drug companies over the issues of advertising, research, and generics. She wants to get generic drugs to the public faster, and will push the Food and Drug Administration to clear its backlog of generic drug approvals to help bring down prices. She also wants to prohibit pay-for-delay agreements between generic and brand-name drug makers and lower the patent exclusivity period for specialty biologics.

For pharmaceutical companies to benefit from taxpayer-funded research, they will have to invest a certain percentage of their profits back into basic research. This is based on a similar ACA requirement that insurance companies pay rebates to consumers if their profits and administrative costs exceed a certain threshold.

“As a society, as a government, we need to balance financial incentives that pharma seeks to develop new treatments, which we want to continue, and to control the prices and numbers of patients who get certain medications, so we can afford the innovation that we all want,” says John Ayanian, MD, director of the Institute for Healthcare Policy and Innovation and a professor of public policy at the Gerald R. Ford School of Public Policy at the University of Michigan.

TRUMP

Reduce barriers to bringing in drugs from other countries.

$300 BILLION

Amount Trump claims the country will save by removing barriers to market entry for drug providers.
TRUMP

Trump proposes to remove barriers to market entry for foreign drug providers “to offer safe, reliable and cheaper products,” according to his website, which claims this step could produce savings of $300 billion. This figure confounds many analysts, however, including Bowen. “[Trump's] claims about the level of savings completely fly in the face of reality,” he says.

Pipes finds Trump’s plan for prescription drugs “totally unworkable.” “It spells trouble for both doctors and their patients,” she predicts, because there aren’t enough drugs available elsewhere to supply the American market. She feels it would hinder physicians from getting the latest drugs “that could prolong their patients’ lives and reduce or eliminate hospital surgeries.”

She adds that the issue of importation contradicts Trump’s opposition to imports generally. “He doesn’t want goods coming from China and other countries...so why would he say, ‘But I support bringing drugs in from other countries?’” Pipes says.

However, Parente does not think physicians will see much effect “as long as drug companies do not take certain products off the market in retaliation.”

Kominski also admits to being “skeptical” that Trump’s plan will achieve any cost savings, much less improve the quality of imported drugs. “The FDA travels the world to do site visits of manufacturing facilities to make sure quality of drugs approved for sale in the U.S. meet U.S. standards, so we’re already doing a lot of this,” he says.

Kominski adds that Trump makes “a good sound bite” with these promises but does not see evidence “that simply opening the borders will cause all these products to flood in and drive prices down.”

Kominski says that one barrier to lower prices is patents on drugs, which often prevent cheaper generics from becoming available, and he doesn’t see an alternative. For physicians who provide the drugs, Kominski says “the revenue to their practice might decrease.”

CLINTON

Clinton wants to enhance price transparency requirements to encourage more patients to price shop and promote more physician-patient engagement.

Reaction among physicians is mixed as to whether price should be a factor in clinical decision making, according to a recent study from the Robert Wood Johnson Foundation. But more physicians say they are willing to discuss cost if it’s important to their patients.

Clinton would increase federal subsidies to offset some of the cost-sharing imposed by high-deductible health plans. High out-of-pocket costs prevent patients, particularly those with chronic conditions, from getting the care they need, says John Ayanian, MD, director of the Institute for Healthcare Policy and Innovation and a professor of public policy at the Gerald R. Ford School of Public Policy at the University of Michigan.

Out-of-pocket costs in some plans are so high that they’re forcing people who don’t qualify for subsidies—and even some who do—to forego insurance altogether. Research from RAND finds that individuals use less healthcare when faced with health plans requiring greater3 cost sharing.

“Rising out-of-pocket costs / high deductibles

CLINTON

CLINTON wants to enhance price transparency requirements to encourage more patients to price shop and promote more physician-patient engagement.

Reaction among physicians is mixed as to whether price should be a factor in clinical decision making, according to a recent study from the Robert Wood Johnson Foundation. But more physicians say they are willing to discuss cost if it’s important to their patients.

Clinton would increase federal subsidies to offset some of the cost-sharing imposed by high-deductible health plans. High out-of-pocket costs prevent patients, particularly those with chronic conditions, from getting the care they need, says John Ayanian, MD, director of the Institute for Healthcare Policy and Innovation and a professor of public policy at the Gerald R. Ford School of Public Policy at the University of Michigan.

Out-of-pocket costs in some plans are so high that they’re forcing people who don’t qualify for subsidies—and even some who do—to forego insurance altogether. Research from RAND finds that individuals use less healthcare when faced with health plans requiring greater3 cost sharing.

“Rising out-of-pocket costs / high deductibles

CLINTON

CLINTON wants to enhance price transparency requirements to encourage more patients to price shop and promote more physician-patient engagement.

Reaction among physicians is mixed as to whether price should be a factor in clinical decision making, according to a recent study from the Robert Wood Johnson Foundation. But more physicians say they are willing to discuss cost if it’s important to their patients.

Clinton would increase federal subsidies to offset some of the cost-sharing imposed by high-deductible health plans. High out-of-pocket costs prevent patients, particularly those with chronic conditions, from getting the care they need, says John Ayanian, MD, director of the Institute for Healthcare Policy and Innovation and a professor of public policy at the Gerald R. Ford School of Public Policy at the University of Michigan.

Out-of-pocket costs in some plans are so high that they’re forcing people who don’t qualify for subsidies—and even some who do—to forego insurance altogether. Research from RAND finds that individuals use less healthcare when faced with health plans requiring greater3 cost sharing.

The most important way you can get deductibles and copays down is getting the cost of healthcare down,” says Ezekiel Emanuel, the Clinton adviser.

Getting costs under control will reduce the pressure on the system. The pressure to increase deductibles, which encourage consumers to use less care, will decrease, according to Emanuel. A more strategic approach of having physicians focus on providing higher-quality services, rather than just more services, will add value to care delivery, he explains. Under a Clinton administration, patients buying coverage on the insurance exchanges may qualify for enhanced relief. A tax credit of up to $5,000 per family or $2,500 per individual, will offset out-of-pocket costs and premiums above 5% of income. The plan will also reduce the cap on premiums for families that purchase insurance on the exchanges to a maximum of 8.5% of income, from its current 9.5% threshold.

Currently, individuals earning more than 400% of the federal poverty level are not eligible for premium subsidies on the exchange. Additionally, people who get insurance through their employers do not qualify for subsidies, regardless of income. This can pose real financial hardship for those who are not yet eligible for Medicare, but who...
WHERE THE CANDIDATES STAND

Both Hillary Clinton and Donald Trump have plans posted on their websites stating their positions on a variety of healthcare issues:

Donald Trump’s Seven Point Plan
1. Completely repeal Obamacare.
2. Modify existing law that inhibits the sale of health insurance across state lines.
3. Allow deductions of health insurance premium payments from tax returns.
4. Allow use and greater flexibility of health savings accounts.
5. Require price transparency from all healthcare providers, notably doctors, clinics and hospitals.
6. Block grant Medicaid to the states.
7. Remove barriers so as to allow safe, reliable and cheaper drugs into the U.S.


Hillary Clinton’s Healthcare Platform
1. Defend and expand the Affordable Care Act.
2. Bring down out-of-pocket costs in the form of copays and deductibles.
3. Reduce the cost of prescription drugs.
4. Incentivize states to expand Medicaid.
5. Expand access to affordable healthcare regardless of immigration status.
6. Expand healthcare access to rural Americans.
7. Ensure access to reproductive care.
8. Double funding for community health centers and increase healthcare workforce.

Full details at bit.ly/healthcare-Clinton.

Clinton wants to build on existing CMS programs that are designed to reward providers for improving value and outcomes. She proposes further expanding bundled payment models and encouraging commercial insurers to use this approach. She also wants to give physicians and hospitals more incentives to coordinate care under accountable care organization models. Specific details are not yet fleshed out.

Clinton and her advisers believe these approaches will help slow Medicare cost growth by promoting greater efficiency in the delivery of care. The shift toward more value-based care will be further spurred by enhancing the Medicare Access and CHIP Reauthorization Act (MACRA), which enjoys wide bipartisan support.

Physician compensation (via value-based metrics)

CLINTON

Continue CMS’ progress toward value-based care and expand bundled payments to private payers.

TRUMP

No formal position on doctor pay, but analysts speculate the candidate prefers power by the marketplace vs. government regulators.

CLINTON

Analysts agree that Trump’s plan is missing details about plans for value-based payment models, under which physicians are rewarded or penalized in their Medicare reimbursements according to their performance on a wide variety of quality and outcome metrics.

However, Luke feels that HSAs will appeal to people age 40 and under, many of whom haven’t purchased insurance despite the $600 fine that comes with the mandate, he says. He adds that the ACA miscalculated “that every American wanted insurance [and] that healthy young adults under age forty would all split the cost of paying for the seniors in their golden years who are more expensive.”

Under Trump’s plan, people would take the money from their tax credits on their premium payments and invest it either in an HSA and be able to purchase more competitive plans that meet their specific needs on the open market. Parente favors this approach, although he thinks Trump simply borrowed the idea from Rep. Paul Ryan’s “A Better Way” healthcare plan, and hopes Trump will take more cues from the House speaker’s plan, should he win the election.
Operations
Care coordination

Making care coordination work—and pay

Continued from page 28

In a 2014 study published in Health Affairs, researchers at Weill Cornell Medical College in New York City, conducted a national survey of 1,045 primary care practices with 19 or fewer physicians. The study highlighted the critical role these small practices play in lowering the rate of preventable hospital admissions.

Researchers used Medicare data to calculate practices’ rate of potentially preventable hospital admissions (ambulatory care-sensitive admissions). It showed that compared with practices with 10 to 19 physicians, practices with one or two doctors had 33% fewer preventable admissions, and practices with between three and nine physicians had 27% fewer. Additionally, physician-owned practices had fewer preventable admissions than did hospital-owned practices.

Keeping small physician-owned practices in business should be the business of every healthcare stakeholder, says Oscar Lovelace, MD, a physician in a small primary care practice in Prosperity, South Carolina. “I’m concerned that many private practice physicians are being forced into hospital employment and can no longer be the kind of advocate for a patient that they could be if they were in private practice,” Lovelace says.

As a PCHM, his practice has added staff members to coordinate care. The new employees include a full-time nurse to manage calls dealing with patient appointments, referrals and other patient-related issues, another part-time nurse who follows up with care management related issues for all Medicare recipients and another full-time staff member with a master’s degree in health administration who updates performance metrics for preventive care and chronically ill patients.

NEW PAYMENTS & OPPORTUNITIES

Lovelace says the biggest barrier to meeting performance targets is the financial toll that comes with monitoring patients and documenting their care.

For example, Medicare’s Chronic Care Management (CCM) program—which covers non-face-to-face services related to visits by patients with multiple chronic conditions—requires too much documentation and timekeeping to be worthwhile financially, especially when other program may provide a better return, Lovelace says.

He estimates that it costs the practice $1,000 to $1,500 per month to collate minutes spent caring for patients enrolled in the program, construct a care plan and bill for CCM. However, under the program his office is paid between $2,500 to $3,000 per month.

A better incentive plan could be the Comprehensive Primary Care Plus (CPC+) program, a national advanced primary care medical home model that CMS says is designed to strengthen primary care through regionally-based multi-payer payment reforms and care delivery improvements.

Many of the goals of the CPC+ program, which starts January 2017, will focus on critical areas of patient care that will impact care coordination efforts, such as payment reform, performance-based incentives and improvements to health IT systems.

The CPC+ plan includes two primary care practice tracks, each with its own care delivery requirements and payment options. For example, Track 1 will include practices that are capable of delivering comprehensive primary care, while in Track 2 practices must demonstrate they can advance comprehensive care through enhanced health IT, an ability to improve care among patients with complex medical conditions and the resources and support to provide care to patients with psychosocial needs.

The tracks also have different payment plans. In Track 1 the average Medicare care management fee is $15 per beneficiary per month (PBPM), while in Track 2 the average fee is $28 PBPM.

Lovelace says he’s interested in Track 1 and its $15 PBPM fee, which when multiplied by the 800 patients that could qualify from his practice would bring in $12,000 a month. That sum could make a world of difference to his practice, Lovelace says.

Similarly, Brad Klein, MD, would like to practice medicine as an independent physician for as long as he can. Klein is a 40-year-old neurologist, and one of eight physicians in a group practice in Abington, Pennsylvania. His office participates in a bundled payment program for stroke patients.

Bundled payment programs replace the
Care coordination

The Comprehensive Primary Care Plus (CPC+) model, explained

Get paid 3 ways

1. **Care Management Fee (CMF):** The amount is risk-adjusted for each practice to account for the intensity of care management services required for the practice’s specific population. These payments will be sent to the practice on a quarterly basis.

2. **Performance-based incentive payment:** CPC+ will prospectively pay and retrospectively reconcile a performance-based incentive based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care.

3. **Payment under the Medicare Physician Fee Schedule:** CPC+ practices will continue to bill and receive payment from Medicare fee for service as usual. More advanced practices will see the FFS payment will be reduced in favor of more quality-based pay.

Source: CMS

When the program begins:

**January 2017**

The goal

Practices will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions:

- Access and Continuity;
- Care Management;
- Comprehensiveness and Coordination;
- Patient and Caregiver Engagement; and
- Planned Care and Population Health

Where the program is located

- North Hudson-Capital Region
- Greater Philadelphia Region
- Ohio & Northern Kentucky Region
- Greater Kansas City Region

Region spans the entire state

Region comprises contiguous counties

The traditional practice of charging separately for services such as surgical procedures, post-operative care, and physical therapy, which generates multiple claims from multiple providers, with a model that compensates care teams with a target amount under one bundled payment.

Because care teams rely on the work of their colleagues to keep patients healthy, Klein says CMS’ requirement for quality measures in determining reimbursements raises two key questions: To whom will these quality measures be attributed in a coordinated care model? And who will be penalized if physicians can’t control the quality of their colleagues’ work or the patient’s adherence to the care plan?

“It seems that physicians become liable for patient outcomes, resulting in more responsibility and financial risk on them in the process,” Klein says. “At that point it becomes demotivating to a practicing physician who provides excellent care to patients, but may not be able to succeed in providing idealized clinical measures despite their best efforts.”

Another element of care coordination is improving patient education and engagement. Under Meaningful Use, doctors are required to provide information to patients to advance education and knowledge about their condition. However, Klein says there’s no data showing this works.

“With all the additional measures required by physicians to ‘prove’ quality, it’s as if the physicians and patients are now facing death by a thousand clicks,” Klein says. “I have to find an alternative because supporting new models of care that drain a small practice’s budget is not going to fly.”
“Whatever you are doing with telehealth, you need to be held to the same standard as if you were meeting in person.”

JAMES F. BUSH, MD, INTERNIST, WYOMING TELEHEALTH CONSORTIUM

PAGE 40

“Whatever you are doing with telehealth, you need to be held to the same standard as if you were meeting in person.”

JAMES F. BUSH, MD, INTERNIST, WYOMING TELEHEALTH CONSORTIUM

PAGE 40

The number of questions identified by ONC that practices must answer to ensure data security

PAGE 32

“I think there’s no question that Obamacare is in trouble.”

SALLY PIPES, CHIEF EXECUTIVE OFFICER, PACIFIC RESEARCH INSTITUTE

PAGE 18
The board members and consultants contribute expertise and analysis that help shape the content of Medical Economics.
How do you picture your retirement?

Meet financial advisers who specialize in physicians’ portfolios.

Browse Medical Economics’ Financial Advisers for Doctors listings.

medicaleconomics.com/bfa

Repeating an Ad Ensures It will be Seen and Remembered!
Legal Problems
with Medicare/Medicaid
Licenses Boards, Data Bank, 3rd Party
Payers? HIPAA, Admin, Criminal, Civil?
Federal Litigation, Civil Rights, Fraud,
Antitrust, Impaired Status?
Compliance, Business Structuring, Peer Review,
Credentialing, and Professional Privileges.
Whistle Blower!
Call former Assistant United States
Attorney, former Senior OIG Attorney,
Kenneth Haber, over 30 years experience.
301-670-0016 No Obligation.
www.haberslaw.com

Scribe into EMR
Transcription Service
* Less than a Dollar per dictation.
* One week free trial. No obligation.
* No Start-up costs, no contracts.
* Transcribe in your EMR.
* Same day turn around guaranteed.
* Transcripts to referral doctors same day.
* AAAMTdictate iPhone/Android App.
* Physicians can use from nursing homes
will send transcript by fax same day.
Call: 888 50-AAAMT Email: info@aaamt.com
VISIT AAAMT.COM
FaceSheet App
Highly customized.
Capture visit and send info to biller in 5 seconds.
Forward patients to another provider
with signoff note. HIPAA compliant.
Web interface access for provider & Biller
to check reports. 14% increased revenue.
No lost facsheets. No more paper.
Available as FaceSheet in App store.
www.facesheetMD.com
Call 888-502-2228

Reach your target audience.
Our audience.

Contact me today to place your ad. Tod McCloskey Sales Manager 1-440-891-2739 tmccloskey@advanstar.com

Advertising in Medical Economics has accelerated the growth of our program and business by putting me in contact with Health Care Professionals around the country who are the creators and innovators in their field. It has allowed me to help both my colleagues and their patients.
### Advertiser Index

<table>
<thead>
<tr>
<th>Advertiser</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHIMA</td>
<td>53</td>
</tr>
<tr>
<td>American Lifeline</td>
<td>31</td>
</tr>
<tr>
<td>American Speech Language Hearing Association</td>
<td>51</td>
</tr>
<tr>
<td>athenahealth</td>
<td>21</td>
</tr>
<tr>
<td>Kareo</td>
<td>23</td>
</tr>
<tr>
<td>LayerCompliance</td>
<td>43</td>
</tr>
<tr>
<td>MagMutual Insurance</td>
<td>39</td>
</tr>
<tr>
<td>Pfizer Inc.</td>
<td>Back cover</td>
</tr>
<tr>
<td>Advil</td>
<td></td>
</tr>
<tr>
<td>PNC Bank</td>
<td>47</td>
</tr>
<tr>
<td>Seqirus</td>
<td>13 – 16</td>
</tr>
<tr>
<td>Flucelvax</td>
<td></td>
</tr>
<tr>
<td>The Doctors Company</td>
<td>29</td>
</tr>
</tbody>
</table>

* Indicates a demographic advertisement.
What’s wrong with EHRs
Physicians critique the state of electronic health records, including how they stack up as tools to help their practice to problems plaguing the larger product marketplace. Get exclusive feedback and analysis from more than 2,200 doctors on what’s working—and what’s not—in our 2016 EHR Report Card.

PLUS

Switching EHRs: It’s easy to say you want to switch systems, but harder to actually make the move. Why? We’ll explain.

Measuring your metrics: Goodbye Meaningful Use, hello “Advancing Care Information.” Find out how Medicare’s new reimbursement program will affect physicians’ systems.
Advil® delivers fast relief

You always deliver the best-quality care. So when your patients are suffering from acute pain, recommend the clinically proven, superior choice for efficacy versus acetaminophen.¹,²*

Advil® Liqui-Gels® work faster than Tylenol® for tension headaches

In a double-blind, randomized, parallel-group study evaluating the onset, relief, and safety in the treatments of tension-type headaches, Advil liquid-filled capsules (ibuprofen 400 mg) were significantly faster than acetaminophen 1000 mg and placebo for all time-to-relief measures. Advil also demonstrated significantly superior overall analgesic efficacy and provided a clinically relevant advantage of speed.¹

At OTC doses, Advil has a proven favorable overall safety profile, including gastrointestinal, cardiovascular, and acute overdose safety.³-⁶

For samples and coupons, call 1-888-278-6528

Get more facts at AdvilAide.com/First

*Among OTC brands.
Use as directed.