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VOL. 101 NO. 1 JANUARY 2024

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How to manage higher costs, declining reimbursement in 2024

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IF YOU COULD PREVENT SHINGLES, WHY WOULDN'T YOU?

Shingles: know the facts

Shingles is a painful rash that can have serious and long-lasting complications.[1,*]

The risk sharply increases in patients ≥50 years of age[1,2]

Age-related decline in immunity is a dominant driver of shingles, no matter how healthy your patients feel.

SHINGRIX is made for shingles protection[3]

SHINGRIX delivered >90% efficacy against shingles regardless of age in those ≥50 years old.[3,†]

Your recommendation matters.
Make shingles vaccination a priority year-round for your patients 50 years and older.

Patient portrayal.

*SHINGRIX is not indicated for the prevention of herpes zoster–related complications.[3]
†Data from the phase 3 ZOE-50 (≥50 years of age) trial (median follow-up period 3.1 years) and pooled data in individuals ≥70 years of age from the phase 3 ZOE-50 and ZOE-70 trials (median follow-up period 4 years) in subjects who received 2 doses of SHINGRIX (n=7344 and 8250, respectively) or placebo (n=7415 and 8346, respectively). These populations represented the modified Total Vaccinated Cohort, defined as patients who received 2 doses (0 and 2 months) of either SHINGRIX or placebo and did not develop a confirmed case of herpes zoster within 1 month after the second dose.[3,4]

Indication

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

SHINGRIX is not indicated for prevention of primary varicella infection (chickenpox).

Important Safety Information

- SHINGRIX is contraindicated in anyone with a history of a severe allergic reaction (eg, anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX
- Review immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX
- In a postmarketing observational study, an increased risk of Guillain-Barré syndrome was observed during the 42 days following vaccination with SHINGRIX
- Syncope (fainting) can be associated with the administration of injectable vaccines, including SHINGRIX. Procedures should be in place to avoid falling injury and to restore cerebral perfusion following syncope
- Solicited local adverse reactions reported in individuals aged 50 years and older were pain (78%), redness (38%), and swelling (26%)
- Solicited general adverse reactions reported in individuals aged 50 years and older were myalgia (45%), fatigue (45%), headache (38%), shivering (27%), fever (21%), and gastrointestinal symptoms (17%)
- The data are insufficient to establish if there is vaccine-associated risk with SHINGRIX in pregnant women
- It is not known whether SHINGRIX is excreted in human milk. Data are not available to assess the effects of SHINGRIX on the breastfed infant or on milk production/excretion
- Vaccination with SHINGRIX may not result in protection of all vaccine recipients

Please see accompanying Brief Summary of Prescribing Information on the following pages or visit SHINGRIXHCP.com.

SHINGRIX
(ZOSTER VACCINE RECOMBINANT, ADJUVANTED)

References: 1. Harpaz R, Ortega-Sanchez IR, Seward JF; Advisory Committee on Immunization Practices (ACIP) Centers for Disease Control and Prevention (CDC). Prevention of herpes zoster: recommendations of the Advisory Committee on Immunization Practics (ACIP). *MMWR Recomm Rep*. 2008;57(RR-5):1-30. **2.** Kilgore PE, Kruszon-Moran D, Seward JF, et al. Varicella in Americans from NHANES III: implications for control through routine immunization. *J Med Virol*. 2003;70(suppl 1):S111-S118. **3.** Prescribing Information for SHINGRIX. **4.** Data on file, Study 113077 (NCT01165229). GSK Study Register. Study entry at: https://www.gsk-studyregister.com/en/trial-details/?id=113077

SHINGRIX (Zoster Vaccine Recombinant, Adjuvanted) **BRIEF SUMMARY**

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

1 INDICATIONS AND USAGE

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

Limitations of Use:

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

4 CONTRAINDICATIONS

Do not administer SHINGRIX to anyone with a history of a severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine or after a previous dose of SHINGRIX [*see Description (11) of full prescribing information*].

5 WARNINGS AND PRECAUTIONS

5.1 Preventing and Managing Allergic Vaccine Reactions

Prior to administration, the healthcare provider should review the immunization history for possible vaccine sensitivity and previous vaccination-related adverse reactions. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of SHINGRIX.

5.2 Guillain-Barré Syndrome (GBS)

In a postmarketing observational study, an increased risk of GBS was observed during the 42 days following vaccination with SHINGRIX [*see Adverse Reactions (6.2)*].

5.3 Syncope

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

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared with rates in the clinical trials of another vaccine and may not reflect the rates observed in practice. There is the possibility that broad use of SHINGRIX could reveal adverse reactions not observed in clinical trials.

Adults Aged 50 Years and Older

Overall, 17,041 adults aged 50 years and older received at least 1 dose of SHINGRIX in 17 clinical studies.

The safety of SHINGRIX was evaluated by pooling data from 2 placebo-controlled clinical studies (Studies 1 and 2) involving 29,305 subjects aged 50 years and older who received at least 1 dose of SHINGRIX (n = 14,645) or saline placebo (n = 14,660) administered according to a 0- and 2-month schedule. At the time of vaccination, the mean age of the population was 69 years; 7,286 (25%) subjects were aged 50 to 59 years, 4,488 (15%) subjects were aged 60 to 69 years, and 17,531 (60%) subjects were aged 70 years and older. Both studies were conducted in North America, Latin America, Europe, Asia, and Australia. In the overall population, the majority of subjects were White (74%), followed by Asian (18%), Black (1.4%), and other racial/ethnic groups (6%); 58% were female.

Solicited Adverse Reactions: In Studies 1 and 2, data on solicited local and general adverse reactions were collected using standardized diary cards for 7 days following each vaccine dose or placebo (i.e., day of vaccination and the next 6 days) in a subset of subjects (n = 4,886 receiving SHINGRIX, n = 4,881 receiving placebo with at least 1 documented dose). Across both studies, the percentages of subjects aged 50 years and older reporting each solicited local and general adverse reaction following administration of SHINGRIX (both doses combined) were pain (78%), redness (38%), and swelling (26%); and myalgia (45%), fatigue (45%), headache (38%), shivering (27%), fever (21%), and gastrointestinal symptoms (17%).

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

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

Adverse Reactions	Aged 50-59 Years		Aged 60-69 Years		Aged ≥70 Years	
	SHINGRIX	Placebo[c]	SHINGRIX	Placebo[c]	SHINGRIX	Placebo[c]
Local Adverse Reactions	**n = 1,315 %**	**n = 1,312 %**	**n = 1,311 %**	**n = 1,305 %**	**n = 2,258 %**	**n = 2,263 %**
Pain	88	14	83	11	69	9
Pain, Grade 3[d]	10	1	7	1	4	0.2
Redness	39	1	38	2	38	1
Redness, >100 mm	3	0	3	0	3	0
Swelling	31	1	27	1	23	1
Swelling, >100 mm	1	0	1	0	1	0
General Adverse Reactions	**n = 1,315 %**	**n = 1,312 %**	**n = 1,309 %**	**n = 1,305 %**	**n =2,252 %**	**n = 2,264 %**
Myalgia	57	15	49	11	35	10
Myalgia, Grade 3[e]	9	1	5	1	3	0.4
Fatigue	57	20	46	17	37	14
Fatigue, Grade 3[e]	9	2	5	1	4	1
Headache	51	22	40	16	29	12
Headache, Grade 3[e]	6	2	4	0.2	2	0.4
Shivering	36	7	30	6	20	5
Shivering, Grade 3[e]	7	0.2	5	0.3	2	0.3
Fever	28	3	24	3	14	3
Fever, Grade 3[f]	0.4	0.2	1	0.2	0.1	0.1
GI[g]	24	11	17	9	14	8
GI, Grade 3[e]	2	1	1	1	1	0.4

Total vaccinated cohort for safety included all subjects with at least 1 documented dose (n).

[a] 7 days included day of vaccination and the subsequent 6 days.

[b] Data for subjects aged 50 to 59 years and 60 to 69 years are based on Study 1. Data for subjects aged 70 years and older are based on pooled data from Study 1: NCT01165177 and Study 2: NCT01165229.

[c] Placebo was a saline solution.

[d] Grade 3 pain: Defined as significant pain at rest; prevents normal everyday activities.

[e] Grade 3 myalgia, fatigue, headache, shivering, and GI: Defined as preventing normal activity.

[f] Fever defined as ≥37.5°C/99.5°F for oral, axillary, or tympanic route, or ≥38°C/100.4°F for rectal route; Grade 3 fever defined as >39.0°C/102.2°F.

[g] GI = Gastrointestinal symptoms including nausea, vomiting, diarrhea, and/or abdominal pain.

(continued on next page)

The incidence of solicited local and general reactions was lower in subjects aged 70 years and older compared with those aged 50 to 69 years.

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

There were no differences in the proportions of subjects reporting any or Grade 3 solicited local reactions between Dose 1 and Dose 2. Headache and shivering were reported more frequently by subjects after Dose 2 (28% and 21%, respectively) compared with Dose 1 (24% and 14%, respectively). Grade 3 solicited general adverse reactions (headache, shivering, myalgia, and fatigue) were reported more frequently by subjects after Dose 2 (2.3%, 3%, 4%, and 4%, respectively) compared with Dose 1 (1.4%, 1.4%, 2.3%, and 2.4%, respectively).

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

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

Serious Adverse Events (SAEs): In the 2 studies, SAEs were reported at similar rates in subjects who received SHINGRIX (2.3%) or placebo (2.2%) from the first administered dose up to 30 days post-last vaccination. SAEs were reported for 10.1% of subjects who received SHINGRIX and for 10.4% of subjects who received placebo from the first administered dose up to 1 year post-last vaccination. One subject (<0.01%) reported lymphadenitis and 1 subject (<0.01%) reported fever greater than 39°C; there was a basis for a causal relationship with SHINGRIX.

Optic ischemic neuropathy was reported in 3 subjects (0.02%) who received SHINGRIX (all within 50 days after vaccination) and 0 subjects who received placebo; available information is insufficient to determine a causal relationship with SHINGRIX.

Deaths: From the first administered dose up to 30 days post-last vaccination, deaths were reported for 0.04% of subjects who received SHINGRIX and 0.05% of subjects who received placebo in the 2 studies. From the first administered dose up to 1 year post-last vaccination, deaths were reported for 0.8% of subjects who received SHINGRIX and for 0.9% of subjects who received placebo. Causes of death among subjects were consistent with those generally reported in adult and elderly populations.

Potential Immune-Mediated Diseases: In the 2 studies, new onset potential immune-mediated diseases (pIMDs) or exacerbation of existing pIMDs were reported for 0.6% of subjects who received SHINGRIX and 0.7% of subjects who received placebo from the first administered dose up to 1 year post-last vaccination. The most frequently reported pIMDs occurred with comparable frequencies in the group receiving SHINGRIX and the placebo group.

Dosing Schedule: In an open-label clinical study, 238 subjects aged 50 years and older received SHINGRIX as a 0- and 2-month or 0- and 6-month schedule. The safety profile of SHINGRIX was similar when administered according to a 0- and 2-month or 0- and 6-month schedule and was consistent with that observed in Studies 1 and 2.

Concomitant Administration with 23-Valent Pneumococcal Polysaccharide Vaccine

In an open-label clinical study (NCT02045836) in subjects aged 50 years and older, information about solicited local and systemic adverse reactions was collected using diary cards for 7 days (i.e., day of vaccination and the next 6 days). When PNEUMOVAX 23 was co-administered with the first dose of SHINGRIX compared to when the first dose of SHINGRIX was given alone, a greater percentage of subjects reported fever, defined as ≥37.5°C/99.5°F (16% vs. 7%, respectively) and shivering (21% vs. 7%, respectively) *[see Clinical Studies (14.7) of full prescribing information]*.

6.2 Postmarketing Experience

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

General Disorders and Administration Site Conditions

Decreased mobility of the injected arm which may persist for 1 or more weeks.

Immune System Disorders

Hypersensitivity reactions, including angioedema, rash, and urticaria.

Nervous System Disorders

Guillain-Barré syndrome.

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

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

The risk of GBS following vaccination with SHINGRIX was assessed in self-controlled case series analyses using a risk window of 1 to 42 days post-vaccination and a control window of 43 to 183 days post-vaccination. The primary analysis (claims-based, all doses) found an increased risk of GBS during the 42 days following vaccination with SHINGRIX, with an estimated 3 excess cases of GBS per million doses administered to adults aged 65 years or older. In secondary analyses, an increased risk of GBS was observed during the 42 days following the first dose of SHINGRIX, with an estimated 6 excess cases of GBS per million doses administered to adults aged 65 years or older, and no increased risk of GBS was observed following the second dose of SHINGRIX. These analyses of GBS diagnoses in claims data were supported by analyses of GBS cases confirmed by medical record review. While the results of this observational study suggest a causal association of GBS with SHINGRIX, available evidence is insufficient to establish a causal relationship.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

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

8.2 Lactation

Risk Summary

It is not known whether SHINGRIX is excreted in human milk. Data are not available to assess the effects of SHINGRIX on the breastfed infant or on milk production/excretion *[see Use in Specific Populations (8.2) of full prescribing information]*.

8.5 Geriatric Use

Adults Aged 60 Years and Older

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

The frequencies of solicited local and general adverse reactions in subjects aged 70 years and older were lower than in younger adults (aged 50 through 69 years). [*See Adverse Reactions (6.1)*.]

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PUBLISHER'S NOTE

Navigating declining reimbursement rates

Coming into 2024, physicians are confronted with a formidable challenge — diminishing reimbursement rates. The impact of shrinking reimbursement rates on practice revenue demands careful consideration and strategic planning. Not to mention the profession needs a unified voice to fight for better rates. As our editors write in the cover story this month: "Following a 2% cut in the Medicare Physician Fee Schedule in 2023, doctors will see another 3.37% cut to the conversion factor in 2024. The reduced reimbursement comes during an economic environment in which inflation has hovered around historic highs, good employees are difficult to find, and patients are expecting more and more from their physicians in terms of convenience and service."

When compared with inflation, physician reimbursement rates have experienced a consistent decline, a trend that raises concerns about the sustainability of medical practices. This financial squeeze is influenced by a range of factors, from policy changes to economic fluctuations. Acknowledging and addressing these factors is crucial to maintaining the financial health of medical practices.

Collaboration and advocacy within the medical community is essential to addressing declining reimbursement rates. Physicians must unite to amplify their collective voice, advocate for fair compensation from Medicare and private payers alike, and engage their lawmakers to make needed changes.

While the road ahead may be challenging, the resilience and adaptability inherent in the medical profession position physicians to navigate these changes successfully. By advocating for fair reimbursement policies, embracing innovation, and fostering collaboration, physicians can continue to deliver exceptional care while securing the financial viability of their practices in an evolving health care landscape.

We've got more great content in this issue, including a focus on personal finance for physicians, and advice from an investment adviser on some of the hot-button issues surrounding what physicians should do with their money given the tumultuous economy. It's the perfect read to get your financial year started off strong.

As always, we want to hear from you. Please send us your story ideas, feedback, and any thoughts about the state of the profession. Reach out to editorial director Chris Mazzolini at cmazzolini@mjhlifesciences.com. ■

Mike Hennessy Jr., President and CEO of MJH Life Sciences®

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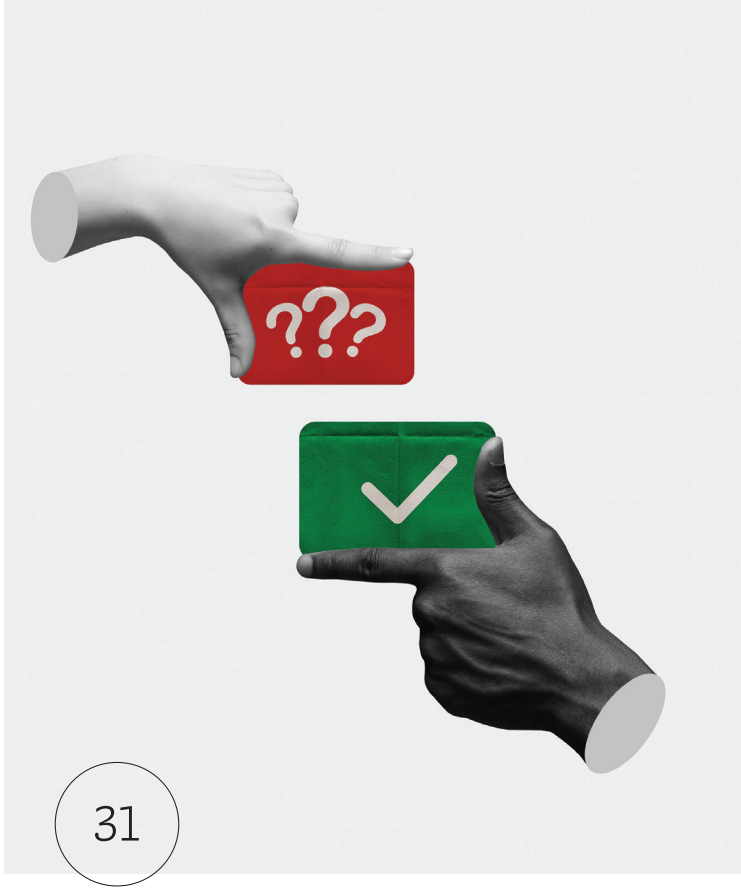

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PHYSICIAN'S MONEY DIGEST

Personal finance advice for physicians Page 12

2024 PHYSICIAN PAYMENT OUTLOOK

Vanishing Revenue

How to manage higher costs, declining reimbursement in 2024

By **Todd Shryock,** Managing Editor

Although most employees had wage gains in 2023 in the range of 4% with about the same increase projected for 2024, physicians, for the most part, have seen nothing but reimbursement decreases.

Following a 2% cut in the Medicare Physician Fee Schedule in 2023, doctors will see another 3.37% cut to the conversion factor in 2024. The reduced reimbursement comes during an economic environment in which inflation has hovered around historic highs, good employees are difficult to find, and patients are expecting more and more from their physicians in terms of convenience and service.

Private payers have their own financial pressures, which can lead to additional demands on doctors and their staff.

"They're trying to navigate increasing costs, increasing infrastructure, COVID-19 — all the things that they have to deal with day to day — but also lower reimbursement," according to Madison Davidson, an associate principal with health care consulting firm Avalere. "As the trend continues in Medicare, private payers are using that as a benchmark, and even if their payment may be greater in dollars, it's still that similar trend of decreasing over time."

The upcoming year looks to be full of financial challenges for doctors. Here is what physicians need to know about reimbursement for 2024 and beyond.

Physician Fee Schedule cut ... again

Cuts to the Medicare Physician Fee Schedule haven't become a question of if they will happen, but rather a matter of how much they will be cut by. Everyone, including most members of Congress, knows the cuts are devastating to doctors and could start to threaten the viability of the program if physicians stop accepting Medicare, but changes are difficult to make in a polarized government.

Anders Gilberg, senior vice president, government affairs, for the Medical Group Management Association, says that although Congress is looking to reduce the cut, physicians would still be facing a 2% reduction to the conversion factor. For primary care physicians, Centers for Medicare & Medicaid Services (CMS) will implement G2211, an add-on code for office and other outpatient services for more complex visits, in 2024, but although it sounds good, it doesn't do much to change the financial picture.

"The complex 2211 visit is something that is supported by primary care and is aimed at helping increase reimbursement rates for primary care physicians," Gilberg says. "Unfortunately, given its budget neutrality impact, that is a significant part of why there's a conversion factor cut."

In other words, where primary care gains with the additional code, it loses it with the overall conversion factor cut, and these continual cuts are affecting patient care and access.

"There's like a head-in-the-sand mentality that we're seeing out there," Gilberg says. "For example, the Medicare Payment Advisory Commission has put out a report saying that there isn't an access problem in Medicare, yet we have primary care practices telling us that if they do accept new Medicare patients, new patient visits are 250 days out. Yes, they take Medicare, yes, they have some availability, but that availability may be 250 days in the future."

Gilberg says that other practices report that even when they are open to Medicare patients, trying to make referrals to specialists who are accepting new patients is becoming challenging.

"While most physicians participate in Medicare for payment purposes, they certainly are not necessarily having the ability to just take every and all Medicare beneficiaries in a timely manner," Gilberg says.

In addition to the fee schedule cut, the 3.5% Advanced Alternative Payment Model incentive expired. The fee was reduced to 3.5% for 2023 and now will be zero for 2024.

"That was something that originally was a 5% add-on for those medical practices and physicians who had participated in an Advanced Alternative

Payment Model — it was a bonus on their fee-for-service payments," Gilberg says.

There is some good news for physicians, mainly in what CMS did not implement: an increase to the performance threshold in the Merit-Based Incentive Payment System (MIPS) from 75 points to 82 points.

"It would have created winners and losers based on their MIPS score, and over 50% of physicians would have received a cut if CMS had increased that to 82 points," Gilberg says. "But in the end, they maintained the performance threshold that existed [in 2023], so it's now again at 75 points."

In addition, telehealth will be reimbursed at a higher rate that brings it on par with an in-person visit, at least through 2024.

Is value-based care fading?

Value-based care was once considered an inevitable destination for all payers and physicians as a means to control costs while focusing on better care for patients. Predictions of the demise of fee-for-service payment models have been common in recent years, but surveys show that most reimbursement is still occurring under the fee-for-service (FFS) model.

"Our members report that value-based care has kind of stalled out," Gilberg says. "At least in terms of Medicare, there aren't a lot of new alternative payment models being put forth, so many specialties outside of primary care don't have alternative payment models to participate in. The incentives are going down. There's just general concern among our membership and as a whole that CMS isn't providing and continuing to evolve its value-based payment offerings."

In fact, the Center for Medicare and Medicaid Innovation, the government agency tasked with producing new cost-saving models, actually increased federal spending between 2011 and 2020 and is expected to continue to increase spending through 2030, according to a report from the Congressional Budget Office. The report asks the question of whether value-based care can produce savings, at least in Medicare.

"With the expiration of that 3.5% bonus, I think it's going to be all that harder for those practices that haven't moved to value-based care to even move," Gilberg says.

As Medicare struggles to implement value-based care programs that save money, experts say that private payers are still looking to move more contracts away from FFS. The difference for private payers is that they tend to have a younger and healthier population than Medicare, so it's easier for them to find savings.

"There was a feeling that the transition to value-based care would be quicker than it has been," says Christi Skalka, a managing director at Deloitte Consulting. "For hospitals, one challenge has been resistance from hospital CFOs [chief financial officers] to give up what is perceived to be lucrative fee-for-service revenue. There is also a perception that payers hold the upper hand in total-cost-of-care analytics, given their closed claims set of data, and that payers are not interested in partnering in attribution models."

Skalka says the shift to value-based care can be very market specific — some geographic markets have hit the tipping point, primarily due to one of the large health systems figuring out how to make money with it, pushing the rest of the market to capitulate in negotiations to stay in network.

Hospitals, health systems and physicians are all seeing downward pressure on FFS rates and a general unwillingness by payers to cover inflationary cost increases beyond historical cost-of-living adjustments.

"The downward pressure on FFS is happening and there are no increases in sight, forcing physician practices to either downsize — which you can only do so much — take less in compensation or join a larger organization such as a health system to seek protection from these payer issues," says Howard Drenth, a managing director at Deloitte Consulting. "Given that more than half of physicians are employed by either a health system or other large health services organization or private equity, they are seeking relief from the FFS pressure while the transition to value takes place."

Davidson agrees, adding that payers are still trying to figure out what the best payment models look like.

"There have been a lot of lessons learned, and I don't think there's been a ton of great success stories with value-based care," Davidson says. "But at the same time, we can't keep going on the fee-for-service path."

As physicians consolidate in larger organizations to cope with declining reimbursement, Gilberg points to CMS as causing some of its own problems. By keeping the conversion factor flat over the past several years, CMS has inadvertently caused some of the consolidation among practices, affecting costs.

"The policies that we're seeing that are keeping physician payments flat and then driving physicians into larger systems are then creating systems that are, theoretically at a macro level, more costly to the overall system," Gilberg says.

Maximizing payments

With so many financial factors working against physicians, experts say that they need to do everything

Washington watch

By **Richard Payerchin,** Editor

The House of Representatives will consider 19 bills that affect various aspects of the U.S. health care system.

The House Energy & Commerce Committee in early December voted to advance various draft legislation for consideration by the full chamber. The actions came this week in a committee meeting involving 44 bills dealing with energy and technology, along with health care.

The batch of bills included House Resolution (HR) 6545, known as the "Physician Fee Schedule Update and Improvements Act," which would affect pay for physicians treating Medicare recipients. Sponsors include physicians in the House.

"The current structure of the physician fee schedule does not provide sustainable, reliable and consistent payment rates for physicians who see Medicare beneficiaries," Rep. Mariannette Miller-Meeks, M.D. (R-Iowa), said in a news release. "These cuts, especially when the costs to practice have markedly increased, further strain our nation's doctors, limiting patient access to care."

"Our members report that value-based care has kind of stalled out. ... There's just general concern among our membership and as a whole that CMS isn't providing and continuing to evolve its value-based payment offerings."

— Anders Gilberg, senior vice president for government affairs, MGMA

Learn about all the bills here:
https://www.medicaleconomics.com/view/committee-sends-19-health-care-bills-for-full-house-consideration

possible to maximize their payments by showing their value to payers. Although there is a shortage of physicians that would seem to favor doctors in negotiations via supply-and-demand economics, that isn't much of a factor.

"I think that high-quality physician services — for example, great outcomes — is a bigger driver of leverage with payers than just the overall number of physicians," Skalka says. "High-cost, low-value physicians will not be able to negotiate as well. Additionally, building a case for better or sustained reimbursement with comparative performance metrics, patient satisfaction scores, and regional or market-based rate benchmarks through price transparency will help physicians in negotiations."

She adds that being open to incentive-based reimbursement will show a willingness to collaborate with payers on their goal of reducing costs in the overall health care ecosystem.

Payers are looking for proof of better outcomes with data and performance metrics, and when physicians can provide this, it helps them in negotiations.

"Physicians will also need to demonstrate that they can properly manage the patient panel they have been assigned as well as ensure they have good patient access and quality reporting," Drenth says.

Davidson says practices absolutely need to have data to prove their value. "I think having that data to present a value story to payers is very valuable because then your plans can work on making you a preferred partner," she says. "It's not necessarily limiting access to others but making sure that they can direct their members to practices with high-value care."

This may require an investment in technology to boost patient care and operational efficiency and includes things such as a revenue cycle management system, telehealth and an improved patient financial experience. These technologies can provide detailed reports to the practice that can be used to its advantage.

"Using this reporting to show excessive administrative burden of medical policies by payers can help in building the case for increased reimbursement," Skalka says. ■

Financial planning for physicians in an uncertain economy

Despite recent economic turmoil, the fundamentals remain unchanged: Save as much as you can and invest for the long term

By **Jeffrey Bendix,** Senior Editor

After a long stretch of relative stability, the U.S. economy has hit a rough patch in recent years. Inflation and interest rates have reached levels not seen in decades, and even though both have started to come down, many Americans feel pessimistic about their financial future.

What do these developments mean for doctors as they plan their savings and investment strategies? To find out, *Medical Economics* spoke with Dan Danford, CFP, founder and CEO of Family Investment Center in St. Joseph and Kansas City, Missouri. During his 39 years as an investment adviser, Danford has worked with dozens of physicians and other professionals. The interview has been edited for length and clarity.

Medical Economics: **For a doctor just starting practice, what are the best ways to accumulate a retirement savings nest egg?**

Dan Danforth, CFP: The first is to use the 401(k) or, if you work for a nonprofit, the 403(b). You want to put away the limit every year. Then be fairly aggressive in how you invest it. This is money you're not going to touch for decades. Let it compound at a high rate.

Medical Economics: **The benefit there is tax-free compounding, right?**

Danforth: Absolutely. It will compound over time especially if you're young. Then you also have some control when you retire about how fast to take it out and when are good times, tax-wise.

After that, it's mostly lifestyle sorts of things. When doctors were going to school, they didn't make a lot of money. Then when they finally get out of school they make what seems like a lot of money to them, so there's a temptation to splurge. I don't blame them, but it's probably not in their long-run best interest.

Medical Economics: **How do you persuade them of that?**

Danforth: I try to show them whatever that number is they're making that year, it's likely to go up. So instead of saying, "I'm making $300,000 this year and I know next year I'm going to make $350,000 so I'm going to buy the car I want and the cabin on the lake," I tell them to wait until they're at the point where they're actually making the money before spending it.

Sometimes a doctor who's been living [frugally] sees a big [salary] number and it seems almost inexhaustible. And you have to show them that it is exhaustible, but if they wait for a few years they'll be able to do the things they want to do.

Medical Economics: **What's been the impact of the inflation we've been experiencing on tax and financial strategies? Has that been affecting investment decisions or retirement planning?**

Danforth: I think the biggest thing there is that we had 25 to 30 years of low inflation, so a lot of people today never really experienced high inflation.

The Federal Reserve's inflation target is 2% a year. But even 2% to 3% inflation over 10 years makes a huge difference in the value of money. So that drives people into investments that can keep up. And in general, stocks do a pretty good job of keeping up with inflation.

The other thing is stock prices have been a little subdued over the past few years. I think there's real growth opportunity there once we wring some of the fear out of the market. I think the economics are pretty good; it's been people's fear that's kind of held things back.

Medical Economics: **Interest rates are at their highest level in a long time and may go even higher. What does that mean for tax and financial planning strategies and the economy generally?**

Danforth: One thing it means is that for the past few years any money you had in bonds or certificates of deposit, any of that [fixed income] stuff, you were getting practically nothing for it. That's ticked up now. Some money market funds are paying over 4%, and some are even bumping up into the fives.

Let's say you have an investment portfolio that's 50% stocks and 50% bonds and other fixed-income stuff. Well, the 50% that's been in bonds hasn't been earning much in the past few years. Now all of a sudden you've gone from zero to 4% or 5% for half of your portfolio. That's a pretty dramatic change and good for investors.

So one of the things we'd say is if you have money sitting in a bank account and it's not earning anything, get invested someplace where you can earn 4% or 5% a year.

Medical Economics: **You mentioned the importance of diversification in investment portfolios. With the understanding that everyone's situation is different, is there a rule of thumb as to how an investment portfolio should be allocated?**

"And you don't want [a portfolio] to be so growth-heavy that it keeps them up at night. But the more it's in growth assets, the more they will have for retirement."

Danforth: My general rule is to be more aggressive than you're comfortable with. So if you're comfortable with a 40% stock portfolio, it probably ought to be 50%. If you're comfortable with 50%, it'd probably be better off at 60%.

I think many people are more risk-averse than they need to be. We know the averages tend to be in your favor if you're a little more aggressive. So I tend to push people up to the edge of what they're comfortable with because I know they'll be rewarded for it in the long run.

Most people need some combination of safe investments and ones that involve some risk. And you don't want it to be so growth-heavy that it keeps them up at night. But the more it's in growth assets, the more they will have for retirement.

Medical Economics: **Is there a value to being less aggressive in your investing approach as you get closer to retirement?**

Danforth: I think that was more the case in the past than now because people live so much longer in retirement today. It used to be people lived seven years in retirement. That's not how it is anymore. Now if there are spouses who are doing well in their 60s, chances are one of them will live another 30 years.

Medical Economics: **That's a nice problem to have.**

Danforth: Yes, but not if you run out of money. You're trying to build a nest egg so you don't have to live just on Social Security. With that time span, you need to continue being fairly aggressive with investments.

Medical Economics: **I want to ask about student debt because I know that's a big issue for a lot of doctors, and not everyone agrees on the best ways to approach it. What's your approach?**

Danforth: Well, two things. One is, I'd look at all the debt the doctor has and go after the highest-costing debt first. That might be credit cards, it might be student debt. But that's how I would work it, paying off the highest first.

But the wild card is [President Joe Biden] keeps talking about reducing or eliminating student debt. So I'd be reluctant to pay it

off faster than necessary at this point. You'd feel terrible about paying it off and then the next week they come in and forgive everyone's debt.

***Medical Economics:* Isn't it more of an emotional decision for some people? They just don't like having debt hanging over them?**

Danforth: Yes, and I get it. It's like paying off a home mortgage. There are some people who can't sleep at night if they have a mortgage. And if that's the case, you just pay it off and find another avenue to create your wealth.

***Medical Economics:* We're starting tax filing season. Are there any changes in the tax code doctors should be aware of?**

Danforth: Nothing significant, but it does bump up a little bit what you can do with retirement contributions. The maximum deferral to a 401(k) jumps to $23,000, and if you're over 50 years old, there's another $7,500 on top of that. The same goes for individual retirement accounts. The contribution now is $7,000 and I think that's up a bit from 2023.

The Social Security COLA [cost-of-living adjustment] is up about 3.4% for next year. It's not as much as it was for 2023 but it's still a nice little bump. Not everyone wants to delay drawing Social Security. But between the ages of 65 or 66 to age 70, it goes up 8% a year. So waiting those four years can make a big difference in how much you get.

"We spend money on stuff that doesn't maintain value very well. You buy that sparkling new car and two days later it's worth $25,000 less."

***Medical Economics:* What are the most common financial planning mistakes you see doctors make?**

Danforth: I think they're easy prey. Everyone's promising them the moon. They're going to tell the doctor to buy this or that stock and they'll double their money real fast. Most of the time that doesn't work. But if people keep calling you, at some point you start thinking maybe there's something to it.

And not just doctors but a lot of Americans make bad spending decisions. We spend money on stuff that doesn't maintain value very well. You buy that sparkling new car and two days later it's worth $25,000 less. Making good spending decisions makes a huge difference in how you fare over time.

***Medical Economics:* How do you determine what's a good spending decision?**

Danforth: A lot of it's just research. Like reading Consumer Reports, which has huge amounts of information on things like the resale value of different cars and which TVs and appliances are better. I don't think a doctor should spend a lot of time poring over that stuff but it's pretty easy to find information on which is the best.

***Medical Economics:* Do you see any differences in how people approach money or financial planning today versus when you started out?**

Danforth: Yes. First of all, there's a lot more information available today. It used to be financial advisers got paid because they knew stuff nobody else knew. That's not the case anymore. I doubt I know anything that you couldn't find out if you wanted to. But the value I bring is that you don't have to look it all up yourself because I can help you do that.

I also think a lot of people think they're doing a good job with investing and finance but they don't know what they don't know.

***Medical Economics:* Doctors would probably say the same thing about patients.**

Danforth: That's exactly right. I can read up on medical stuff but there's a real value for me to sit down with my doctor and he helps me understand it and apply it to my own circumstances. And that's what a good financial adviser does. There's a real value in an ongoing relationship. ■

How to navigate e-visit billing Page 18

Creating a patient-centered practice

Strategies for improving patient satisfaction & retention

Streamlining operations allows physicians to spend their time caring for patients, and for patients to feel cared for

By **Richard Payerchin,** Editor

The new year 2024 will bring new advances in fields that can benefit physician practices, including artificial intelligence, telemedicine, electronic health records, imaging, testing, surgical techniques and pharmaceuticals. If patients need those, they will also want a physician to guide them through illness to health and wellness.

This year during examinations, the doctor-patient conversation will remain the centerpiece of medicine.

"It's an opportunity for the provider to do a temperature check in terms of whether that patient really understands what's happening and gauge where they're at from a choice perspective and what additional information they need to have," said Dawn Plested, MBA, J.D., a Minnesota-based consultant. "It's just a human thing, when you just want to be heard in moments that will affect your health care. When your health is at risk, it feels like it's life or death. It sometimes is life or death."

But beyond the patient visit, there are things physicians can do before and after the appointment to keep the patient engaged and their relationship with the physician and the practice strong. This article details the latest practice and patient management tips to ensure patients are engaged before, during and after their visit.

BEFORE THE VISIT

Online information

Many patients get their first impression of a physician online. Whether good or bad, fair or unfair, physicians must be aware of their practice's cyber image and its effects on attracting new patients and recruiting new workers. That means someone has to monitor websites such as Google, Yelp, Facebook and LinkedIn, said Adrienne Lloyd, MHA, FACHE, a consultant who has worked for Mayo Clinic and Duke Health System.

Basic information online, such as telephone numbers, addresses and open hours, must be accurate. A website or social media page can be fun, too, providing a place to brag about presenting at conferences or simply having a good day at the office.

Cyber scheduling

Find a way to allow patients to schedule appointments online. For years, people have been able to book airline tickets online around the world. "Why not be able to do the same with your doctor?" said

D.J. Kennedy, M.D., FAAPMR, a physician and professor and chair of physical medicine and rehabilitation at Vanderbilt University Medical Center in Nashville, Tennessee.

Patients like online scheduling because it allows more flexibility when selecting a physician or appointment time. Meanwhile, staff spend less time on scheduling and focus more on patient needs. In turn, this results in better care, which is what patients and providers want, Kennedy explained.

Prepare ahead of time

Move as much check-in paperwork off-site ahead of patient visits. It may involve some office coordination, such as a phone call with a nurse, pharmacy technician or medical assistant to get a patient's medication list, Lloyd said. However, doing so allows patients to get in and out more quickly, while the time in between is dedicated to the physician-patient visit.

"As you think about the whole process and the workflows, what can be done off-site? What doesn't even need to be done? What can be done in a more efficient way?" Lloyd said.

Setting goals

On the intake questionnaires, have your patients write down their goals for the visit.

"Our primary care groups have used this with a lot of success, so now it's moving into some of the subspecialty work," said Scott R. Laker, M.D., FAAPMR, senior medical director of CU Medicine at the University of Colorado. "As your provider, [we will know] what the three things [are that] you want to get out of today's visit. That allows me to answer your questions and gives me some breathing room to know whether I'm going to have enough time to answer or ask some of the questions I need to get through."

DURING THE VISIT

The patient arrives

If the day's appointments are not running on time, be sure to let the patients know. When patient satisfaction scores were bad for wait times at Stony Brook Primary Care in New York, staff created a waiting room sign board, said medical director Susan Y. Lee, M.D., FACP. The team would love to have an automated check-in system, an electronic message board and text updates to patients. Until then, they use a whiteboard printed with the physicians' names and color-coded magnets to indicate timeliness: green is on time, yellow is 15 minutes behind and red is 30 minutes behind.

"It's our little rudimentary message board, but it works. We don't have any technical issues with magnets," Lee said.

Have staff to help

That practice's Patient Family Advisory Council agreed with a patient suggestion to create a waiting room concierge. Support staff rotate to a desk in the waiting room to check in and talk to patients. "Health systems should consider having a service like this, because I do feel that patients deserve this concierge service," Lee said. "It's very stressful to go to a doctor, and the waiting room is really a place of anxiety. I do feel that this helps."

She also noted that those methods did not require spending thousands of dollars on new technology or consultants.

"Hi, my name is ..."

Keep employee identification badges, but when patients arrive, consider having staff identify themselves by first name and explaining how they are assisting in each step in the appointment. "As someone is checking in, [say], 'Hi, I'm Katie, and I'm going to be handling your paperwork today. I just have a few questions for you,'" said Katie Lawrence, MHA, CMPE, principal consultant for Willow Strategy Group.

Some practices use paper cards or a list of staff and tasks in patient portals. Those methods help patients know they are interacting with people who know and can explain each step of the process of a medical visit.

Face-to-face

When the patient is ready, take time to review the medical record — even if very briefly — before entering the exam room. "Know why the patient is there today, because it may be different than why they were there the last time," Lawrence said.

If the patient got test results back or had an appointment with a specialist, acknowledge that. "It's about being intentional, showing the patient that they are the focus of the visit, not just another number on an assembly line," she said.

"How can I help you?"

"I start every visit [by asking], 'How can I help you today?'" Kennedy said.

Patient management tips

Before the visit

- Online information
- Cyber scheduling
- Prepare ahead of time
- Setting goals

During the visit

- The patient arrives
- Have staff to help
- "Hi, my name is..."
- Face-to-face
- "How can I help you?"
- Seeing eye to eye
- Talk the talk
- Learning and teaching

After the visit

- Ask for feedback
- Going back online
- Keep it simple

He noted that this does not mean the physician must defer to the patient's every wish for a test, procedure or prescription. However, patient answers will often indicate issues that physicians need to address.

Seeing eye to eye

Eye contact is important, so put the computer to the side and get eye level with the patient, Lawrence said. Don't just look straight into the screen without acknowledging the patient. "It's about who you put first and second," Lawrence said.

Talk the talk

Speak in terms that patients will understand. Physicians, other clinicians and support staff often speak their own language of terms, abbreviations and acronyms that patients aren't familiar with, Lawrence explained.

For example, a word that sounds like "cabbage" could be used to remind patients to eat their leafy greens, or it could mean to get ready for a coronary artery bypass graft surgery, or CABG. "It's not to dumb it down, because it's not that our patients are unintelligent. They just don't speak the same words," Lawrence said.

Learning and teaching

Ask patients to teach back what they just learned. Patients may feel they understand your explanation, instructions or guidance, but they don't have it when they walk out. This goes beyond simply asking patients whether they have any questions.

When they talk, the patient's phrasing probably will be different, "but by helping engage the patient in their own learning, they're going to absorb it better and have a better experience overall," Lawrence said.

Complete your work in real time

Completing work in real time could involve asking the patient whether they mind if you dictate visit notes in front of them, said James Deming, M.D. He integrated that into his practice where he could as a small-town family physician.

"That did several things," he said. "It allowed them to hear what I said. It allowed them to correct me — 'Doc, that's my left shoulder, not my right.' Or, 'It was three weeks, not three months.' It lets them know that I think their knowledge of what I'm documenting is important, and it significantly reduces the cognitive load that I have to carry around with me." But he warned that this is usually not possible by the physician "just trying harder." The whole office system must support this by offloading other tasks that do not require physician input.

AFTER THE VISIT

Ask for feedback

Whether on paper or online, practices need to ask patients what they could do better. "I would highly recommend everybody be doing a patient survey," Lloyd said. "Even asking three to five questions: How do you think your visit went? How would you rate us on a scale of 1 to 10? Is there anything we could have done today that would have made your experience better?"

The survey may prompt complaints, but it is better to address those in person on the day of the visit instead of trying to counteract a negative online review that goes public, she said.

Going back online

Remember the importance of online reviews? If patients are complimentary, hand them a card and ask whether they would post a positive write-up.

"If you have a patient at your front desk who's kind of yelling at you, you might not hand them that card," Lloyd said. "That would be one you try to pull into the office and have a conversation with before they leave."

Keep it simple

Prescriptions and treatment plans are complicated, but communicating them to patients does not have to be. At Stony Brook Primary Care, a group of physicians, led by Archana Radhakrishnan, M.D., wanted to improve patient care through better understanding of discharge instructions.

They used Press Ganey patient survey results from October to December 2022 for baseline data, then created one-page sheets to fill out and give to patients from January to March this year. There are slots for patients to note who they saw for their visit, any changes made during the visit or homework before next visit, the dates of and reasons for follow-up visits, as well as additional notes.

This resulted in better patient evaluation scores, through Press Ganey, for two attending physicians who oversaw residents there. "Through simple homework-style discharge checklists, patients and providers can work together during a visit to improve communication and eventually patient satisfaction," the doctors said in a poster presentation for the New York Chapter of the American College of Physicians.

The new and the old

The business of primary care is more competitive than ever, and patients want care that is both quality and convenient. Following these tips can help practices keep their competitive edge and keep patients coming back for more care. In 2024, the best physicians will look for new ways to reengage their patients and relearn some old methods, too. ■

How to navigate e-visit billing: tips for primary care physicians

In an age where digital advancement is permeating every sector of the economy, health care is no exception. Innovations, especially in telehealth and e-visits, promise to deliver health care more conveniently than ever before. While these changes hold great promise, they also present new challenges — particularly in billing.

Many primary care physicians are turning to digital communication to provide virtual care. This has led to the question of how to bill ethically for virtual health care services while maintaining transparency and trust with patients.

The digital transformation

Digital innovation, undeniably, ushers in an array of new tools and systems that make health care delivery more efficient. Electronic health records (EHRs), telehealth platforms and patient portals are just a few advances that have greatly expanded the capabilities of health care organizations. Such tools not only enable real-time communication, but also foster a more patient-centered approach.

However, these tools come with challenges. One critical area is in how digital technology has enabled "care from anywhere," blurring the once-clear boundary around when a conversation with a patient is billable. As a primary care physician, how do you navigate these waters without alienating your patients or undervaluing your services?

The patient's perspective

From the patient's standpoint, the primary concern is clarity. Patients appreciate the convenience of e-visits but are wary of hidden or surprise charges. They are accustomed to sending an email or calling their physician to ask questions without being charged as though they were receiving in-office services.

This means that physicians need to educate patients on these changes and provide clear guidelines on what types of digital communications and scenarios will be billed. Being clear about the costs up front is crucial to helping patients understand why a change is being made. Transparency not only prevents later misunderstandings but also builds trust.

Compensation for services

On the other side of the equation, physicians want assurance that their services, even when offered digitally, are appropriately valued and compensated. This sentiment is wholly valid, given that e-visits often require the same level of expertise and, sometimes, even more preparation.

The regulatory and insurance policies on e-visit reimbursements are always changing. It's important for primary care physicians to stay up to date on these changes to ensure they're properly reimbursed for e-visits. The American Telemedicine Association is one resource that brings together updates from across the country on virtual health regulation. The U.S. Centers for Medicare & Medicaid Services also has a section on its website dedicated to telehealth-related updates to help physicians stay informed.

Transparent billing

Before educating their patients, physicians need to create a clear set of guidelines on what types of e-visits are billable and what types of patient communication are not. These guidelines will vary from practice to practice, and factors such as insurance reimbursement, specialty and patient demographics should be considered when drafting them.

Here are four tips for creating effective e-visit billing guidelines:

Clear communication with detailed information about charges is crucial. Before initiating an e-visit, provide patients with detailed information about potential charges. Be clear about when a call or email from a patient is billable and when it is not.

Demonstrate and explain the value of e-visits to patients. Patients might not understand the intricacies of e-visits. It is important to explain that these visits require the same level of care, attention and expertise as in-person consultations.

Allow an open dialogue. Encourage patients to ask questions about e-visit charges. The more they understand, the less likely they are to feel blindsided by unexpected charges. The name of the game is transparency and accessibility.

Keep your patients updated. Billing guidelines, especially for newer services like e-visits, may evolve. Stay updated on the latest regulations and best practices and communicate any changes to your patients promptly. ■

Sarah M. Worthy is CEO of DoorSpace.

How tech is changing primary care as we know it Page 22

Is texting the future of patient-centric care?

Patients want more convenience. Are you ready to accommodate them?

By **Smriti Joshi,** contributing author

Physicians know the power of in-person care. There is nothing like seeing a patient in person, not only to gauge their outward physical markers of health but also to read their body language, make eye contact and observe other non-verbal cues that allow doctors to form a bond with their patients. This early and consistent trust-building can be crucial to a patient's health outcomes.

But today's patient isn't just looking for a great health result; they also want a great experience. In one survey of health care consumers, 70% of respondents said convenience was either very or extremely important. This could be specific to a geographical location or virtual options — 60% of patients chose telehealth because it was more convenient — as well as the availability of online scheduling, messaging and easy prescription refills.

In the past couple years, a new modality in the form of text-based offerings has come to the forefront of the patient-centric approach. As chatbots become more advanced, so too can their usage in health care. With the launch of ChatGPT specifically, many specialists in health care information technology (IT) began to ideate on how text-based services and artificial intelligence (AI)-led chatbots could be integrated into the everyday patient experience.

When done right, text-based modalities save physicians time and money while prioritizing convenience for the consumer and providing support even during off-hours. Patients love that they can get in touch with their physician anytime, no matter

where they are in the world. Text-based modalities are accessible and flexible. They also have the benefit of being discreet. It's much easier to text your doctor while at work or sitting on a train than to call them and discuss a health concern aloud. This discretion further increases the odds a patient will reach out in the first place.

To properly implement a text-based modality, physicians must conduct a comprehensive initial assessment to determine a patient's suitability to participate in a text-based program and receive medical advice that way. As with any intake screening, doctors must establish that a patient's concerns, capabilities and overall state of health are appropriate for communication and treatment that aren't always face-to-face.

Similarly, patients must be properly informed about the purpose and limitations of text-based care. This starts with a transparent introduction that details how the system works, what it will be used for and what it won't be used for. By creating boundaries around the work that text-based communications are best suited for, doctors can better manage expectations and assist the client with their health goals. It's also crucial that patients provide informed consent upfront to build trust.

As part of this introduction to text-based modalities, physicians will want to craft open-ended questions to better understand the patient's concerns and work with them to define their ideal outcomes upfront. From there, doctors should have a system for timely, responsive communication. Setting this expectation ahead of time, such as promising to respond within 24 or 48 hours, will go a long way toward customer satisfaction.

It's not enough to get patients on board, though. Implementing a text-based health care modality requires an understanding of legal and ethical implications. To deliver patient-centered services safely in the digital realm, physicians and their IT providers must be certain the following safeguards are in place.

Data privacy and security

Confidentiality is paramount in any health setting. The following data protection practices are key to security in text-based care:

Encryption and secure storage

It's crucial to ensure end-to-end encryption is implemented for all patient communication and that data is stored in compliant and secure databases. Encryption standards must be regularly updated to align with industry security best practices.

Access control

Access to patient data must be limited only to authorized personnel. Role-based access control parameters and regular audits on access should be considered.

Data minimization

Only essential patient data should be collected to minimize data risks. Similarly, all staff should be educated on the importance of minimizing the collection of any data that may not be necessary.

Compliance

Regulations for both health care and data privacy, such as the federal law restricting release of medical information and the General Data Protection Regulation, should be adhered to for any text-based health care. Providers using these modalities should be sure to stay up to date as regulations in these spaces continue to evolve. Frequent compliance audits can help identify any gaps or areas for improvement.

Training

Finally, it's critical that all staff are well trained on data privacy and information security protocols. Fostering a culture of awareness and continuous education ensures patient privacy is always prioritized.

Informed consent

Not everyone will want to use text-based modalities, and that's OK. Allowing patients to opt in is foundational to ethical implementation. Informed consent includes several requirements:

Clear information and communication

The services provided, risks, benefits and limitations should all be clearly outlined for patients within the informed consent form. Importantly, be sure to use plain language and avoid medical jargon to ensure patients can fully comprehend the information.

Consent reiteration

Consent should be obtained at various stages, including before initiating communication via text, when treatment starts or before any information is gathered from other health care professionals.

Digital consent mechanism

Implement a secure digital platform for obtaining and storing electronic consent. Patients must have the ability to easily access and review their consent at any time.

Licensing and jurisdiction compliance

Complying with legal requirements protects physicians and their practice while aligning with professional standards. Regularly verify the licensing and credentials of all health care professionals involved in providing services through the digital platform.

Check regularly to ensure all licenses are valid and up to date.

Text-based care modalities are a game changer in patient-centric care. By giving clients the freedom and flexibility to reach their care team in this way, physicians enhance their sense of empowerment. With this autonomy and control comes a greater likelihood that they will take charge of their health, potentially increasing preventative health practices and improving outcomes.

Written communication not only leaves a text-based record for physicians, which provides an easy way to track progress and revisit recommendations and insights, but it also allows the patient space to self-reflect. Many people find it easier to articulate their thoughts and issues through written communication. Just the act of drafting the note can be therapeutic and empowering.

Text-based modalities can be especially effective for physicians looking to increase their impact on their patients' mental health. Amid today's mental health crisis, many have called for general practitioners of family medicine to take a more active role in this area, but physicians often feel uncomfortable treating more serious mental disorders. Rightfully so!

As a psychologist, I've seen firsthand how powerful text-based therapeutic discussions can be. Supported by research evidence, text-based therapy stands as a legitimate and effective means of delivering mental health services. As a former skeptic-turned-believer, I am continually humbled by the transformative power of text-based therapy. It has allowed me to connect with people on a profound level, offering them not only freedom from structure and time constraints but also a safe space to vent, share and explore their inner worlds.

Text-based health care, either for physical or mental health needs, will never replace traditional in-person therapy. However, it's a powerful and effective method for delivering support in the modern age, improving access, convenience and outcomes for all patients — no matter their background or needs. ■

Smriti Joshi is chief psychologist and a member of the board of directors for Wysa, an AI-guided mental health platform delivering clinically validated care.

By **Dhruv Suyamprakasam**

In 2024, technology will change primary care as we know it

It is not uncommon for people to wait weeks or even months to see a health care specialist after visiting their primary doctor and being told that was the needed course of action to address their issue. On some insurance plans, this is the only way to get an appointment with a specialist. Other plans allow consumers to see a specialist directly, but they have to be in the network. Health care plans — really, the entire system — have grown more complex over the years. Patients are left to maneuver as best they can with little or no guidance, and many are left to bear the sometimes unfortunate consequences of waiting. Technology can help speed up the process of connecting the patient and doctor virtually whether through electronic health records or telehealth.

Albert Einstein famously said, "If you can't explain it to a 6-year-old, you don't understand it yourself." A person would be hard-pressed to easily explain the U.S. health care system to a child. The multiple layers of regulations, insurance requirements and the obstacle course to reach the right doctor have prevented patients from receiving the immediate care they need.

Experts predict the global digital health market will grow at an annual rate of 18.6% by 2030. And although that brings opportunities, health care should be about the people. Here's the catch-22: The only way to make health care about the people is to leverage the right technology. For example, telemedicine platforms have the ability to remove the middlemen (insurance companies) who may limit a patient's treatment options.

Patients challenged with choosing the best treatment option and who are not clear on how to make a health care decision should be able to seek a timely medical second opinion without middlemen delaying that process. Second opinions give patients a better understanding of what is happening as well as a fresh perspective to help them navigate the best next steps.

Technology: The heart of the solution

As technology advances within every industry, including health care, and digital adoption continues to skyrocket since the COVID-19 pandemic, health care providers and the middlemen need to adapt to these changes. Every day, new technologies are introduced that can streamline the process.

For example, during the pandemic, most primary care physicians found a way to shift a portion of their practices to serve patients who were seeking treatment remotely. Doctors were able to easily adapt their skill sets and get on board with telemedicine. The switch to telemedicine provided direct access to patients who needed it most. This proved that you can receive quality information about your health care and connect with doctors using technology. These digital health platforms ensure that doctors have the correct patient information (e.g., medical records or data from the patient). This will help a doctor more quickly understand the patient, which will lead to cost reduction and at the same time streamline the process.

Generative artificial intelligence (AI) and emerging technology have the potential to bring $1 trillion to $1.5 trillion in investments through 2027. To further the use of technology in health care, we have started to see ChatGPT-4 being used to improve, not threaten, physician/patient engagement. It's an enhancement, and it's only

TECHNOLOGY CAN HELP SPEED UP THE PROCESS OF CONNECTING THE PATIENT AND DOCTOR VIRTUALLY WHETHER THROUGH ELECTRONIC HEALTH RECORDS OR TELEHEALTH.

the beginning of how generative AI can play the "AI as an ally" role in health care. The focus is on understanding the true merits and limitations of ChatGPT. Health care professionals need to recognize it and other AI solutions as productivity enhancers.

In broad terms, middlemen in any industry survive because of information asymmetry and the lack of knowledge. AI can help quickly fill the gap in information asymmetry by effectively matching patients and doctors across geographies, which results in faster consultations.

By enabling easier access to global health care solutions, ChatGPT-4 also can help accelerate the creative thinking needed to resolve problems and ultimately benefit the entire health care ecosystem. With generative AI enhancements, doctors will be able to discover new solutions to health issues that have until now had limited treatments. This can lead to better outcomes for patients and contribute to advancing global health care.

We're not there ... yet

Even with the constant improvements in technology, the current American health care system is riddled with problems that lower the quality of care a patient can receive. According to Merritt Hawkins, the time to get an appointment with a physician had increased to an average of 22 days in 2022. For people in need of help, this amount of time is unacceptable. Hence, there is a need to revisit the potential that technology offers and determine how to best harness it to ensure quality, timely care for patients.

WITH GENERATIVE AI ENHANCEMENTS, DOCTORS WILL BE ABLE TO DISCOVER NEW SOLUTIONS TO HEALTH ISSUES THAT HAVE UNTIL NOW HAD LIMITED TREATMENTS.

For example, people should be able to virtually visit a specialist without bank-breaking costs. This is possible by unlocking doctor availability, which can help cost optimization for the patient population. This can happen only with the correct technology in place, such as data interoperability among platforms on a doctor's calendar.

Technology enables more efficient patient/doctor consultations and may result in a healthier patient population. This has the potential to lead to lower expenses for insurance companies because patients will adhere more to prescriptions and treatments. Patients who don't adhere to their medications are a major challenge for the entire country, and adherence can be more effectively tracked and nudged with virtual primary care and allied technology.

The emphasis needs to be put back on providing care for patients as efficiently as possible. Technology can help achieve that goal in 2024 and beyond. There's much work still to be done to ensure the middlemen do not impede needed treatments. To recenter our focus on successful patient outcomes, the health care industry must embrace all that technology has to offer within privacy boundaries. This can be done if the focus is more on the why: the people. ■

Dhruv Suyamprakasam is a co-founder and the CEO of iCliniq.

An interview with **Paul Berggreen, MD**

‘Independent medical practices are not dead’

AIMPA intends to become a new voice for physicians across all specialties, including primary care

By **Richard Payerchin,** Editor

The American Independent Medical Practice Association (AIMPA) launched in October 2023 as a new voice for independent doctors across all specialties, including primary care, internal and family medicine.

The organization started with almost 5,000 members who provide health care for 10 million patients across 39 states. Those physicians are united by a passion for quality patient care that is accessible, cost-effective and unburdened by layers of health system bureaucracy.

“Independent medical practices are not dead,” said Paul Berggreen, M.D., inaugural president and board chair of AIMPA and a gastroenterologist in Phoenix. “We have some very smart physicians who are very much determined to remain independent and are also very much in the mindset of protecting our profession and our patients and delivering the care that we want to deliver, the way we want to deliver it, because we know that’s a great way to practice medicine.”

Berggreen added, “We’re here, we’re going to grow, people are going to hear about our message. And I think it’s going to be remarkably well-received by patients, by physicians and by policy makers.” Berggreen discussed AIMPA and independent practices with Medical Economics. This interview was edited for length and clarity.

***Medical Economics:* What’s your favorite part about being an independent practitioner?**

Paul Berggreen, M.D.: My favorite part of being independent goes with my favorite part of being a physician: talking to patients, interacting with patients, getting to take care of an entire family. You do a good job for the mom and suddenly you’re seeing all the kids and 30 years later you’re taking care of the kids’ kids. I enjoy that. I’ve always been in independent practice. I get to take care of those patients, interact with them on my schedule, the way that I was trained to do it, the way that I’ve found that it works better with my delivering care to my patients. That’s actually what keeps me going, that personal interaction. I think being in independent practice has kept that going for a lot longer. You get to go to work, you chart your own course, you take care of the patients the best way that you know how, you respond to needs, you respond to them quickly and efficiently. It really is the modern-day equivalent of the old-time family doctor who used to just do whatever he or she needed to for their patients. That’s what I think is the most fun.

I will tell you that I’ve also gotten more in tune with some of the policy objectives of the health care system in general and how we can improve the care that we deliver to patients, regardless of practice setting. Specifically, I look at that from the lens of the independent practitioner and [there are] a lot of things out there that we can improve, and we have the flexibility and the nimbleness to do so. That’s been a priority of mine for a number of years now.

***Medical Economics:* There already are a number of physician organizations devoted to various aspects of medicine. How do you define AIMPA’s role?**

Berggreen: To my knowledge, there’s never really been an organization that’s focused [on] independent practices of every specialty. A lot of specialties have their own advocacy organizations, certainly. I’m a gastroenterologist and we have

ours, and we talk about issues that are specific to gastroenterology. But there really needed to be an organization that spoke on behalf of private independent practices exclusively because the landscape has changed in health care, and it's been a remarkable change.

In the '80s, when I was in medical school, about three out of four physicians were in independent private practice medicine. Three out of 4 [By] 2021, that was 1 out of 4. That's shocking. And what you're seeing is that some of these policy initiatives from the government, some of the market forces that exist, some of the consolidation among hospital corporations, all have led to a change in the playing field from an overall strategy standpoint for the profession of medicine.

It got tilted in favor of hospitals basically swallowing up medical groups and taking advantage of some of those works and laws that may have been well-intentioned, but it worked out to be disadvantaging independent practice of medicine.

We're trying to change that. We specifically went across every specialty that we could find to ask, "Are you facing the same challenges?" It turns out, everyone's thinking the same thing, but there was no organization that represented us. And when you look at some of the other organizations that are multispecialty, they really have a broad constituency. They may represent independent practices, employee practices, academic practices, etc., and maybe offer other services.

We're really laser-focused on issues that are important to independent medical practices.

Medical Economics: **How do independent medical practices bring value to patients and communities compared with consolidated hospital care?**

Berggreen, MD: I'll go back to three things. We need to focus on quality, access, cost. We want to deliver the highest quality care that we can. Studies have been done — and they're out there in multiple specialties — showing that care delivered in the independent medical practice setting is no different than care delivered by physicians in the hospital setting. There are no demonstrable changes in quality.

Accessibility is a big one because, in general, in private practice we accept all insurances, including Medicaid, and we have multiple offices in the community. In general, we're spread out, we serve the communities in which we live, and so it's much more convenient. Here's an example. You come to my office, you park right outside the front door, you walk up to the second floor, and that's where my office is and that's where a lot of us are. We're your local physicians. You don't have to drive onto a hospital campus, park in a garage three blocks away, pay $10 for parking and navigate your way through a maze to get to your doctor's office. So there's a convenience factor as well.

But one final issue that I talked about is cost. There are numerous studies that show that care delivered to patients in independent medical practice settings is significantly — up to 30% — less expensive than care delivered in the hospital-based setting. A number of factors contribute to that. But those numbers are out there, and that's our experience as well.

Medical Economics: **How will AIMPA work to inform patients and policy makers about the importance of independent medical practices?**

Berggreen, MD: Our focus right now is actually on policy makers. We need to make sure that policy makers are aware that private practice, independent medical practice is alive and well and that we are an integral part of the communities in which we are based, for the patients whom we serve.

We were on Capitol Hill recently talking to multiple members of Congress. We found very receptive audiences. People will say, "Look, these physicians are important, integral members of the medical community and they are shrinking — different rates of contraction among different specialties, but they're under threat. That does not serve the health care system well." We found receptive audiences with policy makers. And it's funny because a question that we got repeatedly from several members of Congress is, "Where have you been? It's great to see an organization that's here, that represents what we've been thinking as well — where's the counterbalance to the hospital systems?" Well, we've been here all along. We'll say that physicians have been slow to organize and slow to mobilize.

And that's historical, right? We're physicians, we're busy taking care of patients in our offices, and then we do other stuff at night, so that's the dynamic. But we have organized and we are mobilizing now and that's to get our message forward to policy makers first, to local community outreach second. We want to let people know that our practices are still here, we still take care of 10 million patients a year. We can even talk to other groups of all specialties, including primary care, to say, this is what we do, and do you feel it's valuable to join us? What we're getting is a lot of yeses. So it's very encouraging. ■

By **Terry Bauer**

Concierge medicine set to soar in 2024

As 2024 begins to unfold, full of uncertainty and shifting tides in just about every industry, health care is no exception. Older physicians are retiring in record numbers, younger doctors searching for a way to avoid moral injury, employed physicians are seeking autonomy and independence, and the promise or peril of artificial intelligence in medicine will remain an ongoing, urgent question. Of this we can be certain: 2024 will be a year of unending change — and a time of exponential growth for concierge medicine, inspired by doctors seizing the opportunity to forge deeper connections and align their priorities in a post-pandemic world.

This begins with the first wave of concierge physicians, soon ready to retire and looking for worthy successors to care for their valued patients. True pioneers in breaking through the barriers of traditional, fee-for-service medicine later in their career, they were able to extend their years in practice with the more measured and maintainable pace of the Specialdocs concierge model. When I joined Specialdocs almost a decade ago, the average age of our affiliated concierge doctors was 62 for men, 52 for women.

Coming up is a generation not willing to wait; now the average age at conversion is 51 for male physicians and 41 for females. In fact, several of our affiliated physicians are still in their 30s. The impact will be profound, opening the doors to physicians who will thankfully never endure the all-too-common experience of burnout, forced by a dysfunctional health care system to make choices not always in the best interests of their patients. As Specialdocs client Dr. John M. realized at age 37: "I'm only human. I wish I could provide the most in-depth care possible to as many people as possible. But I've come to terms with the fact that we are all limited to a certain bandwidth, or it becomes unsustainable." Converting to concierge medicine early on will bring him enormous satisfaction professionally and personally for decades to come, and benefit his patients with remarkable care and attention.

> "ON THE HORIZON IS HARNESSING AI'S PREDICTIVE POWERS TO IDENTIFY EFFECTIVE MEDICATIONS, EXPEDITE DIAGNOSES, AND ENABLE EARLY, LIFE-SAVING INTERVENTIONS FOR PATIENTS AT HIGH RISK."

Also increasingly drawn to concierge medicine are hospital-employed physicians, burdened by overwhelming administrative tasks and patient volume demands. A client who recently joined a successful concierge practice after 15 years as a hospital employee said: "I was frustrated, always figuring out how to care for a challenging patient at the moment of the appointment, with no time to prepare beforehand or follow up afterward. With time now to do both, I'm finding those patients are not really challenging at all."

Where does AI fit into our year of change? Vividly described by Google CEO Sundar Pichai as "probably the most important thing humanity has worked on," AI is already starting to streamline time-intensive administrative and insurance management tasks for physician offices. On the horizon is harnessing AI's predictive powers to identify effective medications, expedite diagnoses, and enable early, life-saving interventions for patients at high risk. Not coincidentally, AI's evolution will likely be impelled by younger, more tech-savvy concierge physicians, who will have the time and inclination to explore and adopt its most useful capabilities. Promising indeed, but I believe that AI's most important contribution will align perfectly with the enduring mission of concierge medicine: restoring time for physicians to provide care grounded in the irreplaceable long-term connection with their patients.

I encourage you to learn more in 2024 about the rewards of practicing medicine in the best way possible — your way. ■

Terry Bauer is CEO of Specialdocs Consultants, a pioneer in concierge medicine management services that has transformed physicians' professional lives since 2002.

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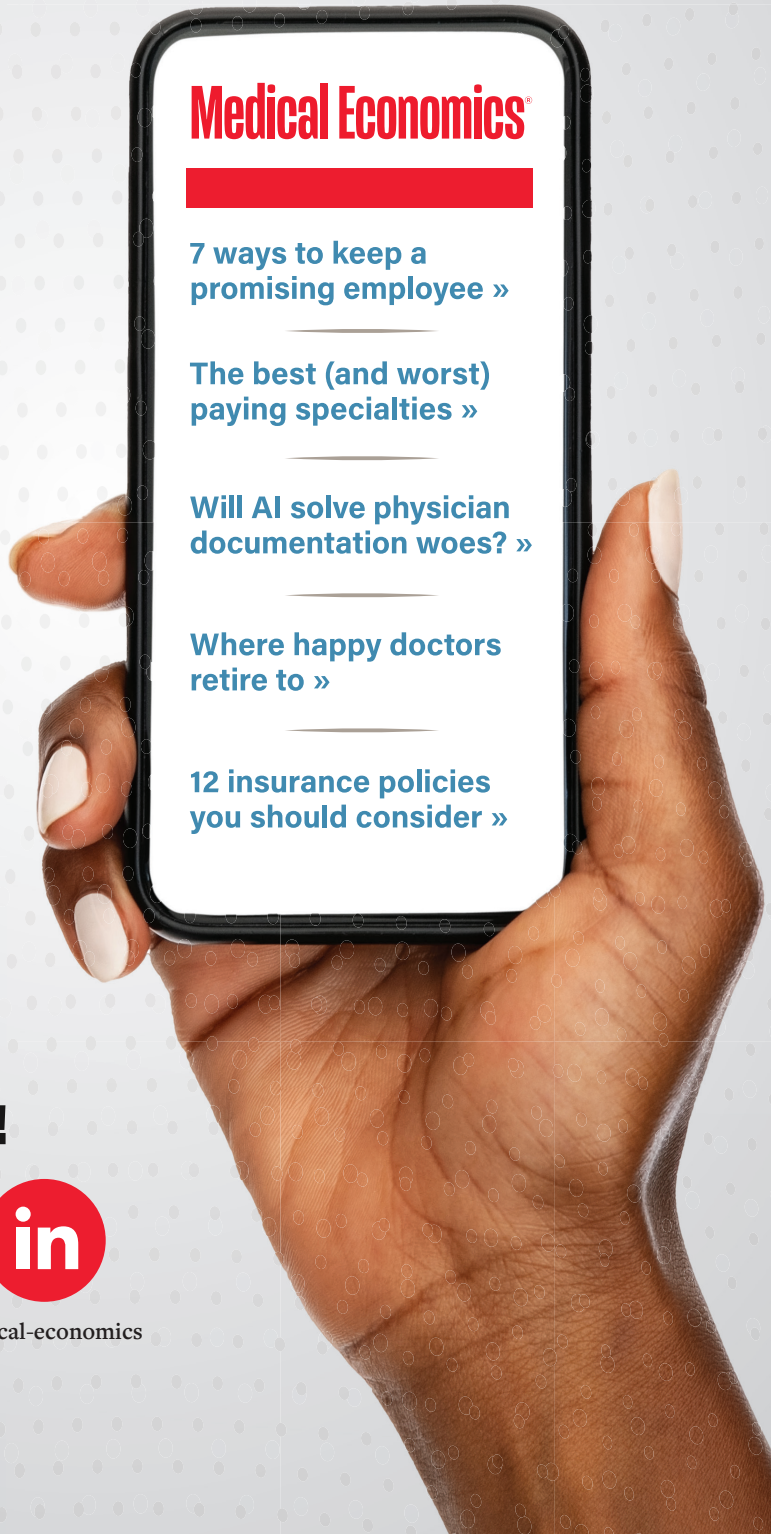

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New language access requirements: What practices need to know Page 30

How captive insurance safeguards patient privacy in medical practices

By **Christopher Gallo,** contributing author

If your medical practice has experienced a data breach or ransomware attack, you're not alone. In today's digital age, it's a growing and relentless threat in the health care sector. The health care industry experienced 295 breaches in the first half of 2023 alone, impacting millions of patients, according to the U.S. Department of Health and Human Services Office for Civil Rights. Even more concerning, ransomware attacks continue to disrupt patient care, with nearly half of health information technology professionals reporting such incidents in a recent survey by the Ponemon Institute.

The impact on small to midsize private practices

These breaches have far-reaching consequences, particularly for small to midsize private medical practices. Unlike larger institutions, these practices often operate with limited financial resources. When faced with the costs of a data breach, which include patient notifications, legal fees, and potential fines, a small or midsize practice can struggle to maintain the quality of patient care.

Furthermore, if you run a practice such as this, you're likely aware that the nature of smaller practices means that trust is paramount. Patients rely on the close relationships they have with their health care providers. A data breach can shatter that trust, leading to patient attrition and tarnishing the practice's hard-earned reputation.

Operational disruption is another challenge. Data breaches divert staff resources to breach response, affecting both patient care and administrative functions. Implementing robust cybersecurity measures and recovering from a breach can also be financially burdensome, especially for practices without the resources to invest in technology and staff training.

Navigating the regulatory landscape

Beyond the immediate financial strains, data breaches can result in costly lawsuits from affected patients, adding legal burdens to the mix. Compliance with regulations, notably the Health Insurance Portability and Accountability Act (HIPAA) and state laws, is paramount, necessitating robust policies to protect patient information and report breaches promptly. The financial impact of noncompliance can be crippling, with substantial fines levied against practices that fail to meet regulatory requirements. These challenges underscore the critical importance of proactive data security measures and a thorough understanding of the ever-evolving landscape of data privacy regulations for such practices.

The role of captive insurance

To effectively address cybersecurity, medical practices need a robust approach to addressing and mitigating this risk that includes a comprehensive set of tactics. Captive insurance emerges as a powerful tool to address the risk and prepare for financial fallout should the risk come to fruition.

Captive insurance is a risk management strategy that involves the creation of a specialized insurance company, known as a "captive," to provide coverage for the unique risks faced by a specific group of affiliated companies or organizations. In

the context of small and midsize private medical practices, captive insurance can offer significant benefits for data privacy and security.

These practices often handle sensitive patient information and are increasingly vulnerable to data breaches and cyberattacks. By establishing a captive insurance company, these health care providers can tailor insurance policies to address their specific cybersecurity and data privacy needs. This customization allows them to ensure that they have adequate coverage for potential data breaches and related liabilities, reducing financial exposure.

Moreover, captive insurance can incentivize better data security practices within the organization, as lower claims can lead to reduced insurance costs over time. Ultimately, captive insurance empowers small and midsize medical practices to proactively protect patient data and safeguard their financial stability in the face of evolving cybersecurity threats.

These are the specific ways a captive insurance company can aid a practice that has experienced a breach:

Data recovery and restoration expenses: Coverage for expenses related to data recovery and restoration helps practices recover quickly after a breach.

Legal and regulatory fines and penalties: Captive insurance can include coverage for fines and penalties resulting from regulatory violations, including those related to HIPAA.

Notification and credit monitoring services: Offering notification and credit monitoring services demonstrates a commitment to patient care and protection.

Reputational damage control: Reputation management coverage helps practices rebuild patient trust and their community reputation.

"In an era where data is not just a valuable asset, but also a critical element of patient care, protecting it has never been more essential."

Customized coverage: Captive insurance policies are tailored to an organization's specific data privacy needs, ensuring comprehensive protection.

Financial resilience: Captive insurance serves as a financial cushion that enables businesses to navigate the aftermath of a data breach without crippling financial strain.

Captive insurance in action

While the types of coverage and financial protection listed above probably all sound helpful, let's look at an example of how this works to illustrate the impact. We'll use a hypothetical practice called CIC Services Family Medicine — a midsize private family medicine clinic serving a suburban community.

In mid-2023, CIC Services Family Medicine experienced a data breach when a cybercriminal exploited a vulnerability in its outdated electronic health record system. The breach exposed sensitive patient information, affecting hundreds of patients.

The impact:

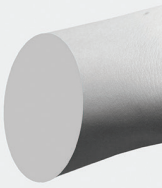
- The clinic faced HIPAA penalties, resulting in a significant financial burden.
- Losses from the disruption of day-to-day operations were substantial.
- Trust and reputation damage led to a decline in patients.
- The clinic incurred substantial expenses from hiring a cybersecurity team and legal fees.

How a captive insurance company would have helped:

- The clinic would have had a dedicated source of funds through its captive insurance program to cover breach-related expenses, minimizing immediate financial strain.
- With the financial support of captive insurance, the clinic could have maintained its operations more effectively during the breach response, minimizing disruptions to patient care.
- Captive insurance would have provided funds for legal support and reputation management.

In an era where data is not just a valuable asset, but also a critical element of patient care, protecting it has never been more essential. As the health care sector evolves to meet the challenges of the digital age, practices that embrace innovative risk management tools like captive insurance can better defend patient data and preserve the trust and well-being of their communities. Captive insurance offers financial resilience and customized coverage, ensuring that smaller practices can navigate the complexities of data breaches and regulatory compliance while maintaining their commitment to patient care. ■

Christopher Gallo spent his career in risk management as a regulator with the Connecticut Insurance Department. He has taken the lessons learned from over three decades to improve risk-mitigating strategies for businesses. After retiring from his regulatory career, he joined CIC Services in 2020 and consults directly with business owners, CEOs and CFOs in the formation of captive insurance programs and as a regulatory liaison for their respective businesses.



Major changes are coming to language access requirements in 2024

In 2024, health care organizations will need to intensify their efforts to reduce disparities and advance equity for the diverse populations they serve. It's not only the right thing to do, it's required for compliance with federal regulations and it makes great business sense too.

Because 68 million Americans speak a language other than English at home, interpretation and translation services are essential to expand access, boost engagement, improve outcomes and elevate the patient experience.

As a language services professional who works with health care organizations nationwide, I would like to offer some considerations for health equity, language services and marketing leaders to keep in mind when planning for the year ahead:

A new rule will strengthen discrimination prohibitions

The top compliance headline for 2024 is that the U.S. Department of Health and Human Services may publish its final rule strengthening Section 1557 of the Affordable Care Act. This section prohibits discrimination in hospitals, clinics, physician practices, pharmacies, nursing facilities and other health care settings.

While the final rule is still pending, organizations can prepare by taking steps to comply with the proposed rule, which was published on Aug. 4, 2022. It differs from earlier interpretations of Section 1557 in its description of the reasonable steps health care organizations must take to provide meaningful access to individuals with limited English proficiency (LEP). Among the notable updates are requirements for organizations to: Create effective language access procedures with:

- Explanations of how the organization identifies individuals with LEP.
- Instructions for workers to engage qualified translators and interpreters.
- A list of translated materials and their locations.

Note: Earlier rulings on Section 1557 required organizations to create formal language access plans. The new rule encourages, but does not require, the creation of a formal plan.

- Appoint a Section 1557 coordinator to implement and oversee language access procedures.
- Train relevant staff on language access procedures.
- Provide qualified interpreters and translators for each person with LEP who is served or affected by a health care service.
- Post notices about the availability of qualified interpreters, translated documents and accessible formats (such as large print, Braille or audio) in the user's preferred language.
- Ensure, as a minimum standard, that qualified human translators review machine-translated materials whenever accuracy is essential or the source material contains complex or technical language.

Note: The proposed rule addresses several potential use cases for machine translation.

Organizations that use this technology should review those provisions closely.

It's also important for health care organizations to be aware that the proposed rule permits a bilingual staff member or other adult who is not a qualified interpreter, or a minor child, to facilitate communication with a patient with LEP only in very specific and limited situations.

Competitive pressures that drive focus on access and equity

As government payers continue to raise standards for health equity in Medicare and Medicaid, health plans are also intensely competing for increasingly diverse populations who are covered through individual insurance marketplaces and employer-sponsored plans.

For example, the Commonwealth Fund recently published research that highlights equity strategies of marketplaces for individual health insurance plans in California, Connecticut, the District of Columbia and Massachusetts. These marketplaces are collecting race and ethnicity data, requiring insurers to achieve health equity accreditation from the National Committee for Quality Assurance, designing plans

to meet the needs of people of color and pursuing strategies to ensure that enrollees can use their plans and receive equitable care.

The work that government entities and other purchasers are driving through their health plans will inevitably impact provider organizations, most likely surfacing during contract negotiations. Health plans are under pressure to improve access to in-language communications as part of the product and service experience and to demonstrate how these efforts create a return on investment. Where the health plans go, provider organizations must be prepared to follow.

Economic forces are driving a focus on measurement and outcomes

Providing quality health care is costly and budgets often are stretched thin across numerous priorities. This is especially true in our post-pandemic world. Trying to do more with less is always a concern, but it would be shortsighted to view language services as just another expense to be trimmed. Over time, language services can elevate the patient experience while yielding cost savings. For example:

- Language access fosters trust. When patients communicate in their native language, they're more likely to share vital details about their health and get better outcomes.
- Competent interpretation and translation contribute to accurate diagnoses and appropriate treatment plans. This helps reduce complications and costly readmissions.
- Patients who feel heard and understood are more likely to adhere to treatment plans and keep follow-up appointments.
- Feedback from patients with LEP yields valuable insights for continuously improving language services and, by extension, the overall patient experience.

As organizations shift from taking reactive, compliance-oriented stances around language services to proactively striving for better outcomes and experiences, more sophisticated measurement strategies will naturally come to the forefront. For many, the current measure of success is timely availability of interpreter services and required document translations. Obviously, these are important, but they should be viewed as the floor rather than the ceiling.

It's heartening to see more organizations measuring the value of language services with metrics like call center volumes, traffic to linguistically and culturally appropriate web pages, and attendance at events that are promoted and delivered in languages other than English.

Language access is critical

Language access and health equity are intrinsically connected. With the richness of linguistic and cultural diversity in our country today, the stakes have never been higher.

Compliance, competition and budgetary factors will have an impact on how health care organizations address language differences in 2024 and beyond. To achieve an equitable health care landscape, a relentless commitment to understanding, respect and inclusion is essential. Partnering with a full-service language services provider may help organizations get up to speed on the nuances faster, as well as identify and implement best practices. ■

Leslie Iburg is director of health care accounts at United Language Group.

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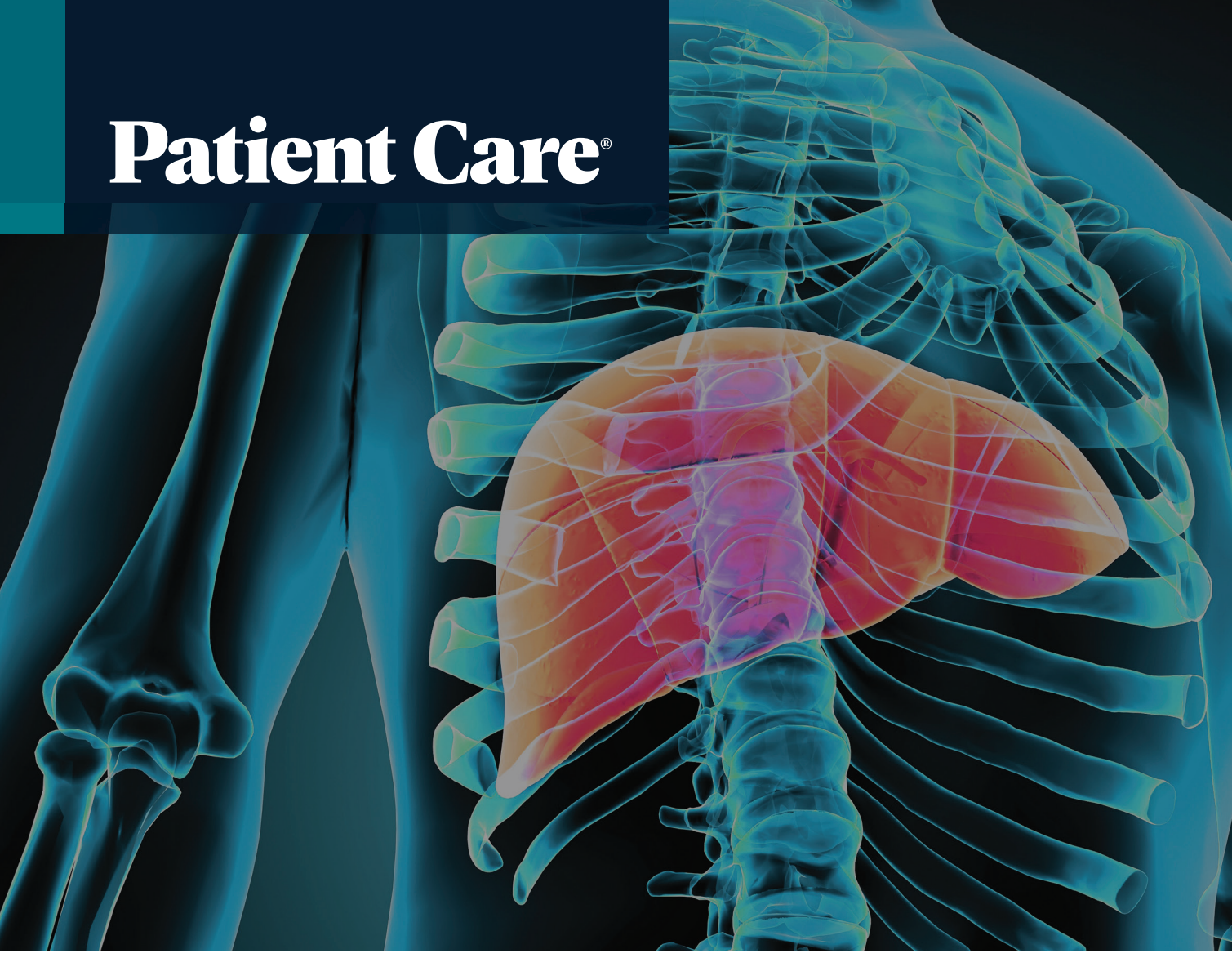

The Liver Meeting 2023, Boston

How to change the course of chronic liver disease

By **Grace Halsey,** Senior Editor

"Change the course of chronic liver disease by creating total health care system collaboration around early mitigation and management to reduce its progression, stigma, morbidity, and mortality, and the inequities in patient care."

This was the vision statement penned by members of a group of thought leaders on chronic liver disease (CLD) from a variety of clinical specialties whose goal was to "identify and explore opportunities to create a 'groundswell' of awareness" around the growing clinical burden of and challenges associated with treating patients with CLD.

Several of the eight members of the working group gathered at The Liver Meeting 2023 in Boston in November for a presentation titled "Changing the Course of CLD — Multidisciplinary Working Group: Initial Recommendations for a Groundswell Movement." Their goals were, first, to ground the working group's efforts in stark data on the rapid and disturbing rise of chronic liver disease and its sequelae in the US; second, to advocate for the essential contribution of the

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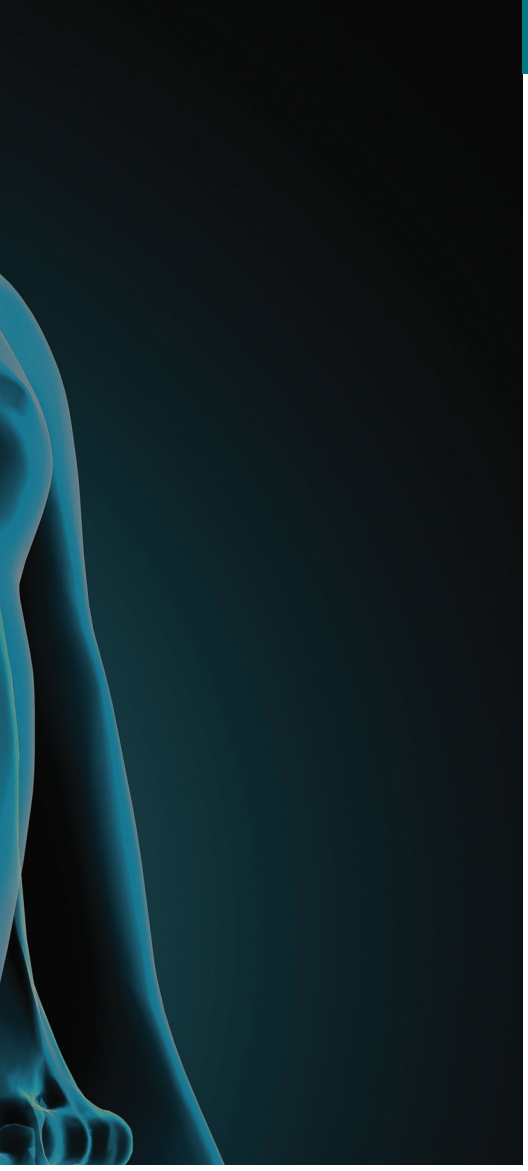


patient's voice in any solution; and third, to share the top-line takeaways from the working group's investigation and introduce its initial recommendations for support from stakeholder organizations to move US health care toward realizing the group's vision.

The Liver Health Annual Trends Report

After an increase of 9% from 2020 to 2021, CLD and hepatic cirrhosis became the ninth leading cause of death in the United States, according to Nancy Reau, MD. She added that CLD-related mortality could potentially triple by the end of the decade and that fatty liver disease-associated cancer has "now eclipsed cancer from all other etiologies for liver transplant in the U.S." During the presentation, Reau, a professor of internal medicine at RUSH Medical College, associate director of solid organ transplantation and section chief of hepatology at RUSH University Medical Center in Chicago, and a member of the working group, walked through other barbed findings from the Liver Health Annual Trends Report, a research effort sponsored by Salix Pharmaceuticals, now in its third year. Key among them, and central to the focus of the working group, she explained, are the significant racial and ethnic disparities in the population with nonalcoholic fatty liver disease, where the burden is highest and growing fastest among Hispanic individuals; the prevalence is estimated to be 1 in 4.

Shortages of specialists and limited access to specialty care for CLD and even to primary care in many rural communities contribute to the disproportionate penetration of the disease and to the trends toward more advanced morbidity and mortality, Reau said. Based on these and related findings around inequities in CLD care access and treatment, the significant role of disparities "is going to have to be part of the conversation" about how to improve patient outcomes if there is to be measurable success, according to Reau.

Low awareness of and comfort with clinical guidelines

Another of the report's disappointing findings, and a topic that the speakers returned to multiple times during the presentation, is the poor awareness among clinicians of national guidelines for screening and management of CLD. This includes approximately half of primary care clinicians, Reau said, adding that "56% of our guideline users are not sure how to translate the information that they have been given into daily practice," which is an increase over 2022's response of a dismaying 332%, she commented. A professional society clinical guideline should be a simple tool that offers an "awesome care cascade" that translates into evidence-based care for patients with CLD, Reau said. But "there is still a disconnect between the information we think we are giving to them and how that information is being used," she said.

Reau also pointed out increases over 2022's findings in the importance to survey respondents of using "third-party guidelines," which means that care will be inconsistent, geographically and potentially between specialties. Liver disease information and resources in electronic health records (EHRs), such as a liver disease order set, are either insufficient or nonexistent, according to the report; 72% of respondents said the former had become even more important year over year and 40% said the same about the order set, she said. All these deficits in practice-based resources throw up additional and more significant barriers to an appropriate care pathway for vulnerable patients, she said. These clinicians serve as the primary portal to the health care system for a person with fatty liver disease, Reau emphasized, and they have myriad boxes to check during their time-limited patient encounters—they need tools that are ready at hand and easy to use.

That need for simple navigation is equally essential for patients, Reau said. As care providers, "we need them to understand our recommendations and to believe that following them will be effective, will change their health, or they are not going to engage. We are obligated to help our patients navigate their care, not to dictate their care," she said.

Reau then turned over the podium to Larry Holden, chief operating officer of the Global Liver Institute, a patient advocacy

organization, and also a member of the working group, for an examination of the patient's perspective.

The 'pipeline to death'

"How do we get patients out of this pipeline to death?" Larry Holden asked the room full of clinicians who treat patients with CLD. The pipeline, i.e., the trajectory of undiagnosed, untreated or undertreated CLD, is where patients with CLD are relegated when they do not or cannot access care for CLD, no matter the stage of illness. Holden expressed his gratitude to sponsor the Liver Health Annual Trends Report for ensuring that patients' voices were of equal volume to health care professionals' voices in the effort to "change the course of CLD." Six patients with liver disease of various etiologies representing patient advocacy groups answered the question, "What do you want from the medical community?" Holden expressed the more personal spirit of the question, which he said is, "What is stopping you from getting this care?" He also summarized the patient consensus:

"Patients are hopeful that the medical community will act as advocates [for] people living with liver disease and address the personal and structural stigma that prevents early disease detection and optimal disease state management."

Holden pointed to an underappreciated but prevalent patient barrier to timely diagnosis of and treatment for CLD: social stigma associated with the disease. The first recommendation from the working group for ways stakeholders can support the final vision is to reduce the stigma and treatment inequities of patients with CLD. They feel it within their communities, fearing that others will associate a diagnosis of liver disease with excessive alcohol consumption or drug use, Holden said, and in the Liver Health Annual Trends Report, patients agreed that they sometimes felt the shadow of stigma when meeting with their health care team. The cumulative effects of the difficult symptoms of CLD, the sense of barriers to effective care and the lack of strong social support are associated with "depression ... and a decrease in the tendency to seek health care," Holden emphasized. Interventions are needed to stop the "stacking effect" of negative experiences, preferably before it begins, he noted.

Working group takeaways

1. A large number of **patients with chronic liver disease (CLD) go undiagnosed and/or do not receive proper treatment** until they begin to experience liver decompensation.
2. **CLD needs to be a priority for a broader group of specialists** beyond hepatologists and gastroenterologists.
3. Changing the awareness, diagnosis and management of CLD needs to **involve a comprehensive approach across multiple care settings,** such as primary care, tertiary care centers, emergency departments, cardiology, endocrinology, etc.
4. **Reducing the stigma and treatment inequities is critical** to achieving the other four imperatives.
5. There is no one big solution; sustainable **change will result from incremental actions taken by multiple specialties, societies and systems.**

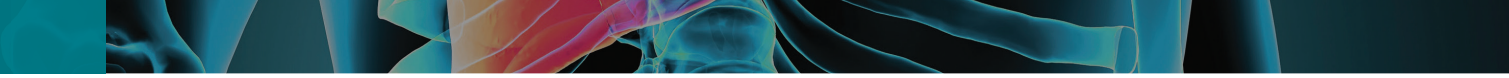
Recommendations of the working group

Bruce A. Luxon, MD, PhD, capped the presentation with the final recommendations put forth by the multidisciplinary working group. Luxon, professor of medicine and the Anton and Margaret Fuisz Chair in Medicine at Georgetown University and chair of medicine and chief physician at MedStar Georgetown University Hospital in Washington, D.C., opened with 5 key takeaways from the working group process (**Sidebar**).

He then added specifics to the recommendations for stakeholder organization support:

1. Reduce the stigma and treatment inequities of patients with CLD.

Beginning with the language used to talk about underlying causes of



CLD, the group suggests that terms such as "obesity," "drug use," "alcoholism" be referred to as diseases vs the implied negative behavioral connotations. They emphasize that the new liver disease nomenclature be put into practice immediately. The group encourages thought leaders in the field to begin using MASLD vs NAFLD, and MASH vs NASH when writing, presenting, creating video recordings, etc., and urges organizations to engage in active promotion of the changes and their meaning. The EHR, a tool clinicians use all day every day, can be used to standardize care, the group states, regardless of the cause of disease or individual lifestyle choices. Once a patient reaches decompensation, Luxon said, the clinical consequences will be similar.

Luxon emphasized that health care professionals need to be aware of their own personal biases about liver disease and about patients with CLD. The working group recommends that organizations develop questionnaires for health care practitioners (HCPs) to uncover implicit bias. The findings can be used for raising awareness and creating educational resources.

2. Increase awareness of the need for earlier diagnosis and optimal treatment of patients with CLD.

Use media of all types, the group suggests, to increase awareness among HCPs of early signs and symptoms of CLD. Identify specific specialties as priority targets for education and then design materials that will "capture interest in and commitment to earlier identification of CLD." An example is a webinar for cardiologists that focuses on the importance of cardiometabolic disease in NASH/MASH etiology. For gastroenterologists, endocrinologists, primary care clinicians and OB/GYNs, find out how to specifically engage all HCPs who have an opportunity to move patients to the next step or to help link them with HCPs who can. Within an organization, expert working groups can be invaluable for developing communications, hosting in-service and grand rounds sessions and deploying other grassroots awareness campaigns.

> **"Patients are hopeful that the medical community will act as advocates [for] people living with liver disease and address the personal and structural stigma that prevents early disease detection and optimal disease state management."**

3. Develop simple-to-use, specialty-specific CLD guidance.

Add to the myriad "catchy" and effective acronyms that help guide disease diagnosis in clinical settings, the working group recommends, based on American Association for the Study of Liver Diseases guidelines. Promote the acronyms to primary care, emergency medicine and other specialties where early signs of CLD may be missed. Critical to stemming the tide of disease progression, Luxon emphasized, is a focused effort to improve care transitions, an effort that will require facilitating cooperation between CLD stakeholders (physician specialties, payers IDN, etc.), at a regional level.

4. Adopt specialty-specific CLD guidance into clinical decision-making.

Ensure that new guidance reaches intended audiences along with education on how to incorporate new features, methods, perceptions and behaviors into daily clinical practice. Luxon and his working group colleagues refer to tools used to create awareness for early disease recognition, such as continuing medical education programs, thought leader presentations, EHR capabilities, etc.

5. Measure the results of programs implemented in this effort.

The working group recommends surveying organization members and measuring changes in patient outcomes in organizations that have created and deployed programs aligned with this effort. ■

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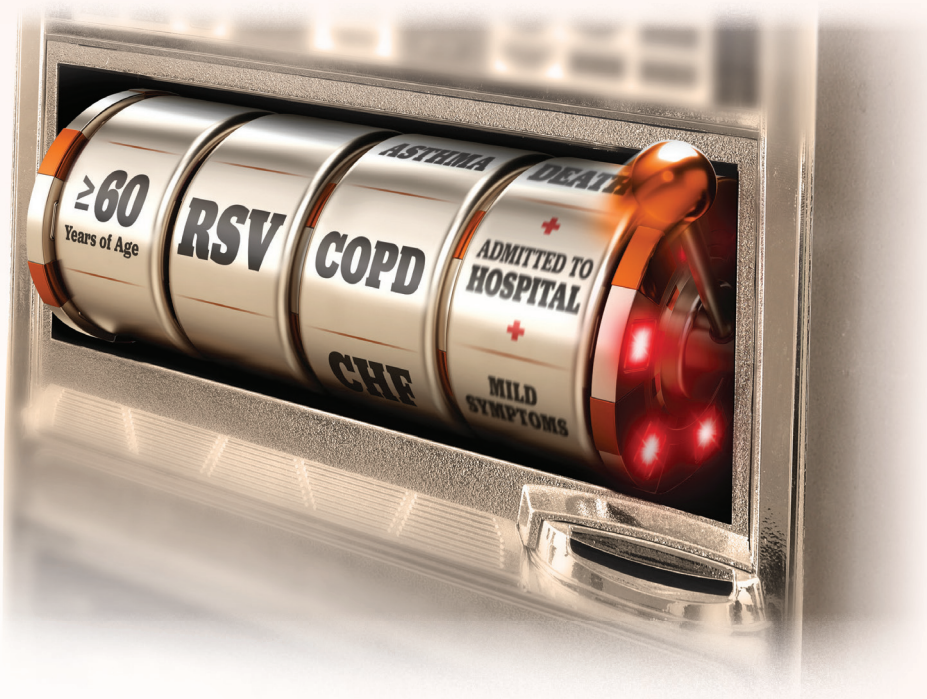
Check out the entire program at:

https://www.patientcareonline.com/conference/aasld

RSV MAY RAISE THE STAKES FOR OLDER ADULTS



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

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

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

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

References:
1. Mesa-Frias M, Rossi C, Emond B, et al. Incidence and economic burden of respiratory syncytial virus among adults in the United States: a retrospective analysis using 2 insurance claims databases. *J Manag Care Spec Pharm*. 2022;28(7):753-765. doi:10.18553/jmcp.2022.21459 **2.** Older adults are at high risk for severe RSV infection. Centers for Disease Control and Prevention. Accessed June 23, 2022. https://www.cdc.gov/rsv/high-risk/older-adults.html **3.** Tseng HF, Sy LS, Ackerson B, et al. Severe morbidity and short- and mid- to long-term mortality in older adults hospitalized with respiratory syncytial virus infection. *J Infect Dis*. 2020;222(8):1298-1310. doi:10.1093/infdis/jiaa361 **4.** Belongia EA, King JP, Kieke BA, et al. Clinical features, severity, and incidence of RSV illness during 12 consecutive seasons in a community cohort of adults ≥60 years old. *Open Forum Infect Dis*. 2018;5(12):ofy316. doi:10.1093/ofid/ofy316

Learn about the risks of RSV at RSVinAdults.com