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MAY 10, 2018 VOL. 95 NO. 9

## CRITICAL CONVERSATIONS

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MAY 10, 2018 VOL. 95 NO. 9

# CRITICAL CONVERSATIONS

Navigating cost of care  
discussions with patients



PREPARE <<<  
FOR NEW  
TAX GUIDELINES



BY KEITH L. MARTIN

## Don't let technology come between you and your patients

**M**ore and more these days, it's either the doctor or the patient left looking at the back of a computer or iPad. It might be the patient, talking to the top of their doctor's hairline while the rest is obscured by a screen displaying their information via EHR. It could be the physician, looking at the back of a smartphone as their care is subject to a second opinion via Internet, or simply trying to get the full attention of a web-enabled patient.

What's the effect of the growing digital generation on physicians' practices? You've already seen how reliant your younger patients are on technology, from using online review sites to shop for care providers to self-diagnosing via numerous websites offering a wide range of reliable—and not-so-reliable—information. And as patient records become more portable and patients are encouraged to take ownership of their health data, patients will take their business elsewhere if your practice doesn't offer what they want.

That can range from seeking more flexible hours to succumbing to a patient's every whim, whether for a quick antibiotic or something stronger.

**“With more distractions than ever, physicians need a new set of skills in their toolboxes to keep patients engaged during a shorter visit...”**

Add to this the growing cost of a visit to your practice. Largely due to high-deductible or what the government calls new, “short-term” health plans, when there is actual treatment required for a condition, the patient is responsible for paying more.

Nowadays, the physician is the one being asked whether the prescribed procedure is really “necessary.”

Discussing cost of care is never easy. From trying not to offend a patient when inquiring about personal income to sometimes not knowing the true cost of a procedure when all is said and done, it can be tough. But it is also more necessary than ever these days as

patients have become cost-conscious about the health services they require.

And technology is playing more of a role, providing both physician and patient with cost estimates whether for a prescription or a major procedure. When this happens, you're likely to have both parties buried in their screens searching for information.

You'll find some sound advice in this issue about how to help patients while also bringing this sometimes uncomfortable topic to a successful resolution. With more distractions than ever, physicians need a new set of skills in their toolboxes to keep patients engaged during a shorter visit and focused on long-term well-being vs. short-term cost.

There is no magic solution to these problems. Luckily, we are here to help and so are your peers. Perhaps the wisdom of the crowd can prevail and a little knowledge can go a long way to restoring precious physician-patient relationships. ■

**Keith L. Martin** is editorial director for *Medical Economics*. What is your biggest challenge in engaging patients in their care—and how have you overcome it? Tell us at [medec@ubm.com](mailto:medec@ubm.com).



**+** READ MORE INSIDE

**Financial discussions don't have to be uncomfortable for physicians** PAGE 30

*“My medical advice is not going to change, but it's not helpful to them if they can't pay to get it.”*

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# YOUR VOICE

Have a comment? SEND YOUR THOUGHTS TO MEDEC@UBM.COM

f FACEBOOK.COM/MEDICALECONOMICS @MEDECONOMICS

## Physicians are losing confidence in their clinical skills

I was struck by the box “High-deductible patients present special challenges,” in your March 10 issue, about concern over ordering a CT scan and labs on a person with suspected diverticulitis.

I think physicians are losing confidence in their clinical diagnostic skills. Maybe it is because I trained before CT scans were widely available and practiced in a state that reformed medical malpractice in 1975, but I think it is pretty easy to tell if a patient has a surgical abdomen, and needs detailed testing, or if it is safe to treat and follow.

Feeling that a CT scan needs to be done every time for abdominal

“Feeling that a CT scan needs to be done every time for abdominal pain, is part of the reason medical treatment costs are higher in the U.S. than in any other country.”

pain is part of the reason medical treatment costs are higher in the U.S. than in any other country. I think a well-reasoned—and well-charted—decision to treat without scans and a serum porcelain test is perfectly justifiable, even in court.

**Mark Bradley MD, FAAFP**  
TUCSON, ARIZ.

## Patients at risk when non-physician providers take over

The article “Physicians face punishment for speaking out about non-physician care” (MedicalEconomics.com, March 31, 2018) is well-written and accurate. Thank you.

My place “closed” its ICU a while back and only allowed “intensivists” to write orders—boarded family physicians, internists, surgeons, etc. were no longer welcome. Nurse practitioners are caring for these very sick patients.

When a critical mass of people are harmed by the (in)actions of unsupervised mid-levels, the public will figure it out. In the meantime, plaintiff attorneys are licking their chops waiting for their paydays, as more NPs, and physician assistants make major mistakes. As with government, the populace is getting the healthcare they have chosen by default, (but don’t deserve). ■

**Anonymous online comment**

### SOCIAL MEDIA

In response to: “Putting process over patients continues to hurt healthcare” by Anish Koka

*“The ‘Blue Light’ Syndrome of progress is at hand and @anish\_koka addresses it perfectly. Kudos! [This is a] must-read if you really are concerned about patient care and not only titillated by virtue signaling.”*

**Parvez Dara MD, MBA**

@JEDIPH

In response to: “3 modern financial tips for new attending physicians”

*“Know how to eliminate #medschool debt, save money without ever paying a cent in taxes, and literally CYA? Grateful to have @MedEconomics publish this.”*

**Daniel Orlovich MD, PharmD**

@DRORLOVICH

In response to: “ChangeMakers in Medicine”

*“Congratulations @LisaLarkinMD for being name a ‘ChangeMaker in Medicine’ by @MedEconomics.”*

**Lisa Larkin MD & Assoc.**

@LARKINDPC

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

**Cindy Whitehead**

@CINDYPINKCEO

COVER STORY

# Critical conversations

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# The Chef Doc finds joy in healthy food and locum tenens



Dr. Colin Zhu is a family practice osteopath whose mother is a Chinese medical doctor, so the holistic approach to medicine was instilled in him from an early age. Eastern medicine — rather than the one-size-fits-all treatments typically prescribed in Western medicine

— looks at the needs of the individual and their unique body in an integrative and preventive way. Dr. Zhu also has a passion for cooking, and attended culinary school during a brief break between med school and residency. He has found food plays an integral role in the way he practices medicine.

“I find that food is medicine, and it can be one of the best solutions to fighting America’s chronic disease burden,” he says. “I use my culinary background and marry it to medicine, and show how food can be used as medicine.”

## Locum tenens and the freedom to live a “nontraditional life”

Dr. Zhu also has a passion for travel, and has found that he’s able to use locum tenens as a way to incorporate his career into his love of the culinary arts and medicine, and exploring the world. To this point, he’s visited 29 countries, and recently made it to Antarctica.

“Locum tenens allows me the freedom and autonomy to be able to dictate the type of lifestyle and work/life balance that I seek personally,” he continues. “I have more time to pursue my other passions. The more that I can improve the way I take care of myself, the more I can dedicate more quality time to my patients.”

## More time for patient care

Dr. Zhu’s discovered that without the administrative burdens that come with a permanent position or owning his own practice, he can spend more quality time with his patients.

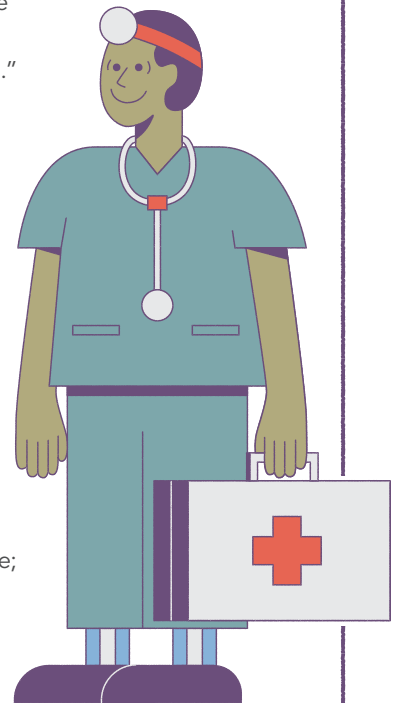
“I can educate my patients more because I have more counseling time,” he says. “My patients really, really appreciate this. I can spend more time explaining their disease process. I don’t have to worry about politics, red tape, or bureaucracy. I can autonomously practice medicine.”

## Using locum tenens to pursue your dreams

“I work locum tenens because I enjoy the work that I do. I give quality service to the patients that I do because locum tenens is a great vehicle and eliminates all the other stresses that I don’t have time to worry about,” he says, “which would come with being employed somewhere full-time. I get to dictate my own lifestyle and practice medicine and treat patients — the way I feel it should be.”

And without the ability to control when, where, and how much he works with locum tenens, Dr. Zhu wouldn’t have been able to achieve his goals.

“Without locum tenens, I wouldn’t have been able to take in and fully embrace all of life’s vast experiences; always continue to not only grow, but thrive, both in my professional and personal life; and share and give back to my audience in meaningful, valuable, fun, and entertaining ways.”



Learn more about Dr. Zhu at [chefdoczhu.com](http://chefdoczhu.com) and locum tenens at

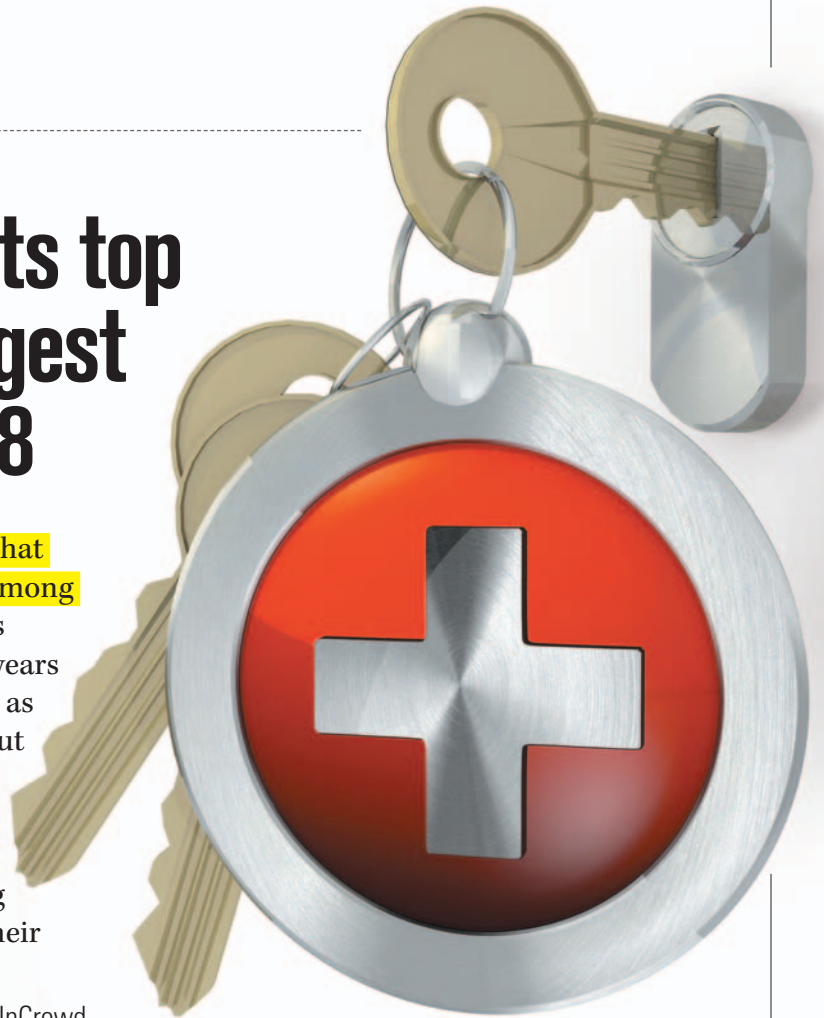
[locumstory.com](http://locumstory.com)



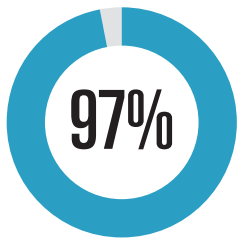
# Healthcare costs top physicians' biggest worries for 2018

“Year over year, physicians indicate that affordability and access to care are among their top concerns. With these issues ranking significantly higher than in years past, physicians appear as uncertain as many Americans when thinking about availability of affordable healthcare. The latest repeal of the individual mandate for health coverage is a critical example of how the changing landscape impacts physicians and their patients.”

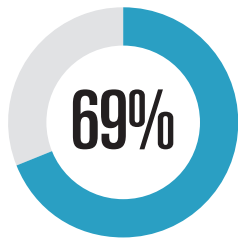
— Diane Hayes, president and co-founder, InCrowd



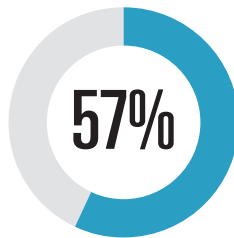
## Among physician respondents:



said their biggest concern for patients with the healthcare repeal is the rising cost of healthcare



said the individual mandate had been effective in increasing insurance coverage over the past four years



said consumers should be required to carry health insurance coverage



said the repeal was good for patients

Source: InCrowd

Thomas Reichhart/Shutterstock.com

[MedicalEconomics.com](http://MedicalEconomics.com)

## Top 8 worst administrative hassles according to physicians

Physicians, especially primary care physicians (PCP), often bear the brunt of what many consider to be excessive regulatory requirements associated with patient care. Here are the most common administrative burdens, according to physicians.

### Pre-Authorization for Medications and Tests

For PCPs, there can be a preauthorization catch 22, because payers often require a specialist order for approval of diagnostic tests, but the consulting specialist often wants to see the test results first, before seeing the patient. Nicole Price Swiner, MD, co-author of *Thinking About Quitting Medicine*, is a PCP in Durham, North Carolina.

"Paperwork is the bane of my existence," Swiner says. As a PCP, she says that she is required to fill out requests for insurance companies to authorize everything her patients need, such as medications, procedures and consultations.

### Managing Consults From Specialists

PCPs, in particular, experience roadblocks when it comes to obtaining and following up on specialty care for patients. Fabiola Antonelli, MD, an internist in Dallas, Texas, shares her experience with this problem.

"My consults are discontinued and denied multiple times, and I have to sign off on preauthorization templates for Lyrica, Plavix and many other specialist-ordered drugs that my patients need," Antonelli says.

### Patient Records

Doctors across specialties learned in medical school that the patient chart is a valuable record to be used for communication between physicians, nurses and all patient care providers.

**+ MORE ONLINE** For the rest of the story, visit [bit.ly/administrative-hassles](http://bit.ly/administrative-hassles).

Topic Resource Center

COPD Practice Management Resource Center

- PCPs fall short on making rehab referrals for COPD patients
- New study links congenital lung variations to COPD

### Bloggers

*"It is clear that (EHR) benefits touted by the federal government are vastly exaggerated if not blatantly false. Yet, our government persisted with passage of MACRA, touting that more information could determine quality."*

**Ken Fisher, MD**, an internist in Kalamazoo, Mich. penning his thoughts on the EHR being an ill-conceived obsession.

*"While other physicians have reported persecution for speaking out about midlevel care, most are hesitant to share their name or identity due to concerns over losing their job."*

**Rebekah Bernard, MD**, a primary care physician in Fort Myers, Fla., writing how physicians are facing punishment for speaking out against non-physician care.

**+ MORE ONLINE**  
Visit the Blog section at [MedicalEconomics.com](http://MedicalEconomics.com)

# Preparing your practice for tomorrow's patients

By **JAMES F. SWEENEY** *Contributing author*

**A** new generation of primary care patients, thoroughly digital and used to getting things on its own terms, is on the horizon and promises to bring with it significant changes for practices and clinicians.

Generation Z, generally regarded as those born from 1995 to 2012, is the first truly digital generation, a group that has never known a world without the internet and whose phones have always

been smart. Their digital fluency may well change how healthcare is delivered and consumed in the coming decades.

While medicine is becoming more digitized in many aspects, it can't happen quickly enough for Gen Z. Though most members now probably are still seeing pediatricians or their parents' doctor, they will soon be choosing their own physicians and they will have definite preferences. And at roughly 80 million

The doctors of tomorrow: [Page 16](#)

Teaching young patients about continuity of care: [Page 42](#)

The physician office of the future: [Page 44](#)



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strong, the largest generation alive, Gen Z is too big to ignore for physicians who plan on being in business past the next 10 years.

Of course, it's easy to overgeneralize when assigning characteristics to an entire generation, but research indicates Gen Z will be different than those that came before it, even the millennials, which they most closely resemble.

### DIGITAL EVERYTHING

Raised on Uber, Netflix, and Amazon Prime, Gen Z will expect its healthcare delivery to be just as immediate and convenient, says Travis Schneider, founder of PatientPop Inc., which offers marketing services to independent practices.

"These patients really have moved to a new reality. They want everything online and they're not going to accept any other way," Schneider says. "It's not a nice-to-have anymore; it's absolutely critical."

Gen Z patients will want to do everything digitally, he says: research physicians, make and confirm appointments, provide insurance information, receive information and test results, and ask follow-up questions. And they will expect it all to be seamlessly integrated and done on their smartphones.

"The last thing a Gen Z patient wants to do is play phone tag with a receptionist," Schneider says.

Jonah Stillman is 18. He and his father, David, form the consulting firm Gen Z Guru and are co-authors of the book "GenZ@Work." Efficiency and ease of interaction will be key to attracting Gen Z patients, Jonah says: "Efficiency is king in this day and age. Gen Z is going to be interested in finding ways to make everything more efficient and streamlined, including healthcare delivery."

"We honestly don't see the difference between an online appointment and an in-person visit. They're the same," he says, adding that "doc in a box" clinics in retailers and telehealth services are regarded by Gen Z as acceptable ways to access primary healthcare.

Practices should begin now to prepare for Gen Z, even if their arrival in significant numbers is years down the road, says David Gans, MSHA, FACMPE, senior fellow for

industry affairs at Medical Group Management Association (MGMA).

"If you are a medical practice, you should be looking to design your practice more for Gen Z and millennials rather than the Gen X and baby boomers that make up the majority of your patients," he says. "As they come into mainstream healthcare, wise organizations will learn to accommodate their different personality."

That can mean offering digital features and conveniences, such as high-speed Wi-Fi and online scheduling that millennials and Gen Z want while still preserving the traditional ways of doing business that Gen X and baby boomers are more familiar with, Gans says. Because their smaller size allows them to change policies more easily, independent practices will be able to adjust more quickly than large multi-specialty groups and healthcare systems, he says.

### DOCTOR SHOPPING

Gen Z is going to comparison shop for its healthcare and prioritize patient reviews when deciding whom to see. "They view (healthcare) as a transaction and they don't do any transactions without getting peer reviews and shopping online," says Es Nash, MD, a population health expert at Deloitte Consulting.

That means physicians and practices must continue to carefully monitor and manage their online reputations on sites like Healthgrades, Vitals, RateMDs, and even Yelp. An inviting website and engaging social media presence also are important, Nash says.

PatientPop's Schneider says a good site should be mobile-friendly, attractive, easy to navigate, easily found through search

**"The last thing a Gen Z patient wants to do is play phone tag with a receptionist."**



—TRAVIS SCHNEIDER, FOUNDER, PATIENTPOP INC.

**“I have to meet patients where they are. If you’d told me 13 years ago that I’d have to pay this much attention to satisfying patients’ expectations, I wouldn’t have believed you, but that’s the new reality.”**



—PAYAL BHANDARI, MD,  
PRIMARY CARE PHYSICIAN,  
SAN FRANCISCO

engines and integrated with common physician review sites.

PatientPop client Payal Bhandari, MD, a primary care physician in San Francisco, works with the firm to regularly tweak her website design and content to attract patients. She uses a second vendor to manage her blog and social media.

“I have to meet patients where they are,” she says. “If you’d told me 13 years ago that I’d have to pay this much attention to satisfying patients’ expectations, I wouldn’t have believed you, but that’s the new reality.”

The patient-friendly approach is working, she says, adding that number of younger patients she attracts has been increasing yearly

**How the balance of power is tipping between physicians and patients**

Continued on page 40 

**Gen Z Doctors**

Of course, Gen Z won’t just be healthcare consumers; many of them will also become healthcare providers.

A 2017 survey by the National Society of High School Scholars found that 41 percent of Gen Z’s highest-achieving students expect to work in healthcare and medicine. The first Gen Z-ers will be graduating from medical school soon.

So what sort of physicians will they be? They’ll almost certainly be comfortable with technology in a way previous generations can’t match, of course. That could make them more comfortable with telehealth and remote diagnosing.

Es Nash, MD, specialist executive for healthcare strategy and operations at Deloitte Consulting, thinks Gen Z doctors will be receptive to Gen Z patients using online reviews and ratings to shop for healthcare and providers, the way they do everything else.

Based on their experiences with stress and depression and

their focus on wellness, they might be less inclined to work the long hours their predecessors do, says Nash: “I expect them to value work-life balance as much or more than millennials and this would shape their job roles,” she says.

Eighteen-year-old Jonah Stillman, has, with his Gen X father, spoken to numerous groups about Gen Z and they co-wrote a book about Gen Z in the workplace.

Many Gen Z doctors will be creators, Stillman says, not content to simply work within a system and settle for the tools they’re given, but will strike off on their own to do research and create tools, such as new apps, that will improve healthcare.

“They’re entrepreneurial and they will always look for a better way to accomplish something,” he says. “They’re not necessarily going to accept something just because that’s the way it’s always been done.”

**FACTS ABOUT GEN Z**

**IT’S HUGE** Gen Z is 26 percent of the U.S. population, trailed by the baby boomers (24 percent), millennials (22 percent), Gen X (20 percent) and Post-War (9 percent).

Source: U.S. Census

**IT’S DIVERSE** It’s the most diverse generation in U.S. history: 49 percent of children 15 and under are minorities.

Source: U.S. Census

**IT’S TIRED** One in three is actively treating or preventing fatigue and they list getting enough sleep as a top health concern.

Source: Hartman Group

**IT NEEDS HEALTHCARE** Dermatological problems (26 percent) and anxiety, aches and pains and asthma (11 percent each) were the most prevalent conditions cited by Gen Z members.

Source: Hartman Group

# Coding Insights

## CODING CASE STUDY: Sinusitis

Getting paid requires accurate documentation and selecting the correct codes. In our Coding Case Studies, we will explore the correct coding for a specific condition based on a hypothetical clinical scenario.

### Clinical scenario

**History:** The patient has a respiratory and sinus illness, with four days of worsening cough productive of green sputum. He has had yellow sinus drainage, sinus congestion, and sinus pressure. No fever or chills. No flu-like symptoms. He used Mucinex over the weekend. No neck pain or stiffness.

### Review of Systems

**Constitutional:** Negative for activity change, appetite change, chills, diaphoresis, fatigue, fever, and unexpected weight change.

**HENT:** Positive for congestion, rhinorrhea (yellow), sinus pain (frontal) and sinus pressure.

**Eyes:** Negative for photophobia, pain, discharge, redness, itching, and visual disturbance.

**Respiratory:** Positive for cough (productive of green sputum, no blood).

**Cardiovascular:** Negative for chest pain, palpitations, and leg swelling.

**Allergic/Immunologic:** Negative for environmental allergies.

**Neurological:** Positive for headaches (+Sinus HA).

### Physical Exam

**Constitutional:** He is oriented to person, place, and time. No distress.

**Head:** Normocephalic and atraumatic.

**Ears:** Tympanic membrane and ear canals normal.

**Nose:** Mucosal edema and rhinorrhea present. Right sinus exhibits frontal sinus tenderness. Right sinus exhibits no maxillary sinus tenderness. Left sinus exhibits frontal sinus tenderness. Left sinus exhibits no maxillary sinus tenderness.

**Mouth/Throat:** Oropharynx is clear and moist and mucous membranes are normal.

**Eyes:** Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light. No scleral icterus.

**Neck:** Normal range of motion and phonation normal.

**Cardiovascular:** Normal rate, regular rhythm.

**Lymphadenopathy:** He has no cervical adenopathy.

### Assessment and Plan

- Bacterial sinusitis
- Acute bacterial bronchitis

### Push fluids

Continue Mucinex DM  
Zpak antibiotic as directed until all gone.

### Documentation requirements

When documenting sinusitis, include:

<b>Temporal factors</b>	Acute, acute recurrent, chronic
<b>Location</b>	Frontal, ethmoidal, sphenoidal, maxillary, other

### ICD-10 codes

<b>J01.00</b>	Acute maxillary sinusitis, unspecified
<b>J01.01</b>	Acute recurrent maxillary sinusitis
<b>J01.10</b>	Acute frontal sinusitis, unspecified
<b>J01.11</b>	Acute recurrent frontal sinusitis
<b>J01.20</b>	Acute ethmoidal sinusitis, unspecified
<b>J01.21</b>	Acute recurrent ethmoidal sinusitis
<b>J01.30</b>	Acute sphenoidal sinusitis, unspecified
<b>J01.31</b>	Acute recurrent sphenoidal sinusitis
<b>J01.80</b>	Other acute sinusitis
<b>J01.81</b>	Other acute recurrent sinusitis
<b>J01.90</b>	Acute sinusitis, unspecified
<b>J01.91</b>	Acute recurrent sinusitis, unspecified
<b>J32.0</b>	Chronic maxillary sinusitis
<b>J32.1</b>	Chronic frontal sinusitis
<b>J32.2</b>	Chronic ethmoidal sinusitis
<b>J32.3</b>	Chronic sphenoidal sinusitis
<b>J32.8</b>	Other chronic sinusitis
<b>J32.9</b>	Chronic sinusitis, unspecified

Use additional code to identify:

- exposure to environmental tobacco smoke (Z77.22)
- infectious agent (B95-B97)
- tobacco dependence (F17-F17.299)
- tobacco use (Z72.0)

### Diagnosis codes

- J01.10** Acute frontal sinusitis, unspecified
- J20.8** Acute bronchitis due to other specified organisms
- B96.89** Oth bacterial agents as the cause of diseases classd elsewhere

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

# CONFERENCE REVIEW

NEWS, NOTES & QUOTES



## Health IT: Technology innovations for your practice

From solving the EHR interoperability puzzle to looking at the technological tools that will revolutionize patient care in the next decade, this year's Healthcare Information and Management Systems Society (HIMSS) Annual Conference tackled major issues in medicine. Our editorial team was on-site in Las Vegas for this year's gathering and compiled the following highlights:

### 8 ways to reduce EHR frustration

Time spent on EHR data entry instead of interacting with patients is a common complaint from doctors

Martin Pricco, MD, MBA, an internist and president of Gould Medical Group in Modesto, Calif., did an evaluation with Paul DeChant, MD, MBA, deputy chief health officer of Simpler/IBM Watson Health, examining how Gould's 360 physicians and allied health practitioners were spending their time in the EHR. The goal was to help the physicians become more efficient and reduce their frustration with the system. Their recommendations included:

Improve the password process. Physicians should not spend any time typing passwords into workstations in

the practice. Instead, provide a proximity password device or other technology solution that does not require the physician to enter a password on a keyboard each time they enter a new room.

Create a review process. Physicians often waste too much time reviewing or approving items that could have been handled by someone else with a lower licensure level. Create a system where all "in basket" items are reviewed by a member of the staff before they are sent to a physician. Items that don't require physician input can be rerouted to the appropriate person.

Install a printer in each exam room. If physicians are spending time walking back and forth to get printouts from the EHR, consider installing a printer in each exam room. The cost of a printer

is far less than the doctor's time.

[To read the rest of their advice, visit [bit.ly/EHR-frustration](http://bit.ly/EHR-frustration).]

### Artificial intelligence is getting real

Artificial intelligence (AI) and machine learning were hot topics at HIMSS. Software companies are now harnessing computing power to analyze usage patterns within an EHR, comparing that to occurrences of medical errors or a physician leaving the company, and developing a set of triggers that can warn when a physician is showing signs of burnout so an intervention or additional training can be provided.

The same is true of diagnostic tools, where AI is be-

ing used to identify patterns to help doctors find the right diagnosis and sort through meaningless data to find the information they need.

Every AI expert emphasized that the software cannot replace a real doctor, and that these are just powerful tools at a physician's disposal to improve care and save time.

### Patients: The forgotten piece of the healthcare puzzle

Another common theme from this year's conference was empowering the patient and giving them a seat at the healthcare table. Companies are providing solutions that give patients more access to their health data and more ways to communicate with their providers.

For more, visit [www.medicaleconomics.com/tag/himss](http://www.medicaleconomics.com/tag/himss)

## CONFERENCE REVIEW

**HIMSS**  
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a primary care physician, that a traditional outpatient setting wasn't for him.

He was seeing 25 patients per day, each for 15 minutes, and half of his time was dedicated to documenting, said

Swenson. "

I wasn't getting to know patients like [I wanted to]... my practice continued to grow and it was successful based on the definition of a traditional primary-care practice, but it had become factory medicine," he said.

Once he left behind factory medicine for a concierge practice, he needed to adopt tech solutions that would help him adjust to a patient-focused practice, especially when it came to communication.

Chatbot is a computer program that simulates conversation with human users, primarily utilizing the internet, he said. The goal of chatbots was to meet patient needs for responsiveness, communication, and better outcomes.

Swenson's concierge practice, Swenson Premier Care in Scottsdale, Ariz., rolled out the chatbot technology in three phases. The first phase was patient-initiated communication, in which they used the technology to schedule appointments and get medication refills. Instead of calling the clinic, patients could securely text through the chatbot system and make those arrangements.

Phase two involved the clinic initiating communication with the patient. The clinic focused on patients receiving preventive care, such as a flu vaccine. In this phase, the tech was still not integrated into the EHR and the process of finding patients eligible for the vaccine had to be done manually.

The final phase, which started in February, aims to solve that problem, as Swenson's practice recently rolled out the chatbot with EHR integration. That means every appointment made through the technology now goes directly into the EHR's practice management suite.

[To read the rest of their advice, visit [bit.ly/chatbots-VBC](http://bit.ly/chatbots-VBC).]

a physician's ability to keep up with the latest medical knowledge.

Kurt Hegmann, director of the Rocky Mountain Center for Occupational and Environment Health, University of Utah, said that physicians would have to read 46 controlled trial studies a day to keep pace with current research and medical best practices.

The proposed answer is clinical support tools that can illustrate the most common treatments for a given diagnosis, thereby bringing more consistency to medical treatment while still giving doctors the ability to vary the treatment, if required. ■

*Information from our partner publication, Physicians Practice, was also used in this article.*

Kristina Sheridan, a patient advocate, emphasized that patients should be an equal member of their own care team and that technology developers needed to remember that these are people behind the data points.

### Lose the wait

With physicians and hospitals looking to reduce no-shows and increase revenue, several companies have developed technologies that allow patients to virtually check-in for care and move appointments as necessary, reducing the amount of time spent in waiting rooms. For one chain of urgent care centers, wait times were reduced from three hours to 30 minutes and the reduction in no-shows paid for the system.

As patients take control of more of their healthcare, they also expect a better patient experience, and reducing wait times is a way to improve patient satisfaction scores.

### Chatbots and value-based care

After a year of running his own practice, it became clear to Brett Swenson, MD,

### Falling behind

New research is outstripping

## The social factors

Social determinants are often associated with low-income patients or those from the inner city, but Susan Taylor, vice president and global manager healthcare and life sciences for business software provider Pegasystems, shared data that illustrates how outside influences affect everyone's health:

- 61 percent have been inspired to make positive changes by someone they know.
- 57 percent say family and friends help them make better choices about their health.
- 57 percent believe financial incentives and rewards would encourage them to make healthy choices.
- 20 percent share their eating habits and exercise on social media.
- 70 percent of consumers focus on health when they feel financially stable.



# Boost MIPS scores while improving osteoarthritis patient management

By **LISA A. ERAMO, MA** *Contributing author*

## HIGHLIGHTS

▶▶ Osteoarthritis functional and pain assessments help meet the overarching goal of MIPS to improve outcomes and reduce costs.

▶▶ Ask patients to come into the office early to get the forms filled out, to prevent EHR headaches later.

**A**lthough there's no cure for osteoarthritis, it's certainly possible for primary care physicians to not only help their patients manage symptoms, but also improve reimbursement for doing so

The debilitating chronic condition affects more than 30 million adults in the United States, according to the CDC. Functional and pain assessments—something many physicians perform regularly—are critical because they help target interventions that ultimately improve patients' quality of life.

These assessments can also boost payments under the Merit-based Incentive Payment System (MIPS), one of two participation tracks under the federal law that seek to reform Medicare payments while improving outcomes and reducing costs.

To satisfy MIPS criteria, physicians must report CPT code 1006F (indicating that they performed an assessment for function and pain) along with one of the following osteoarthritis diagnosis codes:

- M15.-Polyosteoarthritis
- M16.-Osteoarthritis of hip
- M17.-Osteoarthritis of knee
- M18.-Osteoarthritis of first carpometacarpal joint
- M19.-Other and unspecified osteoarthritis

Physicians aren't required to use validated assessment instruments to get credit under MIPS. The only requirement is that the instrument assess pain and various functional elements including a patient's ability to perform activities of daily living. For example, physicians can use a standardized scale or ask patients to complete a questionnaire such as Short Form-36 or American Academy of Orthopaedic Surgeons Hip and Knee Questionnaire. Acceptable pain assessments include the following:

- Visual Analog Scale
- Patient-Reported Outcomes Measurement Information System (PROMIS)
- Numeric Pain Rating System

Acceptable functional assessments include the following:

- General quality of life: Veterans RAND 12, PROMIS (PROMIS 10 or PROMIS Computerized Adaptive Test), or EuroQol-5D
- Foot and ankle: Foot and Ankle Ability Measure or Foot and Ankle Disability Index
- Knee (anterior cruciate ligament): International Knee Documentation Committee Subjective Knee Form or Marx Activity Rating Scale
- Knee (osteoarthritis): Knee Injury and Osteoarthritis Outcome Score (KOOS) or KOOS Jr.

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## Osteoarthritis documentation tips

Anissa Calhoun, COC, CPC, a coding specialist in Boston, says physicians should document the following details for osteoarthritis:

- 1 **Type of osteoarthritis (i.e., polyosteoarthritis, primary, post-traumatic, or secondary).**
- 2 **Affected joints (i.e., hip, knee, first carpometacarpal joint, shoulder, elbow, wrist, hand, ankle, or foot).**
- 3 **Laterality (i.e., left, right, bilateral, or unilateral).**

Generally speaking, payers are looking for specificity at all times, says Calhoun, adding that many physicians continue to document “osteoarthritis” without any additional information. “We had that grace period after ICD-10 went into effect when insurance companies were flexible with unspecified codes,” she says. “But now that time is over, and insurers are starting to require more information.”

- ➔ 24 ■ **Hip (osteoarthritis): Hip Disability and Osteoarthritis Outcomes Survey (HOOS) or HOOS Jr.**
- **Shoulder: American Shoulder and Elbow Surgeons Standardized Shoulder Assessment Form, Oxford Shoulder Score, or Single Assessment Numeric Evaluation**
  - **Shoulder (instability): ASES or Western Ontario Shoulder Instability Index**
  - **Elbow, wrist, and hand: Disabilities of the Arm, Shoulder, and Hand Score (DASH) or Quick-DASH**

### ASSESS FOR FUNCTION & PAIN

Osteoarthritis functional and pain assessments help meet the overarching goal of MIPS to improve outcomes and reduce costs because these assessments help to identify patients who can benefit from early intervention, says James Daniels, MD, MPH, a primary care physician in Quincy, Ill. Daniels served on the American Academy of Orthopaedic Surgeons committee that helped develop the osteoarthritis MIPS measure.

“We’ve got an aging population. This means the volume of patients with osteoarthritis is rapidly expanding,” says Daniels, who is also professor of family medicine and orthopedic surgery at Southern Illinois School of Medicine in Carbondale, Ill. Osteoarthritis assessments can help physicians intervene and potentially improve long-term outcomes, reduce hospitalizations due to falls, and prevent expensive surgeries such as hip or knee replacements.

In many cases, functional and pain assessments paint a more accurate picture of a patient’s experience than a diagnostic image, says Fotios Koumpouras, MD, a rheumatologist and assistant professor of medicine at Yale University in New Haven, Conn. Koumpouras often sees cases in which an X-ray reveals minor disease, but the patient reports significant pain or loss of function that requires intervention.

However, physicians also need to be aware of the potential for inflated pain scores due to the presence of comorbid conditions, says Koumpouras. “We know by studies that individuals with depression, for example, will score worse on the pain assessments not necessarily due to their primary disease but because of comorbid conditions that affect their answers and perception of what’s going on,” he says. In these

cases, physicians may need to address the underlying depression in order to improve osteoarthritis symptoms.

Still, the assessments are a good first step to get patients on the right course of treatment, says Nitin Damle, MD, an internist at South County Internal Medicine in Wakefield, R.I., and past president of the American College of Physicians. Half of his patients over age 50 have some degree of osteoarthritis. “[The assessments] give us a better idea of how to manage the osteoarthritis with anti-inflammatories, physical therapy, weight reduction, stretching, tai chi, balance exercises, or a combination of all of these,” he says.

Aside from helping physicians meet the relevant MIPS measure, osteoarthritis functional and pain assessments can help justify to payers why patients may need physical therapy, says Daniels. The information also helps orthopedists to whom patients are referred. “The orthopedists don’t need to start from scratch, which probably saves a visit or two in terms of trying different methods,” he adds.

Finding the time for patients to complete these assessments—and then incorporating that information into the EHR—is a challenge, says Koumpouras. Some EHR vendors may be able to load the assessments so physicians can send them to patients via the portal for completion prior to their appointments.

Asking patients to come into the office in advance of their scheduled appointment time to complete the forms using the digital pen or completing the forms on paper and scanning them into the EHR may also be an option.

Carl Franzetti, DO, a primary care physician at Riverdale Family Practice in New York City, hopes to use his EHR kiosk to help perform the assessments. Between 70 and 80 percent of his patients over the age of 30 have some form of osteoarthritis. “Ideally, we want the patient to come in and go right to the kiosk to answer a series of questions that populates in the chart right away,” he adds.

The goal is to have as much information as possible in the EHR prior to the physician stepping into the exam room so he or she can spend time recommending treatment rather than collecting information, he says. ■

# Manage rheumatoid arthritis and related quality metrics

By **LISA A. ERAMO, MA** *Contributing author*

**A**pproximately 1.5 million people in the United States have rheumatoid arthritis, according to the Arthritis Foundation. Prescribing a disease-modifying anti-rheumatic drug (DMARD) for patients with rheumatoid arthritis not only helps alleviate symptoms, but it may also help physicians trigger performance-based bonuses from certain commercial payers.

That's because rheumatoid arthritis is a condition included in the 2018 Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of commercial insurers to measure physicians' performance on care and service.

Many payers tie physician bonuses directly to their ability to satisfy HEDIS requirements—in this case, the ability to dispense at least one ambulatory prescription for a disease-modifying anti-rheumatic drug for patients with rheumatic arthritis ages 18 and older

## PRESCRIBING DMARDS

Early intervention is critical for patients with rheumatoid arthritis, and it's also something that payers increasingly must report as a HEDIS measure. If physicians can show that they provide high-quality,

evidence-based care—either through prescribing DMARDs or working with rheumatologists to co-manage care—payers might provide physicians with a performance bonus, says Colleen Gianatasio CPC, CRC, risk adjustment quality and education program manager at Capital District Physician's Health Plan in Albany, N.Y.

Physicians—particularly those in rural areas without easy access to rheumatologists—need to feel comfortable recognizing the signs and symptoms so they can prescribe first-line standard medications, such as methotrexate, says Fotios Koumpouras, MD, a rheumatologist and assistant professor of medicine at Yale University.

"The first thing is to pick up the phone and call the rheumatologist," he says. "A quick phone call can actually make the internist feel more comfortable to initiate a treatment plan."

Nitin Damle, MD, an internist in Wakefield, R.I., agrees. "The more we can communicate with rheumatologists, the better we can be at managing the problems that arise," he says. "If we need to change a medication, for example, that's much easier to do when there's a collegial relationship."

Having a collegial relationship with rheumatologists not only helps physicians meet MIPS and HEDIS measures, it can also assist

## HIGHLIGHT

► **Chronic care management (CCM) programs can help open the lines of communication with rheumatologists. With CCM, practices have already created workflows that promote frequent communication with specialist.**



**“The more [primary care physicians] can communicate with rheumatologists, the better we can be at managing the problems that arise.”**

—NITIN DAMLE, MD, INTERNIST, WAKEFIELD, R.I.

with Accountable Care Organization (ACO) quality reporting, says Gregory Steinmetz, MD, a primary care physician at Associates Primary Care Medicine in Warwick, R.I.

For example, to fulfill its obligations under an ACO contract, Steinmetz’s practice previously had to report whether patients

with rheumatoid arthritis were prescribed a DMARD. Insurers sent the practice lists of patients diagnosed with rheumatoid arthritis, and someone from the practice had to call each patient’s rheumatologist to obtain documentation confirming DMARD treatment. Creating a relationship that promotes the ongoing exchange of information can help practices meet this quality metric more easily, he says.

Chronic care management (CCM) programs can help open the lines of communication with rheumatologists to obtain this information, says Gianatasio. That’s because with CCM, practices have already created workflows that promote frequent communication with specialists who help co-manage chronic conditions, including arthritis. “We really encourage communications between our primary care physicians and specialists,” she says. “We still see a major gap between them. At least once a year, you really should be asking for charts from the specialist.” ■

## Rheumatoid arthritis documentation tips

**Rheumatoid arthritis is a hierarchical condition category (HCC), meaning it holds risk-adjustment value under the CMS-HCC payment model. As such, Colleen Gianatasio CPC, CRC, risk adjustment quality and education program manager at Capital District Physician’s Health Plan in Albany, N.Y., says physicians should document the following details to ensure accurate reimbursement:**

- With or without rheumatic factor.
- Affected joints (i.e., shoulder, elbow, wrist, hand, hip, knee, ankle, foot, vertebrae, or multiple sites).
- Laterality (i.e., left or right).
- Complications (i.e., splenomegaly, leukopenia, rheumatic lung disease, rheumatoid vasculitis, rheumatoid heart disease, rheumatoid myopathy, or rheumatoid polyneuropathy).
- With or without involvement of other organs and systems.

Medication prescribed to treat the rheumatoid arthritis. Linking the medication to the disease (e.g., “Patient has rheumatoid arthritis and is under reasonable control with Methotrexate”) gives physicians credit under risk-adjustment models and for HEDIS purposes, says Gianatasio. Physicians should document this every time they see the patient to refill his or her medication, she says. If the patient is seeing a rheumatologist, document “Patient with rheumatoid arthritis is stable and is being followed by Dr. X.” Without this documentation, it appears to payers as though there’s a gap in care.

### + MORE AHEAD

#### Clinical Economics

How to identify rheumatoid arthritis in primary care. The important role of primary care and tips on examinations, classification criteria, and laboratory testing. **SEE PAGE 35**



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# Navigating cost-of-care conversations with patients

Financial discussions with patients don't have to be uncomfortable for physicians

By **JORDAN ROSENFELD** *Contributing author*

### HIGHLIGHTS

▶ It is helpful for physicians who engage in a greater number of conversations about cost of care to remember that patients have more cost sensitivity than they used to.

▶ If cost-of-care conversations feel awkward, physicians should use scripts and encounter models until it becomes second nature.

**F**or physicians trained to address the ills of the body and mind first, discussing costs of care with patients may feel outside their typical role. Thus, physicians may put off these conversations because they are unsure how to handle them.

However, patients are increasingly interested in knowing what they will pay in advance. The price of health insurance premiums has increased by 55 percent in the past decade, according to a 2017 Kaiser Family Foundation report. As a result, patients are facing greater out-of-pocket expenses and more high-deductible health plans. This requires physicians to conduct more conversations about costs of care with patients.

Fortunately, several organizations have begun to develop scripts and approaches for physicians to tackle these conversations

with greater confidence. That is important, as not discussing costs of care can have a negative impact on patients' likelihood of getting necessary treatments or medications, according to a 2016 study published in *Health Affairs*.

"There's this ivory tower [notion] in medical school that money doesn't matter; just do what's right for the patient," explains Dustyn Williams, MD, a hospitalist and internal medicine clerkship director at Baton Rouge General in Baton Rouge, La. While he agrees that "doing what's right" for the patient's care is most physicians' goal, "the reality is that healthcare costs are really high. And physicians don't have that education until they get into practice."

Indeed, in a 2016 study by the Society for Medical Decision Making (SMDM), physicians only discussed medical costs with patients about 30 percent of the time;





**“The way I look at it, if a patient needs a test, they need a test. My medical advice is not going to change, but it’s not helpful to them if they can’t pay to get it.”**

— LINDA GIRGIS, MD, PRIMARY CARE PHYSICIAN, SOUTH RIVER, N.J.

and of those discussions, only about 40 percent included conversations in which physicians and patients sought alternatives that would save costs on medications or tests.

The study also found that 59 percent to 80 percent of patients want to discuss out-of-pocket costs during their visits with physicians, and 91 percent of physicians believe that managing patient costs is important.

Emmy Ganos, Ph.D., program officer at the Robert Wood Johnson Foundation (RWJF), says the foundation was inspired to take action after reviewing the SMDM study results. “Typically those conversations [about costs of care] were short, some as little as a minute, but when done well, they resulted in changes that were really important to care plans or advice for how to find a drug less expensively,” she says.

The study suggests four strategies physicians can bring up with patients to help lower costs without changing the care plan:

- **changing logistics of care, i.e. the timing, source, or location;**
- **facilitating co-pay assistance;**
- **providing free samples; and**
- **changing/adding insurance plans.**

In addition, the study recommends four strategies for reducing costs by changing the care plan:

- 1 switching to lower-cost alternative treatment or test;**
- 2 switching from brand name to generic medications;**
- 3 changing medication dosage/frequency; and**
- 4 stopping/withholding interventions for a time to allow a patient to save up.**

Ganos says that these strategies can provide physicians a roadmap to help patients reduce their costs.

The RWJF has partnered with Avalere Health, a Washington, D.C.-based healthcare consulting firm, on a research project called “Key Steps to Improve Patient-Clinician Cost-of-Care Conversations.” The foundation also funded eight research studies to help physicians and care teams improve these conversations and hopes to publish their results later this year or early in 2019, Ganos says.

“We feel it’s important to have these conversations while a patient is receiving care/making decisions about care,” Ganos says. This is because sometimes a cost conversation may involve switching a care approach or medication “and that should be made with providers.”

One reason physicians may avoid cost conversations is a lack of transparency about costs to patients from payers, according to Williams. This forces practices and patients to go through lengthy pre-approvals, he says.

There have been efforts to legislate greater transparency—and price transparency tools exist, such as apps and even programs that can be integrated into an EHR—but there’s a long way to go until full transparency has been achieved.

## STANDARDIZING THE CONVERSATION

To help doctors and patients, several health-care organizations, including the American College of Physicians (ACP), are working to standardize these cost-of-care conversations, even providing sample scripts to empower both physicians and patients.

Cynthia D. Smith, MD, vice president of clinical programs at the ACP, points out that providing a script also helps physicians avoid any implicit bias they may have about which patients are likely to need financial assistance.

“You have to be careful to not make assumptions about people,” Smith says. “You

## Patient assistance programs

Patient assistance programs, whether operated by pharmaceutical companies or nonprofit companies, can be helpful to patients who are unable to afford the medications they require. Below are some useful websites for finding more information about them.

Partnership for Prescription Assistance:  
[bit.ly/PPA-programs](http://bit.ly/PPA-programs)

Patient Advocate Foundation:  
[www.patientadvocate.org](http://www.patientadvocate.org)

National Council on Aging:  
[www.benefitscheckup.org](http://www.benefitscheckup.org)

In addition, the American Automobile Association (AAA) and AARP offer discounts on some prescription drug copays to their members. For information, go to:  
AAA: [bit.ly/AAA-Rx](http://bit.ly/AAA-Rx)  
AARP: [bit.ly/AARP-Rx](http://bit.ly/AARP-Rx)



**“What they’re really interested in is not what the charges for giving certain tests or treatments are, but what they’re going to have to pay out of pocket.”**

—WENDY K. NICKEL, MPH, DIRECTOR, CENTERS FOR QUALITY AND PATIENT PARTNERSHIP IN HEALTHCARE

can’t really assume that one patient might have a problem paying for care; you have to ask.”

The ACP has developed a “high value care initiative” that walks physicians through a patient encounter with specific guidelines that include addressing cost-of-care issues. One step is to screen for “logistical and financial barriers to care” with questions such as:

- Are you worried about how your care will be paid for?
- If so, how can we help you with these problems?
- Do you have difficulty getting to appointments or medical tests?

The last question is of great importance to Ganos and colleagues at the RWJF because they’ve found that social determinants of health also play a big role in patients getting treatment. Those kinds of costs are a big unmet need,” Ganos says.

In addition to guiding physicians on how to be sensitive to patients’ financial needs, Wendy K. Nickel, MPH, director of the Centers for Quality and Patient Partnership in Healthcare at the ACP, points out that standardizing the process leads to greater shared decision-making between physician and patient. A standardized script can enable physicians to become better educated on the costs of treatments, procedures and medications.

Ganos points out these conversations don’t always have to be solely up to the physician, but should happen within care teams.

She’s seen the importance of engaging other staff members, such as receptionists, who field a lot of cost-related questions, or nurse practitioners and medical assistants. Ganos encourages physicians to work with their staff to put together a list of answers to frequently asked questions in advance of patient visits.

It might also be helpful for physicians who are engaging in a greater number of conversations about cost of care to remember that patients have more cost sensitivity than they used to, says Nickel. “What they’re really interested in is not what the charges for giving certain tests or treatments are, but what they’re going to have to pay out of pocket.” That, she says, is “a very complicated answer to come up with.”

## More than just a message

In addition to having a script to discuss cost of care with patients, Wendy K. Nickel, MPH, director of the Centers for Quality and Patient Partnership in Healthcare at the American College of Physicians, recommends one more subtle way to improve these conversations. She says that body language is as important as the content of these conversations and suggests the following cues:

- Uncross legs and arms.
- Make direct eye contact (instead of looking at the patient chart).
- Nod to indicate the physician is listening.
- Face the patient (instead of multi-tasking by writing in charts or setting up equipment).
- Maintain appropriate distance (if a patient takes a step back, it can mean the patient feels the physician is too close. if a patient takes a step forward, it can mean they feel the physician is too far away).

## BECOME A PATIENT ADVOCATE

Linda Girgis, MD, a primary care physician in South River, N.J., makes a point of helping her patients find out the costs of tests and medications she prescribes to ensure that they follow through on their treatments.

“The way I look at it, if a patient needs a test, they need a test,” Girgis says. “My medical advice is not going to change, but it’s not helpful to them if they can’t pay to get it.”

She explains to them that they have the right to know price → 34



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**“There’s this ivory tower [notion] in medical school that money doesn’t matter; just do what’s right for the patient. ... The reality is that healthcare costs are really high. And physicians don’t have that education until they get into practice.”**

—DUSTYN WILLIAMS, MD, HOSPITALIST AND INTERNAL MEDICINE CLERKSHIP DIRECTOR, BATON ROUGE GENERAL, LA.

→ 32 information up front before they get a test or a treatment. “I tell them to shop around, to ask for prices and be sure they know their coverage.” She says her patients feel better knowing she is advocating for them.

Girgis recommends physicians take the time to find some key resources to help patients and have those accessible during visits. She suggests keeping phone numbers on hand, such as those for the local facilities that perform certain tests, as well as those of social workers who can help patients find financial assistance.

Williams sees more pressure on physicians to add more tests and treatments, refer out, and even get unnecessary testing. He hopes physicians can push back against this pressure particularly when a patient is concerned about being able to afford their treatments or medications.

He encourages physicians to prescribe generic medications whenever possible. Though, he acknowledges, this can be difficult for physicians who are getting pressure from pharmaceutical reps and even their own medical systems to prescribe brand-name drugs. He takes the approach that the patient and the physician are a team and physicians should try to be a patient’s advocate at all times.

If a patient is resisting a medication or treatment the physician has prescribed due to fear of its cost, he urges physicians to be sensitive to the patient’s financial status. “Having those conversations isn’t about questioning the physician’s decision, it’s about questioning this gargantuan broken system that both the physician and patient have to work within.” The goal is to get the patient the best treatment option they can afford.

If cost-of-care conversations feel awkward, Ganos hopes physicians will use scripts and encounter models such as those

created by the RWJF and the ACP until it becomes second nature.

## PATIENT RESOURCES

Equally important to ensuring open communication around costs of care is empowering patients to ask the right questions, says Ganos.

She directs patients to a document published by the non-profit Consumer Health Choices, on five questions patients should ask their doctor before a test, procedure, or treatment. The questions are:

- Do I really need this test or procedure?
- What are the risks?
- Are there simpler, safer options?
- What happens if I don’t do anything?
- How much does it cost?

Nickel urges physicians to remind their patients to familiarize themselves with the mechanisms of their health insurance plans. “If you have a high-deductible health plan, what are the implications if you paid off your deductible late in the calendar year and then require some sort of expensive treatment? Although it might be covered in December, if you wait until January of the next year, you will have to pay out of pocket. It’s important to know those kinds of things,” Nickel says.

Websites such as Healthcare Bluebook allow patients to plug in the cost of specific insurance premiums and compare them to other premiums online. Apps such as GoodRx and Amino offer some price comparisons for some treatments and procedures, but not all.

However, Ganos says that it’s a lot to ask of patients to use these tools on their own.

“Patients making decisions in the absence of a provider may prove to be less than helpful to their care,” she says. ■

SPECIAL REPORT

## Identifying rheumatoid arthritis in primary care

By **SARAH DILL, MD**, and **KEVIN D. DEANE, MD, PHD**

**R**heumatoid arthritis (RA) is a systemic inflammatory autoimmune disease primarily affecting the joints. It affects only ~1 percent of the population; however, due to the high morbidity and increased mortality associated with RA, as well as the high cost of therapy, it represents a significant burden on society.

A number of recent studies have demonstrated that one of the best ways to improve long-term outcome and quality of life in RA is to diagnosis the disease quickly, and institute disease modifying therapy, preferably within six months (or sooner) of the onset of symptoms of disease.

Negatively impacting this approach for the early diagnosis and treatment of RA is the growing shortfall of rheumatologists. A 2015 American College of Rheumatology workforce study predicted a nationwide shortage of providers by 2030, leaving patients who have rheumatologic conditions seriously underserved.

### A CRITICAL ROLE FOR PRIMARY CARE

Because of this need to identify RA early, and the shortfall of rheumatologists, identification and co-management of RA by primary care providers will become

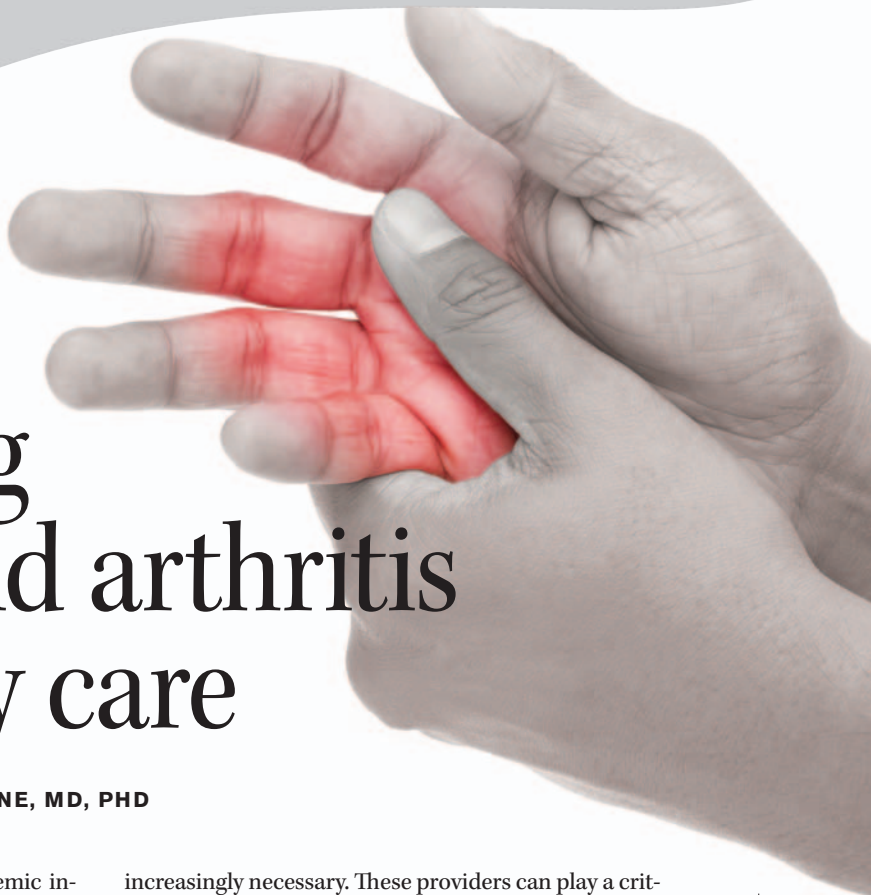
increasingly necessary. These providers can play a critical role in the early diagnosis and referral of patients with RA and work with rheumatologists in co-managing established disease.

In particular, primary care providers must contribute by recognizing the signs and symptoms of RA early so that appropriate referrals and treatment can be implemented in a timely fashion.

### DIAGNOSTIC HISTORY AND EXAMINATION FOR RA

The key aspects of the diagnostic history and examination for RA allow the physician to differentiate between inflammatory and non-inflammatory causes to determine the source of pain or other joint symptoms. Patients with RA typically report pain in and around their joints, often with associated stiffness and self-reported swelling.

Although RA can affect nearly any synovial joint or tendon, typically involved are the proximal interphalangeal (PIP) joints, metacarpophalangeal (MCP) joints, wrists, and metatarsophalangeal (MTP) joints. Of note, the distal interphalangeal (DIP) joints are associated with osteoarthritis or other forms of inflammatory arthritis (IA), such as psoriatic arthritis, rather



than RA. Joint involvement in RA most often is symmetrical, although in early RA the manifestations may be unilateral.

Combined with location, the timing of symptoms—onset as well as duration and variation throughout the day—can provide helpful clues in identifying RA. Patients often describe morning stiffness or increased stiffness after periods of inactivity (“gelling phenomenon”). Although morning stiffness is not included in the 2010 criteria, a duration of morning stiffness of more than 30 minutes to 60 minutes before maximal improvement can be a useful historical point to help identify IA. During the history, a clinician should engage the patient and get him or her to clarify specifically which joints are involved. Recording this information allows for a targeted physical exam and for tracking disease activity over time.

Of note, most of the historical evaluation for the presence of IA and in particular RA is focused on the patient’s current history. However, various epidemiologic, familial, and genetic factors can affect RA risk. In particular, RA is more likely to develop in women than in men, the risk in families is increased five-fold to seven-fold, and tobacco use increases risk, according to a 2016 study published in *Lancet*.

Assessing these factors may be useful, but their effect on the pretest probability for RA is largely unknown. As such, the diagnosis of RA relies on the joint symptom history and the physical examination, laboratory, and imaging findings. Other historical features (fatigue, general malaise) may be reported and should be assessed, but they are less specific for a diagnosis of RA.

### PHYSICAL EXAMINATION: THE “GOLD STANDARD”

Once a clinician’s suspicion for inflammatory arthritis is raised by the history, then the physical examination needs to be done to assess for signs of inflammatory arthritis which on examination is typically exhibited by joint tenderness, swelling and sometimes warmth and redness. Early inflammatory arthritis can be subtle, so it takes a careful examination, and even removal of clothing (e.g. pants to see the knees, socks to see the toes) so that the examination can be as detailed and accurate as possible.

Imaging with ultrasound or MRI is being used increasingly in managing many forms of IA, including RA, but the “gold standard” in clinic for identifying the synovitis of RA is currently the physical examination. Although identifying joint findings of synovitis can be difficult without extensive training, the examiner should evaluate joints carefully for the objective signs of warmth, swelling, and effusion that can represent underlying synovitis, as well as tenderness.

About 4 kg/cm<sup>2</sup> of pressure applied by the exam-

iner’s fingertips—typically the amount of pressure required to blanch the nailbed—is recommended, as detailed in a 2014 study published in *Rheumatic Disease Clinics of North America*. Swelling can range from as subtle as loss of feeling in a sharp joint line at the MCPs to an obviously spongy or boggy feeling.

For an examiner who is not highly trained to identify synovitis, perhaps the most important aspect of the examination is a thorough evaluation of not just symptomatic joints but also the joints typically involved in RA (PIPs, MCPs, wrists, and MTPs). Recording tenderness and swelling in these joints can help demonstrate to a rheumatologist that RA is suspected and can be useful in monitoring response to therapy and disease activity.

According to the 1987 ACR criteria, the presence of rheumatoid nodules also supports the diagnosis. Often found on extensor surfaces, nodules can vary in size and may feel, to the examiner, like a firm lump under the skin. Because nodules usually are later manifestations of RA, they typically are not useful in early diagnosis.

Of note, while the most important aspect of first identifying inflammatory arthritis is the history and physical, knowing the established RA classification criteria, and identifying several historical, examination, laboratory, and imaging features can help clinicians narrow the differential to inflammatory or autoimmune-based joint pain and, following that, a more specific diagnosis of RA. However, a caveat is that patients with early RA may not fulfill criteria, or have other forms of inflammatory arthritis (such as gout). As such, even if RA criteria are not fulfilled, if a patient has inflammatory arthritis, the clinician still should consider referral to a rheumatologist.

### CLASSIFICATION CRITERIA FOR RA

There are now two sets of established criteria: the 1987 American College of Rheumatology (ACR) criteria and the 2010 ACR/European League Against Rheumatism (EULAR) criteria. Each provides valuable understanding of RA and both are appropriate to use in diagnosis, but because the 2010 criteria can identify patients earlier than the 1987 criteria and incorporate newer autoantibody tests, they are becoming increasingly popular in clinical practice.

Of note, these criteria were developed primarily for research. Although they serve as good guides for clinical diagnosis, patients who do not meet the full criteria may still be diagnosed and treated for RA. In addition, patients may meet the criteria and be seronegative for rheumatoid factor (RF) and antibodies to citrullinated protein antigens (ACPA). Because these patients may have other forms of arthritis or autoimmune disease, they are best treated at the discretion of a rheumatologist.

*Clinical Economics continued on page 38*



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**Clinical Economics** continues from page 36

Following are the 1987 ACR classification criteria:

- Morning stiffness > 1 hour
- Arthritis of ≥ 3 joint areas
- Hand arthritis
- Symmetric arthritis
- Nodules
- Elevation of rheumatoid factor
- Radiographic changes

For these 1987 criteria, four or more criteria must be met for diagnosis and the first four findings must be present for six or more weeks. Arthritis must be observed by a physician. Patients with one or more swollen joints consistent with synovitis not better explained by another disease should be tested.

Following are the assessments for the 2010 ACR/EULAR RA Classification Criteria:

**Joint involvement:** 1 large joint, **0**; 2-10 large joints, **1**; 1-3 small joints, **2**; 4-10 small joints, **3**; > 10 joints (at least 1 small), **5**

**Serology** (at least 1 test needed): negative RF and ACPA, **0**; low positive RF or ACPA, **2**; high positive RF or ACPA, **3**

**Acute-phase reactants** (at least 1 test needed): normal C-reactive protein (CRP) level and erythrocyte sedimentation rate (ESR), **0**; abnormal CRP level or ESR, **1**

**Duration of symptoms:** < 6 weeks, **0**; ≥ 6 weeks, **1**

A patient who meets these criteria with a score of **6/10** or higher can be classified as having “definite RA.”

## LABORATORY TESTING IN THE INITIAL EVALUATION

Extensive testing may be needed in the initial evaluation of IA, but here we focus on tests useful in RA. RF and ACPA are the autoantibody tests in the 2010 criteria. In most U.S. clinical settings, ACPA is assessed by the commercial assay anti-cyclic citrullinated peptide (anti-CCP) antibody.

Both RF and CCP are about 80 percent sensitive for RA, although specificity of RF is 80 percent for RA and more than 95 percent for anti-CCP. Several healthy patients have positive RF, and RF can be elevated in diseases like hepatitis C, Sjögren syndrome, and systemic lupus erythematosus. ACPAs as a class have had a large impact on the diagnosis of RA because of their high specificity for RA. Although there is an argument that anti-CCP testing should replace RF testing in RA, at this time testing for both RF and anti-CCP offers increased sensitivity for RA and maintains high specificity.

Other lab tests in RA include inflammation tests,

such as the CRP level and the ESR. These should be assessed if RA is suspected because, according to the 2010 criteria, they can assist in diagnosis. However, it must be noted that if inflammatory arthritis is present, the patient needs further evaluation, even if CRP and ESR are negative. In fact, up to 30 percent of patients with early RA may have normal CRPs and ESRs. Importantly, the CRP and ESR also provide some prognostic information because higher levels portend worse outcomes. Periodic assessment is appropriate to gauge response to therapy.

At the time of diagnostic evaluation, routine testing for a complete blood cell count, liver injury, and renal function is important to understand a patient's general health and to help guide initial therapy (e.g., methotrexate or MTX may be contraindicated in renal failure). Identifying other comorbidities that could affect therapy—such as infection with hepatitis B and C, HIV, and tuberculosis—at baseline is also important.

In symmetric arthritis, joint aspiration typically is not needed to make a diagnosis. However, it can be a critical diagnostic procedure in cases where only a single joint is inflamed, crystalline disease is suspected, there are additional symptoms (e.g., rapid onset of arthritis or fever suggesting infection), or there is other diagnostic uncertainty. If joint fluid is obtained, assessment of total white blood cell count and differential, crystals, and a gram stain or culture should be sufficient to make most diagnoses.

## IMAGING TECHNIQUES FOR IDENTIFYING SYNOVITIS

Synovitis or joint damage characteristic of RA may be identified with a variety of imaging techniques, including plain radiography, ultrasound, and MRI. For a primary care physician, plain radiography of symptomatic joints is an acceptable starting point in the initial diagnostic workup.

When a patient is suspected of having RA, plain radiography (including two views of the hands, wrists, and feet) can help identify the bone damage and erosions that are typical for RA and that, if present, indicate more severe disease—further emphasizing the need for timely initiation of appropriate therapy.

Having a patient who is referred to rheumatology bring the actual images to the consultation allows the rheumatologist to review them personally. ■

**Kevin D Deane, MD, PhD**, is associate professor of medicine in the division of rheumatology at University of Colorado.



**Sarah Dill, MD**, is a clinical and research fellow in the division of rheumatology at University of Colorado.

# Financial Strategies

## Understand, prepare for 2018 tax changes

### Marginal tax rates

Marginal tax rates determine how much you will pay in taxes according to your taxable income. Your taxable income determines your tax bracket, which is based on the highest tax paid, which is your marginal tax rate, or the rate that one pays on the next dollar of income. Keep in mind not all income is paid at the highest rate.

The tax rates for 2018 have changed, slightly leaning on a 3 percent reduction overall compared to 2017 for all brackets.

What you will need to consider during 2018 is if and how to move your taxable income into a lower bracket to save on taxes. Guidelines have changed if you are a physician employed by a hospital or own your practice. Each entity has its own rules on what itemized deductions can be taken off its taxes. The standard deductions have doubled for everyone, but might not make up for limitations on itemized deductions.

If you think you might be able to deduct yourself into a lower tax bracket, work with an accountant and your business manager to anticipate any adjustments you can make to lessen your 2018 tax burden.

### Pass-through entities

A Limited Liability Company (LLC), Personal Service Corporations, other partnership, or S corporation may choose to be taxed as a "pass-through business." It becomes a pass-through because it doesn't pay taxes itself as a corporation, but instead passes profits on to the owner, who pays taxes based on his or her own individual rate. Many physicians have pass-through businesses. Most small businesses organize as a pass-through entity or as a business owner who files a Schedule C.

Pass-through businesses have new rates with the 2018 Tax Code. For C corporations, there is a flat tax of 21 percent, whereas in the past the tax was a progressive 15 percent to 39 percent. For those with personal service corporations, the new rate is a flat 25 percent. Pass-through entities have ordinarily been taxed at the individual level after separately stated items are "passed through" via form K-1.

The pass-through income deduction is 20 percent of your share of W-2 wages that the business pays you up to \$157,000 for single filers (who are single, married filing separately, head of

### 2018 individual income tax rates

If taxable income is:	The tax due is:
\$0 – \$9,525	10% of taxable income
\$9,526 – \$38,700	\$952.50 plus 12% of amount over \$9,525
\$38,701 – \$82,500	\$4,453.50 plus 22% of amount over \$38,700
\$82,501 – \$157,500	\$14,089.50 plus 24% of amount over \$82,500
\$157,501 – \$200,000	\$32,089.50 plus 32% of amount over \$157,500
\$200,001 – \$500,000	\$45,689.50 plus 35% of amount over \$200,000
\$500,000 & up	\$150,689.50 plus 37% of amount of \$500,000

Source: IRS

household, or qualifying widow(er) with dependent child) and \$315,000 for joint filers (married filing jointly). Above these thresholds and up to \$415,000, the deduction is the greater of 50 percent of W-2 income or 25 percent of W-2 income plus 2.5 percent of the cost of tangible depreciable property.

Specified service corporations have a phase-out for higher income earners. In 2018, the phase out of the 20 percent deduction begins at \$157,000 for single filers off their allocable share of business income.

### Conclusion

The 2018 tax plan has many changes that can affect you and should be examined with the advice of a licensed tax professional.

There are many options and potential pitfalls that can happen in adjusting your income to qualify for a lower tax bracket. ■



**Seth Swenson, MBA**, is president of Orchid Wealth Management. Send your financial questions to [medec@ubm.com](mailto:medec@ubm.com).

*Disclaimer: The author of this article is a Registered Investment Advisor and not a Licensed Tax Professional. The information in this article should not be considered tax advice and is meant to highlight some of the changes that physicians should be aware of and research further.*

Continued from page 16

# Tomorrow's patients want a say in their healthcare

and that her online and survey reviews have improved. "I am convinced my model is the model for the future," she says. "It is consistently working in regards to patient and

physician satisfaction, sustainability, and efficiency."

In addition to patient reviews and ratings, Gen Z will have greater access to outcomes and Medicare data on individual doctors, Nash says. Gen Z will not hesitate to switch doctors if they're unhappy or inconvenienced, she adds, a move which will be easier when EHRs become truly interoperable.

"Customer satisfaction is as important as clinical outcomes," she says, adding that smart practices will heed patient suggestions and criticisms and adjust their operations accordingly.

That will require doctors to be more solicitous of, and responsive to, patient complaints, says Schneider, who predicts practices will use more surveys and other means to gauge patient satisfaction. "It's really putting pressure on the physicians to improve their game," he says.

## MENTAL HEALTH AND WELLNESS

For a number of reasons ranging from growing up around world events like 9/11 to peer issues, Gen Z is stressed. Members report a lot of problems with stress, depression, and other mental health issues.

A 2015 survey by the Hartman Group, a marketing research firm, found that 46 percent of teens are actively treating or preventing anxiety or stress and 30 percent are actively treating or preventing depression.

Jean Twenge, Ph.D., a professor of psychology at San Diego State University, in 2015 examined four surveys of younger Americans and found that high school students in the 2010s reported more somatic symptoms (e.g. trouble sleeping, thinking and remembering, shortness of breath) and were twice as likely to have seen a professional for mental issues compared with students in the 1980s. College student health centers also report an increase in demand for mental health services.

What does that mean for pri- ➔ 42

**"If you are a medical practice, you should be looking to design your practice more for Gen Z and millennials ... . As they come into mainstream healthcare, wise organizations will learn to accommodate their different personality."**



— DAVID GANS, MSHA, FACMPE, SENIOR FELLOW FOR INDUSTRY AFFAIRS, MGMA

## Talking About Your Generation

While there is no universal definition, here are the generally accepted dates for the generations:

Generation	Years of Birth
Post-War Cohort	1928-1945
Baby Boomers I	1946-1954
Baby Boomers II	1955-1965
Generation X	1966-1976
Millennials	1977-1994
Generation Z	1995-2012



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→ **40** primary care providers beginning to see Gen Z patients? They should be aware that their young patients could already be under the care of a mental health professional, and know how mental illness can cause or exacerbate physical conditions.

Gen Z has grown up in a culture of wellness and realizes the importance of integrating physical, mental, and emotional health, according to the Hartman Group report, which also found them more aware of the importance of nutrition. Stillman predicts Gen Z patients will prefer doctors who incorporate, or at least respect, alternative

and Eastern medicine.

**CUSTOMIZED MEDICINE**

Over the past 10 years, doctors, sometimes grudgingly, have learned to deal with patients doing their own research through websites such as Google or WebMD; Gen Z will not only have its own research, but its own data.

Affordable genomic testing, wearable monitors, fitness trackers, and other devices are more likely to be adopted by younger patients and will provide users more raw information about their health. That will require physicians to incorporate patient-generated

**THE IMPORTANCE OF CONTINUITY OF CARE**

Get younger patients to take a long-term view of health

By Keith Loria

M

illennials are more likely to book a one-time appointment rather than build a relationship with their own doctor, according to a majority of U.S. physicians surveyed by SERMO, a social network for doctors.

The reasons 57 percent of physicians cited this trend included millennials challenging doctor recommendations, self-diagnosing, and bargaining for cheaper medical care.

Susan L. Besser, MD, a primary care physician at Mercy Personal Physicians at Overlea in Nottingham, Md., says the challenge is also partly due to lifestyle and the availability of instant care.

"It's a more mobile society and people don't continue a relationship with the family doctor like they used to, especially millennials," she says. "The younger generation doesn't want to interrupt a busy schedule to establish [a relationship] with a

primary care physician when it's so easy to pop into an urgent care and get seen for the immediate issue."

Primary care doctors serve as the custodians for the patient's comprehensive health record, and most doctors agree that it's important for younger patients to know that a primary care provider can make a significant difference in their long-term health.

"Having a personal relationship with a doctor is important in several ways, especially when it comes to primary care," says Brent Boyett, DO, a primary care physician in Hamilton, Ala. "From childhood vaccines to screening colonoscopies, there is no substitute for the advice of a physician who knows the patient."

Laura Norman, DO, a primary care physician for the AMITA Health Medical Group in Downers Grove, Ill., says that establishing care with a physician at a young age is extremely important as this patient population is often

at their prime health and may not fully grasp how the choices they make now can affect their longevity and quality of life later.

"Physicians should try and educate their patients on the importance of being proactive rather than reactive when it comes to their health," she says. "This is the time to focus on preventative medicine, vaccinations, and annual physicals, all of which will ultimately enable them to enjoy full function as long as possible."

**Engaging Patients**

Building rapport is essential for every patient population; however, it can help foster long-term relationships when dealing with younger individuals.

That's why before Norman begins an encounter with a patient, she engages them in conversation before directly dealing with their chief complaint.

"I personally try and take the social history the first time I meet a patient, because it allows

data into their own findings, says Bertalan Mesko, MD, Ph.D., director of the Medical Futurist Institute, which studies trends in medicine. Doctors will be responsible for helping patients understand and act upon their data, he says.

"So, the [physician] will rather act as a health coach in the future," he says. "The doctor will interpret health data if something is not clear, give advice when results are not optimal while spotting and checking irregularities based on data as soon as possible."

Gans predicts physicians will share tools and information more with Gen Z than pre-

vious generations, partly because the patients will demand it.

Rather than rolling their eyes, doctors should welcome Gen Z patients engaged enough to do their own research, Stillman says. Though he concedes that physicians will be more knowledgeable than patients, he adds, "We live in a time when anyone can become expert through [online] research."

### PATIENT POWER

The balance of power in the patient-physician relationship, already tilting toward the patient, will shift even more with Gen Z, says Gans, adding that patients will expect phy-

me to ask follow-up questions and learn about their interests," she says. "I also close every visit with a plan for potential follow-up or a reminder of when they are due for their next preventive examination. I also inquire about barriers to the treatment regimen and address any questions or concerns."

Norman believes all physicians should optimize their use of the EHR and online patient portal, as millennials appreciate the convenience of email and it helps establish loyalty to their physician.

Kevin Gebke, MD, a primary care physician at Indiana University Health in Indianapolis, says talking about the positive effects of lifestyle modification helps all patients understand the non-pharmacological aspects of medicine and can help a physician keep a patient coming back.

"Many times, it encourages them to contact me or my team for advice and information," he says.

Boyett says patients often move from one clinician to

another for convenience, which is why keeping the patient engaged and coming back can be a challenge. A way to help is for physicians to offer appointment times during standard lunch hours, evening hours, or an early morning start.

He, like most physicians today, also believes that making the patient a partner in their own care agreeing on goals and then motivating that patient to

achieve those goals can be very helpful in the process of patient engagement.

"We always look for the opportunity to celebrate even the smallest of victories with the patient in the process of achieving the goals of care," Boyett says.

At the end of each appointment, he explains the reason for the next visit and what he plans to do, and all patients leave with a follow-up appointment and an appointment card with the time and date for the appointment with electronic appointment reminders sent by robocall or automated text message.

Besser says doctors should get out more in the public's eye by volunteering at functions as well, posting on social media, and offering free "meet and greets" with the community.

"It never hurts to be aware of non-medical things you can discuss with people—movies, music, whatever—to build a relationship," she says. "Don't just be a doctor, try to be a friend, too." □

**"The younger generation doesn't want to interrupt a busy schedule to establish [a relationship] with a primary care physician when it's so easy to pop into an urgent care and get seen for the immediate issue."**

—SUSAN L. BESSER, MD,  
PRIMARY CARE PHYSICIAN

sicians to deliver care the way they want or they will go elsewhere. "I think the doctors are going to have to learn to work extra hard to maintain the relationship with a patient," Schneider says.

Students at Missouri State University don't have the provider choices they will later in life, but the school still caters to their digital preferences, says Frederick Muegge, MD, an internist and university director of health and wellness services. The university's new health center offers online appointments and prescription refills, counseling, a portal for sharing lab results and text alerts for pharmacy pick-ups.

Muegge describes his young patients as curious and collaborative: "They are often engaged with their medical care and interested in understanding the pathophysiology of the illness. Often, many have done primary internet research," he says.

Bhandari says doctors should regard Gen Z's challenges, not as a threat, but as a way to improve. "We've built practices for the physician experience, but we're turning that upside down and asking if that's good for patient services," she says. "It always seems like medicine is 10 to 20 years behind. It has to catch up or we're not going to provide these patients the services they want." ■

## The Future of the Office Visit is Here

By Robert Greenspan

**T**ry to imagine how the practice of medicine will change in the next 10 to 20 years—not an easy job considering recent healthcare reform efforts, new scientific discoveries, and wearable technology. But that is what the Health Benefits Fund staff in New York attempted to do with the construction of its new Brooklyn Health Center which opened in 2017.

With almost 1,000 employees, the Health Benefit Fund provides more than 700,000 medical encounters annually at five health centers for members of the New York Hotel Trades Council and Hotel Association of New York City.

We had two major goals for this building. First, we wanted to create a strong image of our health center that supported our brand and welcomes our members. Second, we insisted on a vigorously patient-centered environment with top-of-the-line care that exceeds the efficiency, comfort, and quality of typical commercial healthcare institutions. We wanted our members

to enjoy an unmatched healthcare experience.

Are there high-tech full body scans as portrayed in Star Trek, an iPad in the hands of every healthcare provider, and a hologram of their doctor beamed into their home for a virtual visit? Not yet, but rising costs and increased demands on our healthcare system certainly forces a transformation in the role of today's healthcare providers.

Healthcare in the center is patient-centered and takes full advantage of a collaborative team approach and real time locating services (RTLS).

The Brooklyn Health Center currently treats about 800 patients a day and will complete approximately 200,000 visits this year. Utilizing RTLS technology, 85 percent of our health center patients have their medical visit, blood drawn, make follow-up appointments, pick up their medications and leave our building in within one hour. Physician productivity has increased by more than 30 percent, while physician percep-

tion is that they are not working as hard.

How do we do it? The technology touches many facets of the patient visit. First, gone are traditional waiting rooms. In the new health center, patients are welcomed in the lobby, assigned a treatment room, and are given a "Patient Care Connector," an RTLS badge that communicates the patient's location in the building. Thanks to an integration with RTLS, when the patient arrives in their treatment room, the patient engagement system greets them by name on the monitor and advises them that their care team is on the way.

Patients no longer move throughout the building accessing the various services they need. Rather, those services are co-located within pods of 10 treatment rooms. Consider a patient with diabetes. The patient arrives in the treatment room, a medical assistant or nurse is immediately alerted to their presence, greets them and takes their vital signs. Those critical measures of health

**“[Younger patients] are often engaged with their medical care and interested in understanding the pathophysiology of the illness. Often, many have done primary internet research.”**



—FREDERICK MUEGGE, MD, INTERNIST, DIRECTOR OF HEALTH AND WELLNESS SERVICES, MISSOURI STATE UNIVERSITY



The Brooklyn Health Center is embracing technology, from spacious waiting areas providing privacy for phone calls and views of the neighborhood (left) to state-of-the-art exam rooms (top) offering privacy and a view of patient records for both physician and visitor to view together. (Photos courtesy: Health Benefits Fund)

no longer have to be written down and typed into the EHR; they are transmitted electronically directly from the vitals bar into the record.

While this is the start of the visit for the patient, the visit for the staff began much earlier with a team huddle in the morning where it was noticed that the patient needed a diabetic foot exam and a new blood test. Those orders were placed into the EHR before the patient arrived. The lab tech who will draw the specimen and the podiatrist who will perform the foot exam know

exactly where to meet their patient because of the RTLS.

The primary care physician, the nurse, the lab tech, the podiatrist all see the patient in the same room during the same visit. They communicate with each other via Care Team Communicators, devices that resemble cell phones but allow secure encrypted messaging between team members. When the patient's visit ends, a staff member enters the room to answer questions and make any necessary follow-up appointments.

If the patient has a medication ordered, they can stop off at the health center's pharmacy to pick it up. The prescription was transmitted electronically during the visit and filled it before the patient arrived.

The "Patient Care Connector" badge uses RTLS to connect patients to, staff, rooms and equipment. With this technology, we no longer need to tie a specific room to one provider, which increases room and provider utilization.

RTLS technology is used by many innovative health centers to help create a collaborative, efficient patient-centered care environment. Now that we're one of them, we're looking ahead to the next disruptive technology. We know it is just around the corner, we just don't know what it is. The technology to reach patients virtually and manage their health remotely is not here yet, but it is coming and health care needs to be ready. ■

**Robert Greenspan** the chief executive officer of the New York Hotel Trades Council & Hotel Association of New York City, Inc. Employee Benefit Funds.

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“Treat your life as a business (Me, Inc.) and you are the CEO.”



**George G. Ellis, Jr., MD**  
Internal Medicine  
Boardman, Ohio

“One of my professors once told me the day you stop learning is the day you hang up your stethoscope.”



**Antonio Gamboa, MD, MBA**  
Internal Medicine / Hospice  
and Palliative Care  
Austin, Texas

“Focus on your family, and don’t let your wife and kids ever feel like they don’t know you anymore.”



**Jeffrey M. Kagan, MD**  
Internal Medicine / Hospice  
Newington, Conn.

“The hospital is not your friend.”



**Melissa E. Lucarelli MD, FAAFP**  
Family Medicine  
Randolph, Wis.

“Always thank a patient for asking about your family or about your health, and always send a sympathy card when your patient dies.”



**Joseph E. Scherger, MD**  
Family Medicine  
La Quinta, Calif.

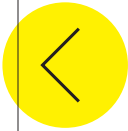
“Spoken words evaporate. Written words are eternal.”



**Salvatore Volpe, MD**  
Pediatrics/Internal Medicine /  
Pediatrics  
Staten Island, N.Y.

“Slow down.”

The board members that contribute expertise and analysis to help shape content of *Medical Economics*.



# IN CASE YOU MISSED IT

“It always seems like medicine is 10 to 20 years behind. It has to catch up or we’re not going to provide these patients the services they want.”



PAYAL BHANDARI, MD,  
PRIMARY CARE PHYSICIAN,  
SAN FRANCISCO

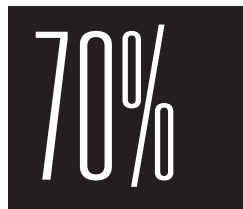
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“If a patient needs a test, they need a test. My medical advice is not going to change, but it’s not helpful to them if they can’t pay to get it.”

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LINDA GIRGIS, MD, PRIMARY CARE PHYSICIAN, SOUTH RIVER, N.J.



of consumers focus on healthcare once they feel financially stable

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SMARTER BUSINESS. BETTER PATIENT CARE.

### CONTENT

SARA MICHAEL  
VP, Content & Strategy  
GEORGE G. ELLIS JR., MD, FACP  
Chief Medical Adviser

KEITH L. MARTIN  
Content Channel Director  
203-523-7112 / keith.martin@ubm.com

JEFFREY BENDIX, MA  
Senior Editor  
440-891-2684 / jeff.bendix@ubm.com

CHRIS MAZZOLINI, MS  
Senior Content Manager  
440-891-2797 / chris.mazzolini@ubm.com

ROSE SCHNEIDER KRIVICH  
Content Specialist  
440-891-2627 / rose.schneider@ubm.com

TODD SHRYOCK  
Editor  
440-891-2634 / todd.shryock@ubm.com

### DESIGN

ROBERT MCGARR  
Art Director

### PRODUCTION

KAREN LENZEN  
Production Director

### AUDIENCE DEVELOPMENT

JOY PUZZO  
VP, Marketing & Audience Development

CHRISTINE SHAPPELL  
Director, Audience Development

WENDY BONG  
Audience Development Manager  
218-740-7244 / wendy.bong@ubm.com

### PUBLISHING & SALES

THOMAS W EHARDT  
Executive Vice-President, Senior Managing  
Director, UBM Life Sciences Group

GEORGIANN DeCENZO  
Executive VP, Managing Director

ERIC TEMPLE-MORRIS  
VP, Business Solutions Sales  
503-203-1060 / eric.temple-morris@ubm.com

ANA SANTISO  
Associate Publisher  
732-346-3032 / ana.santiso@ubm.com

HEATHER SHANKMAN  
National Account Manager  
732-346-3054 / heather.shankman@ubm.com

JOHN CURRID  
Director of Sales, Business Solutions  
212-600-3134 / john.currid@ubm.com

TOD McCLOSKEY  
Account Manager, Business Solutions  
440-891-2739 / tod.mccloskey@ubm.com

JOANNA SHIPPOLI  
Account Manager, Recruitment Advertising  
440-891-2615 / joanna.shippoli@ubm.com

JILLYN FROMMER  
Permissions and International License  
(732) 346-3007 / jillyn.frommer@ubm.com

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KARA BAEKEY  
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### REPRINTS

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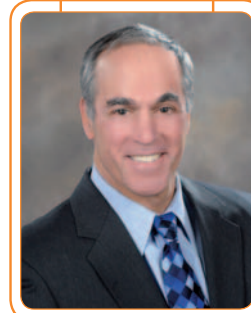
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