PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

SUMMER 2023 | VOL 33 | NO.3

THE BUSINESS OF MEDICINE

TMLT
Texas Medical Liability Trust

Travis County Medical Society

TMLT and Travis CMS team up to expand the Safe Harbor Counseling Program

Safe Harbor was created to help clear the roadblocks many physicians face when seeking help for a mental health issue. The program provides a limited number of confidential counseling sessions to physicians.

TMLT will pay for up to four visits with the Travis CMS network of counselors for any policyholder (four visits for policyholder and four visits for spouse/partner).

Counseling sessions are conducted by Travis CMS-vetted, doctorate-level counselors. The sessions are not reportable; no diagnosis is made; no insurance is billed. There is no identifying information shared between TMLT, the counselors, and the Travis CMS Wellness Program.

You will have access to this program when your policy renews beginning in May 2023.

Travis CMS Safe Harbor Counseling Program
Available through a partnership with TMLT

Access the program at
www.tmlt.org/wellness


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CONTENTS – The Business of Medicine

On The Cover: ***Patio Pots*** by Marsha Clements

PANHANDLE HEALTH is published quarterly by the Potter-Randall County Medical Society, (806) 355-6854. Subscription price is $12.00 per year. POSTMAN: Send address changes to PANHANDLE HEALTH, 1721 Hagy, Amarillo, Texas 79106. ISSN 2162-7142

PHOTOCOMPOSITION AND PRINTING BY COLORART-AMARILLO.

President's Message

by Nicole Lopez, MD, FAAFP

As summer ushers in, I look forward to longer days and warmer weather. I welcome getting home with extra hours of daylight to go on leisurely walks with the dog or work in the garden. In private practice, I often spent many hours after clinic closed working on my charts. After the implementation of our Electronic Health Record, it felt like every year I had more charting responsibilities. Administrative burdens seemed to bear down even more heavily with the implementation of new ICD-10 codes, prior authorizations and patient portals.

As a family physician, I was already skilled in offering preventative medicine services and screenings, and I accepted the additional documentation requirements that our clinic had selected to achieve our quality measures. I still enjoy my role in helping to keep my patients healthy and developing long term relationships with them.

Physicians are free to choose whether they would like to enter solo practice, group practice, direct patient care or employment by a hospital-based system. I have worked in a small group practice, a hospital-based practice and an academic practice. In more recent years, I have served as clinic medical director in addition to seeing patients and have learned much about the business of medicine. I am appreciative of the team of dedicated nurses, janitors who keep our clinic clean, patient support staff, billers and administrators who make our office run. Clinic work-flows, never-empty task boxes, refill requests, and lab orders and follow-ups are woven into the day, in addition to providing medical care.

At the Texas Academy of Family Physicians interim business meeting this past April, I had the opportunity to meet with family physicians across Texas and discuss ideas and solutions related to ways to reduce administrative burden for physicians. The TMA is continuing to support legislation in Texas for improving eligibility for the Gold card for prior authorizations, improving access and coverage for postpartum mothers, supporting graduate medical education, and fostering physician well-being. I am encouraged by this movement to support individuals who work in healthcare settings in the Texas Panhandle, and I am appreciative of our editorial team for seeking to educate us on the business of medicine.

Our Next Issue Of *Panhandle Health* Features:

Resurgence of Old Diseases

Guest Editorial: The Practice of Medicine

by Rouzbeh Kordestani, MD, MPH

I was honored when asked to participate as the Guest Editor for the summer issue of Panhandle Health. I say that because, like many previously young physician/surgeons, I felt a pride in starting a practice to offer my skills to the people of the Panhandle. However, as I have lived through the changes in the last 20 years, I can admit and confess that it has been a challenge.

To say that "The Practice of Medicine" has become complex is truly an understatement. When I began my practice in Amarillo about 20 years ago, our focus was very much on patient care, and we had a cordial relationship with the hospitals and the facilities. Now, practically nothing is recognizable. The focus on profit has changed practice within our hospitals. Somewhat similarly, the insurance companies now routinely block patient care and access. Since COVID, they have become less accessible and friendly and, in fact, far more adversarial. In some cases, the deductible(s) for patients and their health plans have become so high that many patients have insurance in name only, with no true coverage. For many, it is difficult to have the basics of life AND also to afford their medications. To add to this picture, we now experience economic difficulties where living costs are increasing weekly while paychecks for patients have gone static. In this environment, the practice of medicine has become far more difficult. Many practices have simply given up. Others have decided to relegate their management to the corporate structure and simply to focus on trying to survive. Because of the cost of running a practice and because of the lack of capable personnel, some practices have simply shuttered and their physicians have retired. With all of these changes, it is at times difficult to look to the future with hope.

Even though challenges exist, the practice and the art of medicine still offer a truly life-changing experience to those willing to take the leap. I have pondered many a time about what I would do if I were not a physician/surgeon. As I get older, I have a harder time thinking of myself as anything but a surgeon. Once you feel that you have made a difference in people's lives, it is hard to change the course of your life path. Please do not misunderstand. In my practice, I face challenges daily that rattle me to my core. However, I feel strengthened in the realization that I am by my patients as they move forward in their health struggles. I feel that I have purpose.

The intent of this issue is first to educate us about the history of insurance, third party payors, and how it applies to the practice of modern medicine. We will then attempt to educate the younger members of our community about the pitfalls and the concerns of setting up and succeeding in a medical/surgical practice. This will involve pearls on how to weather the "insurance game". We will then try to further educate our readers about the different types of practice--solo, group or corporate--and their advantages and disadvantages (including the ACOs). And, last but not least, there needs to be a discussion for all of us (myself included) considering when to think about retirement and the steps needed to make that a reality both for the physician, their practice, and their patients.

The practice of medicine is hard. But most things that are valuable in life come with a price. I for one am very happy I became a physician. I feel honored and privileged for the opportunity. For our younger members, this journal will hopefully act as a framework/guidebook for your initial steps as you take the leap. I for one welcome you with open arms to "The Show"…

PRCMSA: At The Power of the Purse Luncheon

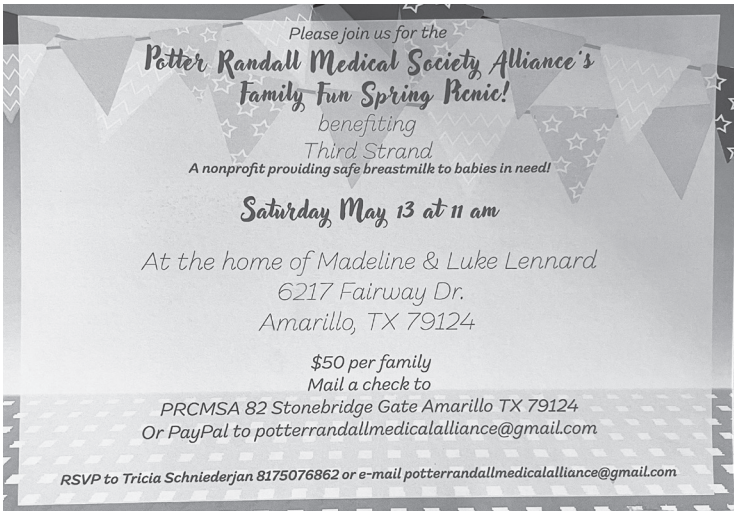
by Tricia Schniederjan

On April 13th, the Alliance was proud to support the Laura W. Bush Insitute for Women's Health by purchasing a table to The Power of the Purse Luncheon.

The Alliance also put on the Family Fun Spring Picnic on May 13th.

Don't forget to renew your membership to the Potter-Randall County Medical Society Alliance!

(this event has already occured)



The History of Medicare

by Rouzbeh Kordestani, MD, MPH

On July 30th, 1965, Lyndon Johnson signed into law the Medicare Bill. With its signing, the United States for the first time chose to extend health care insurance to the elderly (above 65) and the unemployed poor. Prior to the enactment of this law, no such coverage existed. Unlike most industrialized nations, the United States did not guarantee access to health care for all of its population. In the United States, until the signing of the law, employers were the major providers of health insurance to their employees and their dependents. This, or course, left a significant portion of the population without coverage.

The initial push for the enactment of health benefits for the population at large was started by President Franklin Roosevelt in 1935. Unfortunately, the idea was thought to be too unpopular. For this reason, when President Roosevelt signed the Social Security Act into law in 1935, medical benefits were specifically left out of the bill. President Harry Truman, too, was concerned about the lack of appropriate health coverage. However, he was concerned for a different reason. President Truman was alarmed by the number of draftees during World War II who failed their induction physicals. It became painfully clear to him that the general state of health of the country was poor. Furthermore, it meant that the average citizen could not afford visiting the doctor to maintain his or her health. In response to this situation, President Truman advocated comprehensive health coverage. In 1945, he pushed forward his first proposal providing for health insurance coverage for working-age Americans and their families. This first proposal was defeated soundly by different interest groups, the largest of which was the American Medical Association (AMA), which branded the president's plan as "socialized medicine," making full use of the stigma associated with Russia and communism. Additional proposals followed. Even though President Truman was able to bring the issue to the forefront of the national discussion, he was not able to pass any of his comprehensive health agenda.

Like President Truman, President Eisenhower had a vested interest in a coherent and expanded medical care system. However, in the post World War II years, the focus was directed more towards outside threats than domestic concerns. During the Eisenhower presidency, the House Ways and Means Committee was created and was given, amongst its many tasks, the issue of health care. The members of the original committee, mostly Republicans and Southern Democrats, however, were not in favor of a comprehensive health care law. For this reason, there was little change in sentiment or action until President Johnson took office.

In 1964, in the aftermath of the Kennedy assassination, President Lyndon B. Johnson was elected into office in a sweeping landslide. With a great deal of political capital gained, President Johnson was able to place the issue of health care once again in the forefront of his agenda. It was a part of his "Great Society" initiative. More importantly, the Democratic Party now controlled both houses of Congress and the Presidency. Along with this, more progressive members from both parties sat on the Ways and Means Committee. These factors combined to allow for favorable consideration of the new health coverage agenda.

One of the champions of the cause of expanded health care was the Chairman of the House Ways and Means Committee, Wilbur Mills (Democrat-Arkansas). He helped to decide between the three different pieces of legislation that were put forth in front of Congress for consideration. The three versions of the bill were sponsored by Rep. John Byrnes (Republican), the AMA (better known as Eldercare), and the administration (better known as Medicare). After much deliberation, the AMA version was rejected. The two remaining versions were combined. This combined bill went through more than five hundred amendments before being passed by both the House and the Senate.

The legislation created two amendments to the Social Security Act of 1935. Title XVIII, which is better known as Medicare Parts A and B, provided for hospital insurance for the aged and for health provider coverage, respectively. Title XIX, which is now known as Medicaid, provided for the states to extend health care to individuals who were at or close to the public assistance level with federal matching funds.

In 1965, President Johnson signed the bill into law, making it Public Law 89-97. He chose to sign the law in Independence, Missouri, at the Truman Presidential Library as a tribute to President Truman's efforts. President Johnson thanked President Truman for "planting the seeds of compassion and duty which have today flowered into care for the sick and serenity for the fearful."

In 1966, President Johnson presented the now elderly and retired President Truman and his wife with the first and second Medicare cards ever printed.

THE SPECIFICS OF THE MEDICARE BILL

In 1965, when Medicare and Medicaid were passed as functional amendments to the Social Security Act of 1935, they were met with much suspicion. However, since its inception, Medicare and Medicaid have done much to ease the fear of the elderly and the poor in regards to their health care needs.

The amendments have specific provisions that have to be considered. **Medicare Part A** covers inpatient hospital stays for ninety days per illness, plus sixty lifetime reserve days. Part A also covers up to 100 days per illness for post-hospital skilled nursing facility care, hospice, and some home health care. Every person eligible for Social Security and over the age of sixty-five is eligible for Medicare Part A. Medicare enrollees are not charged premiums for Part A, but are subject to deductibles and co-insurance fees similar to commercial insurance programs.

Medicare Part B covers physician services and many outpatient hospital, diagnostic, therapy, and ancillary medical services. Medicare Part B is optional, although most Part A enrollees also sign up for Part B. Part B enrollees must pay a monthly insurance premium to CMS and are also subject to deductibles and co-insurance.

Medicare Part C is also known as Medicare Advantage. Part C plans provide Medicare-approved coverage from private companies as an alternative to Original Medicare for health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D. In most cases, enrollees will need to use doctors who are in the plan's network. These plans typically have lower out-of-pocket costs than Original Medicare, but choices of services and providers are limited by the plan. Part C plans may also offer extra benefits that Original Medicare doesn't cover, such as vision, hearing, and dental services.

Medicare Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines). Medicare drug plans are purchased in addition to Original Medicare or included in Medicare Advantage Plans that provide drug coverage. Plans that provide Medicare drug coverage are run by private insurance companies that follow rules set by Medicare. Plans have variable deductibles and specific formularies, and payment amounts are defined by three phases:

Phase 1. Patients must first satisfy a deductible, then they will owe a co-pay for their medications until the spending limit of $4,660 is reached.

Phase 2. At this point, the patient will enter the "donut hole" where the drug plan limits coverage. For 2023, the enrollee will pay no more than 25% of the cost for prescription drugs until out-of-pocket spending reaches $7,400 under the standard drug benefit.

Yes, I Would Like To Contribute To The Potter-Randall County Medical Society Endowment Fund

The endowment fund was established in 1981 to promote the advancement of general education in medical science in Potter and Randall counties through discussion groups, forums, panel lectures, and similar programs. It is the hope of the society that, through the endowment fund, the work of our physicians will be continued by increased public awareness and understanding of the advances in medical science.

We are happy to accept memorials and/or honorariums. Notification of gift is sent immediately. Amount remains confidential. Your contribution is tax deductible. Please make checks payable to Potter-Randall County Medical Society and send to PRCMS, 1721 Hagy, Amarillo, Texas 79106.

Enclosed is my contribution of $_____

Print Name_____

Address _____

City _____ State _____ Zip _____

My gift is in memory of _____ My gift is in honor of _____

Please send acknowledgement of this gift to:

Name _____

Address _____

City _____ State _____ Zip _____

Phase 3. Once the $7400 out-of-pocket limit is reached, the beneficiary enters into the catastrophic coverage phase and medications will only cost a small co-pay for the rest of the year.

If a beneficiary does not want to sign up for a Medicare Advantage plan, they may choose to purchase a Medigap policy. Medigap, or Medicare supplement, plans are extra insurance to pay for all or part of the deductibles, coinsurance, and copayments associated with Original Medicare. They are purchased from private insurance companies. There are ten different types of plans, and consulting an insurance specialist is recommended to navigate what might be the best plan for the individual.

As time has gone on, the Medicare and Medicaid amendments have been expanded to cover home health care needs, hospice, end-stage renal disease, and many other services. In addition, the disabled were brought under the Medicare umbrella in 1972. These additions were mostly due to political pressure. Even though groups have challenged various aspects of the law, no litigant has ever challenged the constitutional basis of the act as a whole.

THE FUTURE OF MEDICARE/ MEDICAID

Medicare costs were $7.7 billion in 1970. By 2000, Medicare spending exceeded $200 billion, and by 2021 the total cost of Medicare services grew to $900.8 billion, accounting for 21% of total National Health Expenditures (NHE). In addition, all NHE grew 2.7% to $4.3 trillion (or $12,914 per person) in 2021 and represented 18.3% of the U.S. Gross Domestic Product (GDP). Experts and economists agree that, at this rate, health care costs and the percentage growth will overshadow the expenditures on defense and cripple the economy. The COVID pandemic also increased NHE. CMS has published the following predictions on the trajectory of NHE over this decade:

- On average over 2021-30, National Health Expenditures (NHE) and Gross Domestic Product (GDP) are both projected to grow 5.1 percent per year; as a result, the projected NHE share of GDP in 2030 (19.6 percent) is predicted to be similar to 2020 (19.7 percent).

- Near-term NHE patterns are significantly influenced by the COVID-19 pandemic. NHE growth in 2021 is projected to have slowed to 4.2 percent (down from 9.7 percent growth in 2020) as federal COVID-19 supplemental funding declined substantially.

- Following the declines observed in 2020, health care utilization is expected to rebound starting in 2021 and to normalize through 2024. By 2024, the government (federal, state & local) share of health spending is expected to fall to 46 percent as COVID-19 supplemental funding is expected to wane, down from an all-time high of 51 percent in 2020.

- The percentage of the population with health insurance is expected to peak in 2022 at 91.1% (mainly due to Medicaid enrollment) before falling back towards pre-pandemic levels as the public health emergency is assumed to end. The 2030 rate is projected to be 90.5%.

- For 2025-2030, factors that typically drive changes in health spending and enrollment, such as economic, demographic, and health-specific factors, are again expected to be the major cost drivers in the health sector.

The concern about cost and expenditures is well-founded. The bit-by-bit addition to the coverage of Medicare/ Medicaid is termed by some as incrementalism. This incrementalism is the point of contention for many as, bit-by-bit, more and more is being placed under the national coverage. This is at the heart of the increase in Medicare/Medicaid cost increases. But, as in 1965, there must be movement for change, and patients and physicians have to be accepting of change for it to occur. How this will impact us is unsure. One thing for certain is that it will have a tremendous impact.

Leaving Residency

Edited and compiled by: Elaine Bruno, DO

INTRODUCTION

Earning the title of doctor takes roughly ninety thousand hours of studying and hard work. Once you have secured the designation of "physician" on paper, you will spend the next three to seven years in residency pursuing board certification in a specialty. Generally, for those seeking a career in primary care, the first two and a half years of residency are structured for your success and advancement. However, in your third year of residency, as you head towards the end of organized training, there is a sudden realization that, in a few months, you'll need to start practicing medicine on your own, which means finding a job.

There is little guidance when searching for jobs as a third-year resident, and most advice is by word of mouth. In addition, there is minimal instruction on how to filter the inundation of emails from recruiters across the country looking to fill positions. The decisions on how to look for jobs, who to network with, and how to evaluate contracts can be overwhelming. This article aims to relieve some of the stress when starting the job search and to provide up-and-coming third years with a field guide for securing positions in primary care.

Below is the compiled advice from recently graduated and soon-to-graduate residents who have successfully landed jobs in primary care. The individuals below have varied interests and have acquired positions including academics, full-time outpatient work, and even positions as a hospitalist. These residents have provided their pearls and pitfalls when searching for post-residency jobs and have included items they wish they would have known before their last year of residency.

Matthew Thigpen, MD
Education: Texas A&M College of Medicine
Residency: Texas Tech Family Medicine; Graduated in 2022

Position Accepted: Faculty/Associate Program Director for Texas Tech Family Medicine-Amarillo

Interests: academics, nutritional medicine, sports medicine, hospital medicine, procedures.

• Start networking with residents who have recently graduated from the programs you are interested in applying to. They will be able to provide you with some insight about the program, administration, and training they undergo to make sure that it aligns with your goals.

• Keep in mind that many academic positions require 1-3 years of experience working in medicine, specifically in the areas of practice that their residency heavily trains in. If you are applying to faculty positions that expect you to be proficient in, for example, inpatient care or obstetrics, you should spend your third-year electives building your skills in those areas.

• It may be beneficial to start bolstering your application with additional certifications in education. I had a master's in education before residency, but there is a fully online fellowship education program through the Texas College of Osteopathic Medicine that can be started in your third year and that could make you more desirable when applying to academic positions.

• In academic medicine, you are not only expected to understand how to practice medicine but also how to guide residents. I strongly encourage you to use an elective during residency to work alongside teaching attendings. Working with attendings who teach can give you practice and exposure to academics before joining as a faculty member in a program. It is one thing to practice medicine, but it is entirely different when you are responsible for the education of another physician.

Carly Hubbard, DO
Education: Texas College of Osteopathic Medicine
Residency: Texas Tech Family Medicine; Current third-year resident

Position Accepted: Faculty with Texas Tech Family Medicine-Amarillo
Interests: academics, education, inpatient & outpatient medicine, osteopathic manipulative medicine

• I recommend speaking to the existing faculty within your residency program about how they entered academics; my faculty provided a lot of guidance when I was searching for positions.

• I looked for positions that mirrored or were similar to my training. When I was looking to start as a teaching attending, my goal was to be able to support residents and be strong in their areas of training. If you are a robust outpatient physician, you should look for faculty positions in programs that are similar, You don't want to get thrown into a heavy inpatient program and be unprepared.

• Start early! If you are interested in an academic position, especially in your own program, start building relationships early, so your program can form that future with you. Even if you are interested in academics outside of your home program, you need to start early, because getting credentialed and approved takes an extended period. It took about ten months of talks before I was offered the position. After receiving the offer, it took another six months to get set up with credentialing. Starting late could delay your start.

• Consider looking into other junior attending positions available at other programs so you have information on competitive salaries, benefits, and schedules when you negotiate your contract.

Koley Pack, MD
Education: Texas A&M College of Medicine
Residency: Texas Tech Family Medicine; Graduated in 2022

Position Accepted: Full-time outpatient clinician with Northwest Texas Physicians Group
Interests: Continuity of care, preventive medicine

• Regarding contract negotiation, I did not hire a lawyer to review my contract. I relied heavily on my recently graduated colleagues who were newly hired for positions similar to the jobs I applied for. They offered insight into line items and clauses that I was unaware of, which could have significantly impacted my earnings.

• Make sure you review offers that include a sign-on bonus. I realized that many sign-on bonuses are short-term loans in disguise. Many "bonuses" have stipulations requiring you to pay back the "bonus" with interest if you leave the position earlier than you originally signed for or if you were to be terminated. You can negotiate this and adjust the interest required or the amount owed to ensure that you do not break the bank if you have to leave a position early.

• I recommend researching how your future position will bill for services and how you will be compensated. Specifically, in the outpatient setting, billing methods can vary, including fee for service, a set salary, or relative value units (RVU). Understanding how you will bill and how you are paid makes a difference in how much money you take home.

Brandon Pires, MD
Education: Texas Tech School of Medicine (Family Medicine Accelerated Track)
Residency: Texas Tech Family Medicine; Current third-year resident
Position Accepted: Full-time outpatient clinician with Aspen Family Care in Highland Ranch, Colorado
Interests: Broad-spectrum family medicine, procedures, education/academics

• If you are considering looking out of state for work after residency, I recommend starting with location. Figure out a handful (three to five) places you would be comfortable relocating to. Like applying for residency, you don't want to apply too broadly without considering where you might end up having to accept a job.

• If you are applying outside of the state you trained in, I recommend making a list of the requirements for credentialing and licensing for each state you apply to. Each state is different and may have hidden tests, fees, or certificates for you to be able to practice medicine. Doing this will save you a lot of time when you start applying for positions.

• When you apply out of state, each position will ask you for a stack of credentialing documents, and managing each of these can be overwhelming for you to do on your own, especially while you are working. I advise residents looking at out-of-state jobs to invest in an account with the Federation of State Medical Boards credentialing service (FCVS). This service will compile all your credentialing documents and send them to each position you apply for.

• I did a large portion of my residency training in the inpatient/hospital setting. I initially applied for inpatient positions outside of Texas and struggled to find hospitals willing to consider me for inpatient work as a family medicine physician. Even though I had significant hospital-based training, fewer positions allow family medicine physicians to work in combined inpatient and outpatient settings than I initially anticipated. Consider looking into rural positions that allow family medicine physicians a broader scope of practice, especially if you want to work on the wards.

• Investigate regional and local equivalent positions to the openings you are applying to. Understanding how similar practices in the same area structure their salaries, bonuses, and non-compete clauses can be extremely helpful when negotiating your contract.

• Start prepping sooner rather than later. Job hunting is a full-time commitment and is more daunting when going across state lines. Trying to apply and interview while your boards are looming over you will be challenging.

• Know that you'll probably spend about five thousand dollars for this whole process. Between getting your license, applying for positions, travel, hotel stays, credentialing, and extraneous costs, you are going to invest a significant amount of money. That being said, be judicious about where you apply and how much money it will cost you to interview and land the job you are interested in.

Jacob Hall, MD
Education: Texas Tech School of Medicine (Family Medicine Accelerated Track)
Residency: Texas Tech Family Medicine; Graduated in 2022

Position Accepted: Full-time outpatient clinician with the Saint Alphonsus Medical Group in Boise, Idaho
Interests: Preventive care, continuity of care

• Know your worth! You have spent a lot of time and money to become an attending. Make sure that, as you search for and select a position, you refrain from settling for benefits or a salary that does not represent your worth as a physician and person.

• I joined an established practice with multiple physicians. I wish I had asked more about how time-off and vacation were divided between each of the physicians. It turns out that only thirty percent of the doctors in my practice can be out of the office at one time, so all my vacation had to be approved and coordinated with the other partners. There are fewer opportunities for quick planned trips/travel when you are required to coordinate every leisure hour with four other people.

• Understand your priorities when you are searching for positions and speaking to potential employers. Specifically, I recommend making a list of the things most important to you in both work and life outside of the job. My priorities were to be close to family and have a chance for my sons to grow up near my relatives, so I took a pay cut to be closer to home, and it was worth it. You can always make more money, but sometimes other things are more important.

Joshua Sorenson, MD
Education: Texas Tech School of Medicine (Family Medicine Accelerated Track)

Residency: Texas Tech Family Medicine; Current third-year resident
Position Accepted: Full-time hospitalist physician with BSA hospital
Interests: Full-scope family medicine, procedures, emergency medicine

• Before you sign a contract, I suggest that you investigate the relationship between the current staff and the administration you will be working under. You want to sign with a group or company that makes you feel valued and responds to its employees' needs and concerns. Asking questions of the current staff and possible future co-workers can reveal problems that may be less visible in a one-on-one interview.

• If you want to practice full-scope family medicine (including inpatient practice), consider all your options, especially those outside the big cities. I love primary care because it has a large variety of training and scope of practice. When you look outside of the metropolitan areas, there is so much opportunity in rural locations or smaller cities for Family Medicine doctors who want full-scope positions. Amarillo was a great example of how a smaller city allowed me to practice full-scope family medicine in a way that would not be possible in the Dallas or Houston area.

IN CLOSING:

As more residents graduate from training programs each year, finding open job positions that meet graduates' financial and personal needs becomes difficult. In addition to the advice given by current and graduated residents, the Texas Medical Association (TMA) has online resources under its Resident and Fellow section. This site provides free education and resources about early career education, transitioning into practice, disability insurance, and more. The world after residency can be intimidating, and everyone needs help navigating the terrain. Now, armed with advice from fellow residents and online resources, searching through the job market should be a less intimidating and instead more exciting transition point in your journey in medicine.

TMA Residents and Fellow Section: https://www.texmed.org/rfs/

Thank you to all my fellow residents and previous upper levels who contributed to this field guide. Your advice and your time was greatly appreciated.

New Physician Practice

by Jerry Kirkland, MD

Stepping into the practice of medicine is challenging. Currently, most physicians graduate from residency and are corporately employed by practices or health systems. Many of the hurdles presented when professionally transitioning from residency to private practice have been anticipated by the future employer. However, a number of challenges still remain. The privilege is mine to speak to some of these challenges.

PATIENT ASSESSMENT OUTSIDE OF THE CLINIC

Our medical skills have been well developed during medical school and residency. This development occurs within the confines of a structured practice environment in the clinic or hospital setting. A number of disease processes and treatments are standardized with guideline-driven assessments and therapies. These pathways should be utilized to ensure that we are providing up-to-date, evidence-based comprehensive care for our patients. These guidelines are not restrictive but provide a framework to provide the best customized care based on the specifics of our patients. The routine of seeing patients in the clinical arena is standardized as well. We take our patient's vital signs, assess their medication use and changes since last visit, inquire of any recent illnesses or hospitalizations, and can access information from previous visits as we discuss the current concerns and issues for this patient. This process is protective for us. Airline pilots use a checklist prior to takeoff to determine readiness for the flight. We make use of routines in our personal lives as we prepare for our daily activities. We put the required items for the day in their usual place so that we do not forget them.

Challenges to this patient assessment process are presented when patients ask for treatment in a nonclinical arena such as at the grocery store, sporting events, after church, and other social events in the community. In my early practice years, a script could be called to the pharmacy with the only requirements being the patient's name and the date of birth. Patients sometimes came to our house to inquire about their health concerns. The normal process of information gathering and patient assessment is not available and is not followed in these settings. We lose the protection that our usual clinic process provides when patients are encountered outside of the normal clinical setting. We are enticed into a potential treatment decision because of the bestowed expertise and the implied compliment being paid to us when others ask about their diseases and want potential treatment options. The nonclinical setting gives greater opportunity for error if a medical treatment is delivered because we have not engaged in our normal office/hospital process of evaluating and treating patients. Physicians should abstain from the situational jeopardy of these patient encounters in a nonclinical setting. Our normal process of assessing patients protects us and the patient, improves the quality of our care, and provides safety for our medical decision-making environment.

DEBT

Resident physicians are challenged by a change in financial status after graduating residency and entering active medical practice. Residents have lived under the burden of student loans and limited income while struggling to maintain reasonable living conditions. New physicians have endured years of delayed gratification. They often have accumulated indebtedness from educational and personal loans as they have moved through the rigors of medical school and residency. Newly graduated physicians are tempted to satisfy these postponed comforts with the receipt of a signing bonus and promise of significant future earnings. They feel the urge to park a new car in the driveway of their new house and fill the closet with a new wardrobe as they dress for success. These purchases can further tighten the financial noose even though their income has greatly increased. Our first mortgage included an interest rate of 14% due to the national economic turmoil at the time. Luckily, we would move in one year from that location which relieved us of this stiff home mortgage interest rate.

Since most new physicians are employees of the practice where they work, they will encumber few practice-related expenses. Previously acquired educational and personal debt can be suffocating. New physicians should evaluate their financial health, seek financial advice and develop a plan to become debt-free. A personal budget can protect new physicians from this self-inflicted purchase misery by having a strategy to handle their new income responsibly. My wife is a saver which helped motivate us to pay off school loans, car loans and other indebtedness. This example employed the strength of my wife as we pursued financial independence.

New physicians should be "boss" of their money as they follow financial moderation after graduation. Accelerated debt payments can quickly remove these burdens from your financial landscape and facilitate becoming debt-free. Reasonable choices can be made for living environment, reliable transportation, hobbies, clothing and travel. Monthly house payments (inclusive of principle, interest, taxes and insurance) should not be more than 28% of monthly income. Purchase of a reliable used car will lessen initial car expenses. These selections can keep us out of the deep end of the swimming

pool of debt. High interest debts such as credit card balances should be paid off first and should be avoided by paying credit card balances in full each month. Lesser interest rate debts can then be paid down as one pursues the freedom of becoming debt-free. Once the burden of debt is removed, we are freer to contribute to worthy causes. When we freely give to those in need, we make a tremendous difference in our communities. Future purchases can be anticipated with a preemptive savings schedule so as not to encumber new debt for the next car or house. Furthermore, to help plan for the future, we made use of 529 savings plans for our children's college educational expenses.

LIFE BALANCE

Training in medical school and residency places great demands on our time, energy and interest. Personal and family priorities often are postponed during the training years. Once one has arrived in a new practice, our attention should be redirected to personal, family and friend priorities to deepen the relationships that may have suffered during the training years. As much as possible, we should put our family first and our medical practice second. Proper balance of our professional and personal life can be exercised as we invest time and energy in the rewarding work of developing (or redeveloping) meaningful relationships with the important people around us. We can ask our family and friends how to re-engage relationships after years of attention diverted to developing our medical craft.

We can aspire to be a great person in the lives of our family and friends while pursuing a rewarding medical practice. We should attend the activities of our family and friends, which allows us to enjoy memories of these experiences with these people later in life. We can enjoy the simple routines of family time, quiet evenings with friends and personal investment in our hobbies while maintaining a delicate balance with our professional demands. As our kids were growing up, I changed my office clinic schedule to attend their band concerts, baseball games, PTA meetings, and baseball parents meetings.

Practicing medicine can be a life-long joy as we improve the quality and quantity of our patients' lives. Keeping our practice of medicine within the confines of our office protects us from the excess liability of frivolous undocumented patient encounters. Debt can strangle our financial life and has to be eliminated to enjoy the freedom of giving to others. The relational priorities of our family and friends should be preserved in proper balance with our medical practice. This balance can insure that these lifelong relationships will sustain us long after our retirement from medicine practice.

What Do They Mean My Care Is "Not Medically Necessary?"

by Kerrie A. Pinkney, MD, MPH, JM, FAAP, FACHPM, FAAHPM

You have been taking care of your patients in your community hospital for years. You have gotten yet another letter from an insurance company denying inpatient hospitalization as "not medically necessary." You are angry that they keep telling you your patient does not need to be in hospital. Why do they keep denying your patients hospital care, and what exactly does this mean???

WELL, IT LIKELY MEANS ONE OR MORE OF A FEW THINGS (1,2).

• If you do planned procedures in the hospital, it may mean that prior authorization was not requested/obtained from the insurance payor ahead of your patient's planned admission to the hospital. Prior authorization is required for the procedure and inpatient admission. Prior authorization does not guarantee payment.

• The claim was not filed in a timely manner.

• Services provided are not eligible under the plan or are deemed "experimental."

• You planned an outpatient procedure such as a routine cholecystectomy or colonoscopy, but the status may have been listed as "inpatient" when orders were written or entered in the computer for the stay. Each year, CMS (Center for Medicare & Medicaid Services) publishes a new list of In Patient Only procedures (IPO). It can change significantly from year to year. Refer to this list prospectively and keep it updated for your office team who obtain those prior authorizations. It can be confusing initially but will save aggravation later.

• The hospital may be out-of-network for your patient. Contracts may change with hospitals every few years, and, while your favorite facility may have been in-network last year, if the contract with the payor expired and no agreement to renew the contract was reached, that hospital may now be off that payor's approved list. This is another good reason for the prior authorization, as details such as this are almost always caught at that time of request—thus allowing for a dialogue to get your patient the service they need, and in an approved location, so they do not get a huge bill later, requiring the lengthy appeal process.

• The biggest reason insurers deny inpatient hospitalization as "not medically necessary" has nothing to do with whether your patient needs to be in the hospital or not. This is a common misconception. They are not trying to tell you that your patient is not sick enough to be in the hospital. Instead, this all relates to the level of care and payment system, which in turn stem from the CMS 2-midnight rule. A status conflict occurs when the status your patient should require does not fit with their status as listed by the hospital--inpatient, observation, or outpatient.

INPATIENT OR OUTPATIENT HOSPITALIZATION? (1,2)

Not all hospital care requires inpatient level of care. Many services can be provided at an outpatient level of care. When a Medicare beneficiary is brought into the hospital, the provider must decide which level is appropriate. This is an important decision, as it affects which payment structure is used and requires disclosures to the patient (remember, the patient often shares the costs for outpatient level of care).

These two different payment structures, inpatient status and outpatient status, exist for Medicare payment because of the Medicare legislation. These statuses are generally adopted by most insurers as well. Insurers will often utilize established programs such as InterQualTM or MCGTM guidelines for determining severity/inpatient level of care. These guidelines are not substitutes for medical judgment by any means, nor are they all-inclusive. That is where medical directors employed by the insurers can use their medical expertise/judgment based on your documentation to override these guidelines and approve the status you have designated.

So, document your concerns and what you are thinking/working up. Be careful not to just point and click "No acute distress" when your patient with COPD is breathing 30 times a minute with accessory use (just a frequent example). If your documentation is merely a copy of the prior days' notes, there will not be enough information to approve an inpatient stay, and ultimately this can lead to fines. This is one common reason a peer-to-peer call may be necessary. EMRs have contributed significantly to this problem. This should not be a contentious process, as the peer reviewer is just seeking clarity from the documentation they have received. They are NOT questioning your care, nor just looking to deny. Truthfully, most medical directors are looking for reasons to approve a patient stay. Often, they have not have received all the relevant documentation for your patient. There are many reasons for this to have occurred. Insurers in recent years are striving to employ subspecialty physicians to review patient records in their same specialty to ensure appropriate reviews and peer-to-peer conversations.

HOW DOES IT WORK? THE TWO-MIDNIGHT RULE

Generally, acute care hospitals are paid under the Hospital Inpatient Prospective Payment System (IPPS) /Medicare Part A. Rates are generally established annually in a prospective manner based on severity, diagnoses, and/or procedures. And nearly all insurers follow these rules.

The Hospital Outpatient Prospective Payment System (OPPS)/ Medicare Part B is a hybrid fee schedule and prospective payment structure, and varies based on cost of service, procedure(s), and services provided.

The CMS Two-Midnight Rule specifically states that all treatment decisions are to be based on the judgement of qualified physicians and medical practitioners and does NOT preclude care being provided at any hospital, regardless of expected duration. If the admitting physician expects the care to span 2 midnights or longer, then Medicare Part A is the appropriate payment system. Documentation of the expectation of a 2 midnight or longer stay (in addition to documentation of the intensity of illness for the longer stay) should be done. Sometimes unforeseen circumstances may shorten the stay to less than 2 midnights, such as an unexpected death, a patient leaving AMA, transfer to a higher level of care, or rapid clinical improvement. These may trigger a denial if the insurer is not aware of the circumstances. Again, a peer-to-peer conversation should easily correct most of these to approved inpatient stays. Some procedures, as outlined above, while anticipated to be under the 2 midnights, are significant enough that they are automatically designated IPO (In Patient Only) but prior authorization for in patient level of care and the planned procedures must be obtained.

WHAT ABOUT SHORTER STAYS (<2 MIDNIGHTS?)

CMS Recovery Audits have identified high error rates in hospital services that have been provided in inpatient—as well as extended observation--instead of outpatient level of care settings. It is important to note that observation services do not count toward the mandatory 3-day inpatient level of care stay required prior to Medicare skilled nursing facility services, which can lead to even longer stays. The Two-Midnight rule was created in response to requests for clarity by hospitals and other stakeholders to ensure correct determination of level of care for Medicare Part A and B.

If the physician expects the patient to need fewer than 2 midnights of hospital care (and not an IPO or other listed national exception), an inpatient admission may be payable under Part A. The documentation must be robust for the reasoning; so anticipate there will be a medical review, and possibly a peer-to-peer call. Documentation is the key.

WHAT ABOUT DENIALS?

If an insurance plan refuses to approve/pay for a medical claim, your patient has guaranteed rights to appeal. These rights were expanded as a result of the Affordable Care Act. The provider (as well as the facility) may request a peer to peer or appeal. The denial letter outlines your options for disputing or appealing the decision. Note that there is almost always more than one level of appeal as well. There are deadlines which are also spelled out in the denial letter along with contact information. Think of these situations as a contract dispute. Your contract with the insurer or the patient's contract (which may differ) dictates how the dispute is to be handled/resolved. This process really should not be contentious. Even though you may be angry or frustrated, usually these situations can be easily resolved.

Finally, remember that the insurer must provide, in writing, the following things (3):

- Information on rights to file an appeal
- The specific reason claims or coverage were denied
- Detailed instructions on submission requirements
- Key deadlines to submit an appeal
- The availability of a Consumer Assistance program, if available (state by state)

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Surviving in the Age of Accountable Care

by Sheryl Williams, MD, FACP, SFHM, MSHQSM, MSPOP Health

When I first went into practice many years ago in a galaxy far, far away, I was in a private office with five internist partners. We owned the practice, shared call, and arranged our own insurance contracts. We did participate in an HMO, but there were not too many patients enrolled. We participated in a shared insurance network connected to the hospital, and yes, we took Medicare and Medicaid. That was about as complicated as it got for the reimbursement side of the practice. I was told to see patients, fill out the (paper) billing sheet, and turn in my hospital charges on handwritten 3X5 cards.

Obviously, today's practice environment is more complicated, automated, computerized, accountable, and, for most physicians, involves an employed practice model. There are still uninsured self-pay patients, a myriad of new insurance products, HMOs, PPOs, Medicare, Medicaid and replacement Managed Medicare and Managed Medicaid. As a new practitioner, or even a well-seasoned one, your organization may one day tell you that you have been enrolled in an Accountable Care Organization (ACO). So how will this affect your practice patterns, metrics for success, and honestly what is this new-fangled ACO thing?

The Centers for Medicare and Medicaid Services (CMS) launched the Medicare Shared Savings Program (MSSP) in 2012 to curb Medicare spending by incentivizing physician efficiency. This was launched for Medicare Fee for Service patients through an ACO. If the ACO met certain metrics and saved CMS money beyond the average costs from the baseline year, then a pre-designated percentage of the savings was split between CMS and the physicians enrolled in the ACO. As the ACO gained experience in managing costs, they could take on more risk in managing their patient population. If successful, they could potentially reap a higher percentage of shared savings. If they did not have shared savings, they would pay a penalty for spending "too much" money on their patients. The plan had both up-side benefits and down-side costs.

CMS has modified the ACO programs available to physician groups several times since its inception and estimates that, in 2021, the MSSP saved Medicare more than $1.6 billion, while still providing high quality care (1). To quote CMS: "Shared Savings Program ACOs are groups of doctors, hospitals, and other health care providers who collaborate to give coordinated high-quality care to people with Medicare, focusing on delivering the right care at the right time, while avoiding unnecessary services and medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, the ACO may be eligible to share in the savings it achieves for the Medicare program" (1). CMS wants to have all traditional Medicare enrollees enrolled in an ACO of some variety by 2030. In January of this year, three more innovations were announced to "grow and provide higher quality care to more than 13.2 million people with Medicare in 2023. More than 700,000 health care providers and organizations will participate in at least one of the three initiatives – the Medicare Shared Savings Program and two CMS Innovation Center accountable care model tests. This growth furthers achieving the CMS' goal of having all people with Traditional Medicare in an accountable care relationship with their health care provider by 2030" (2). If you see Medicare patients, this goal will eventually impact your practice.

Now that your practice has joined an ACO, how can you be successful and hope to share in those savings? Your individual practice will define how those dollars are distributed (check your contracts!), but there are certain metrics that seem to hold true no matter which ACO you join. Some of these metrics are even collected and measured by commercial insurance contracts, as they are basic to good, preventative medicine that is provided at the right time without unnecessary services. Preventative medicine is highly valued as a method to mitigate risk to your patients and focuses on the quality of care, not the quantity of billable services. But success in an ACO is not just about the care provided; it is also dependent on the documentation, coding and billing you provide in your chart.

QUALITY METRICS

CMS has released information that shows "Nearly all ACOs – 99% – reported and met the quality standard required to share in savings under the Shared Savings Program. ACOs had higher mean performance on quality measures compared to other clinician groups not in the program. This includes higher performance for quality measures related to diabetes and blood pressure control; breast and colorectal cancer and fall-risk screening rates; flu vaccination; tobacco screening and smoking cessation; and statin therapy for the treatment and prevention of cardiovascular disease. ACOs also had better performance on depression screening and depression remission rates, underscoring how this type of coordinated, whole-person care can improve treatment of behavioral health conditions in ACOs,

Specialty Care - *Close to Home*

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in helping to achieve the goal of strengthening behavioral health quality in CMS' Behavioral Health Strategy" (1). These quality metrics are fairly standard for almost any ACO, whether run by CMS or by commercial insurance. All patients should receive screening and testing for these conditions. More importantly, you should document what screenings have been recommended and follow through with the results.

RISK DOCUMENTATION

Risk equates to complexity. The more complicated diagnoses a patient has, the more effort the physician will have to exert to keep them healthy and out of the hospital. Remember that the ACO is expecting you to tackle the risk of this patient to achieve shared savings, so you need to get credit for the work you are doing to manage this complex patient. Physicians in managed care organizations are judged by their risk adjustment factor (RAF) score at the end of the year, with reimbursement tied to how complex the patient panel is to manage. "Risk scores generally range between 0.9 and 1.7, and beneficiaries with risk scores less than 1.0 are considered relatively healthy" (3) . The RAF score is calculated based on patient's demographics and the presence of high-value Hierarchical Condition Codes (HCCs). An HCC diagnosis must be billed at least once every calendar year to give credit to the physician or practice. HCC codes not only describe the complexity of the patient but help to predict their healthcare resource use. Maximizing your RAF score by capturing those high value HCC codes will result in higher reimbursement and getting paid for what you are really doing to manage your complex patients. Some of the most important HCC codes to capture are diabetes with any type of complication, congestive heart failure, chronic kidney disease and morbid obesity. But it is important to document these problems with specificity. Diabetes without complication has a RAF score of 0.105, but diabetes with polyneuropathy is weighted at 0.302. RAF scores are additive, so the more HCCs that you document, the higher to total RAF score will be. This is not gaming the system but getting credit for what you do.

ANNUAL WELLNESS VISITS

Medicare pays for a "Welcome to Medicare Preventative Visit" for all patients that enroll in Medicare Part B. This visit is free to the patient (the provider is reimbursed) and is geared to promoting good health through disease prevention and detection. After that first year, Medicare pays for an Annual Wellness Visit (AWV), again free to the patient, that focuses on providing Personalized Prevention Plan Services (PPPS). THIS IS NOT AN ANNUAL PHYSICAL. In fact, Medicare does not pay for patients to have annual physicals unrelated to treatment or diagnosis of specific illness, symptoms, or complaints. The purpose of the AWV is to screen patients for preventable conditions such as colorectal cancer, breast cancer, falls or vaccine needs, and to discuss a personalized wellness plan. This is aimed at reducing risk and downstream costs that preventative medicine could have recognized early or prevented all together.

The AWV completion rate is a common metric used by ACOs to measure risk management of the patient population. This is also a perfect time to capture those HCC codes on a yearly basis and maximize the RAF score. The AWV may be completed by an Advanced Practice Practitioner, nurse, medical assistant, or even a pharmacist under the direct supervision of the physician. Some organizations are using home visits with a telehealth link to the physician for these visits. There are good references regarding what must be documented for these visits, and there are probably templates in whichever EMR your clinic uses. I recommend checking out the information found on the American Association of Family Physicians (AAFP.org) website for full details and links to current requirements on AWVs, HCC coding, and RAF scores. Another resource is a podcast produced by Vanderbilt Health detailing AWVs and other useful practice subjects at https://www.vhan.com/mini-vhan-podcast/episode/performing-documenting-and-billing-awvs-with-vanderbilt-medical-group/ .

CONCLUSION

When (not if) your practice becomes involved with an ACO or other managed care arrangement, the basics of good medicine will still apply. Provide value to your patient in the form of prevention and counselling, treat their complaints and problems effectively and efficiently, and advocate for their health. But you will be measured on how well you manage your patients, so maximizing those metrics that demonstrate how well you are caring for your patients is a key to success in accountable care.

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Telehealth and Remote Monitoring

by Sheryl Williams, MD, FACP, SFHM, MSHQSM, MSPOP Health

Telemedicine, once a construct of Star Trek and George Jetson, came of age during the COVID pandemic. Telemedicine is not just used in the realm of primary care, but is utilized by rural facilities without access to local experts (stretching consults for subspecialty shortage areas), Hospital at Home, and Hospital to Home pilot projects. Telehealth does not replace in-person physician visits but augments the ability of patients to seek medical care without traveling to a clinic for certain types of care. Telehealth is widely used by hospitals to provide consultative services for specialties such as neurology, psychiatry, and infectious disease, as these specialists are often hard to attract to smaller communities. Remote monitoring is another facet of telehealth used to prevent hospital admissions and provide actual hospital levels of care at home.

CLINIC BASED TELEHEALTH

Telemedicine visits exploded during the pandemic and were encouraged by insurance and CMS waivers for Medicare and Medicaid patients, in order to increase availability and equity of care. This stimulated a "record investment of $14.1 billion dollars in 2020 and widespread telehealth adoption that saw a 43% uptick in traditional video telemedicine" (1). The AMA funded a COVID-19 telehealth study that examined provider and patient acceptance of this new technology and "79% of patients reported being very satisfied with the care they received during their most recent telehealth visit, and 73% said they will continue to use telehealth services in the future. For providers, a vast majority say they are motivated to increase telehealth usage in their practice." (2). CMS has recently extended telehealth waivers past the Public Health Emergency declaration (ending May 2023); they are now valid until December, 2024. How clinics will continue to utilize telemedicine remains to be seen.

I spoke with Eileen Harpole, Director of BSA Family Medicine. She said that, during the pandemic, televisits were an important way to provide care for their patients. However, once the COVID case rate dropped off, patients have wanted to see their provider in person again. Even at BSA Urgent Care, on-demand video visits comprise less than 10% of monthly volume. She has placed posters in the clinic and at Urgent Care, and links are prominently displayed in the patient's My Chart portal advertising virtual visits. But patients really want to see their doctors in person. Dr. Alan Keister at Amarillo Medical Specialists became very experienced with telemedicine during the pandemic and agrees that the volume has decreased somewhat. But, in certain demographics (such as mothers with young children or elderly patients), the convenience offered by not having to arrange transportation or childcare continues to fuel the demand for telemedicine visits. Younger physicians who are still in training seem to have no trouble embracing the telemedicine movement. I wanted to see how resident practices in other states might be using telemedicine, so I took advantage of discussing this with Dr. Jessica Williams, a second-year family practice resident in Lawrence, Massachusetts. Resident clinics there are structured so patients calling in for acute problems are first offered a televisit instead of an in-person visit. She also will routinely schedule telemedicine follow-up visits for patients starting new medications, diabetes management, and post-procedure follow ups.

SPECIALTY TELEHEALTH SERVICES

The same waivers that apply to clinic telemedicine were expanded until Dec 2024 for specialty telemedicine consults. Behavioral health has particularly benefitted from the availability of telemedicine. There are several national enterprises that market telepsychiatry services to patients at the individual patient level. The American Psychiatric Association reports that telepsychiatry is important in many different settings of care. "Telepsychiatry is helping bring more timely psychiatric care to emergency rooms. An estimated one in eight emergency room visits involves a mental health and/or substance use condition, according to the Agency for Healthcare Research and Quality. Many emergency rooms do not have psychiatrists on-site to support people with serious mental health issues in person, and the ability to access psychiatric care through technology enhances the ability for emergency departments to provide appropriate care and treatment to these individuals. Telepsychiatry is being used in nursing homes to provide both ongoing and emergency psychiatric evaluation and care. Many states use telepsychiatry in correctional facilities where people that are incarcerated require ongoing mental health care. In all of these examples, telepsychiatry can be helpful alongside or instead of in-person care to make sure that people who need it have access to high-quality care" (3).

Neurology and stroke diagnosis have also benefitted from telemedicine. This is usually a more technology-intense application as many hospitals employ a "robot assisted" camera that can fully allow the neurologist to see the neurologic changes in the patient. When time is brain, access

to expert neurologic care in small hospitals or as an adjunct in larger hospitals to provide 24/7 coverage can be lifesaving. Add to this the availability of AI-assisted reading of CT scans to more quickly alert radiologists to a possible large vessel occlusion, and stroke care has improved drastically over the past few years.

HOSPITAL AT HOME

Johns Hopkins is known for pioneering the model of Hospital at Home for elderly patients who require inpatient hospital services but who could be safely treated at home or who have refused hospitalization. Early trials of this model of care found the total cost of care at home was 32% less than in the hospital ($5,081 vs $7,480) and length of stay was reduced by a third (4). In a nutshell, care is provided both in person and virtually. "A caregiver meets the patient at home and a physician—either in person or via video—explains the treatment protocol. Orders are written and clinical staff, including respiratory therapists, physical therapists, and other caregivers arrive as needed to administer intravenous medications and fluids, provide nebulizer treatments, and conduct tests, including ultrasounds, X-rays, and electrocardiograms. Meals are arranged if necessary. The patient's vital signs are monitored electronically (4)." Since the initial studies, CMS has approved a waiver to provide reimbursement for Hospital at Home programs through Dec 2024. Each facility that wishes to develop a Hospital at Home program must meet safety and reporting metrics and be approved by CMS. Telemonitoring and telemedicine visits are instrumental to providing an efficient method for providers to see these patients on a daily basis as required by the regulations.

HOSPITAL TO HOME

Hospital to Home models of care are usually aimed at providing close monitoring after a hospital stay for high risk patients or simply to help prevent re-admissions by providing an early warning that the patient has had a change in medical status. Coupled with phone contacts and/or actual telemedicine visits, patients can be rapidly triaged to treatment by the provider or, if needed, referred to the clinic for an in-person visit. The worst-case scenario is the patient returning to the emergency room *in extremis*, so early warning of a change in medical condition is key to keeping the patient at home. Multiple remote monitoring devices have been developed including pacemaker/ICD data interrogation, implantable loop recorders, and even wearable defibrillators. In addition, expansion of re-admission prevention strategies suggests that a more aggressive home telemetry monitoring program can decrease high-risk re-admissions to the hospital (5). Telemedicine visits are a key feature to providing prompt intervention to stave off returns to the ED or the hospital.

THE FUTURE OF TELEMEDICINE

Patient safety and convenience are the underlying tenets in telemedicine. Increased use of technology, new methods of reimbursement, and financial incentives to keep patients out of the hospital are all driving the adoption of telemedicine. Patients desire more convenience and less travel, and it is easier to ensure equity. In the end, patient-centered care is the main driver of the adoption of more widespread virtual care and monitoring.

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Facility Professional Fee Services Coding and Documentation Changes for 2023

by Cynthia Willis, MJ, CDEO, CRHCP, RH-CBS, RHIA, CRCR, CPC

Evaluation and management (E&M) codes account for approximately 40% of all CPT codes reported. Because of this volume, evaluation and management codes are also the most frequently audited. E&M codes were first implemented in 1992, saw updated guidelines in 1995, with another update in 1997. There was an attempt to create and publish new rules in 1997 but, instead of replacing the 1995 guidelines, the 1997 guidelines became a tool for specialty providers. Prior to January 1, 2023, coders and auditors applied whichever set of guidelines that were most advantageous to the provider. Due to the confusion of two sets of guidelines, CMS created a section in their Claims Processing Manual regarding medical necessity for evaluation and management codes. That section stated that medical necessity was the overarching criterion for payment and that the volume of documentation should not be the primary influence upon which a specific level of evaluation and management service is reported.

In 2021 we saw a change to guidelines in the office/outpatient setting. In 2023 that change became effective for facility professional services. The primary objectives in changing evaluation and management service guidelines are:

- Decrease the administrative burden of documentation and coding
- Decrease the need for audits
- Decrease unnecessary documentation – such as note bloat
- Move away from counting tasks or bullet points to focusing on services that affect the management of the patient
- Add detail within the guidelines to create consistency and continuity across all payers.

Physicians are only required to document that they have reviewed and verified information regarding the chief complaint and history that has been recorded by the ancillary staff or the patient. Selection criteria for the codes are now simpler--more clinically relevant and intuitive. There is more consistency across all payers due to the addition of greater detail within the CPT evaluation and management guidelines, and we now see an alignment with current documentation guidelines from CMS and CPT to ensure minimal disruption to workflows and practices.

Hospital	Discharge On	Code(s) to Bill
< 8 Hours	Same calendar date as admission or start of observation	99221-99223
8 Hours or more	Same calendar date as admission or start of observation	99234-99236
< 8 Hours	Different calendar date than admission or start of observation	99221-99223
8 Hours or more	Different calendar date than admission or start of observation	99221-99223 & 99238-99239

Effective January 1, 2023, evaluation and management services CPT codes for facilities were updated, consolidated, and deleted. As a summarization:

- Evaluation and managements introductory guidelines were updated and consolidated
- Hospital observation services were deleted and folded into inpatient case codes
- Hospital inpatient and observation care services now use the same codes
    - Hospital care codes, regardless of inpatient or outpatient, status fall under the same code set
        - Initial 99221-99223
        - Subsequent: 99231-99233
        - Admit/Discharge same calendar date: 99234-99236
        - Discharges: 99238-99239
- Consultation codes were revised
    - 99241 and 99251 were deleted
    - Documentation requirements remain the same
- Emergency services were revised
    - 99281 no longer requires a physician to see the patient
- Nursing Facility services, long term care, and home services were all revised
- Prolonged services were revised and are applicable only when billing services are based on time

The new guidelines eliminate history and physical exam as elements for code selection. This does not mean providers are no longer required to document these elements; it just means that the level of history and exam are not going to be counted as required elements toward the level of service selected. However, providers need to document a medically appropriate history and exam.

We also saw the creation of a new prolonged service code with shorter time increments. The new code shortens the time increment to 15 minutes and can only be used with 99223, 99233 or 99236 (hospital services) when time is the primary basis for the code selection.

The new guidelines allow the level of service to be selected based on medical decision making (MDM) or total time. On the surface, it would seem time may be the easier of the two choices, but time requirements are detailed, and the tracking of time may be too cumbersome. when considering time as determining a level of service, counseling and coordination of care are no longer required to dominate the visit. The documentation of total time spent is required. To calculate the total time, practitioners should include only total time spent by the provider or qualified healthcare professional. Total time may include non-face-to-face time provided that the non-face-to face activities occurred on the same date as the face-to-face encounter.

Activities that may be included in time calculations include:

- Preparing to see the patient (example: reviewing tests or pre-charting)
- Obtaining and/or reviewing separately attained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Time cannot be included in total evaluation and management time if performed by clinical staff, or spent on separately billable services. This means that the time spent by a nurse, medical assistant, or anyone who is not a physician or qualified healthcare professional cannot be included in total time under the physician. If additional services are provided, documented, and billed separately, time performing those services is not included in the total time for the E&M service and each code has a time threshold.

INITIAL CODES:

Code	MDM	Time
99221	Straightforward or Low	40 minutes met or exceeded
99222	Moderate	55 minutes met or exceeded
99223	High	75 minutes met or exceeded

SUBSEQUENT CODES:

Code	MDM	Time
99231	Straightforward or Low	25 minutes met or exceeded
99232	Moderate	35 minutes met or exceeded
99233	High	50 minutes met or exceeded

ADMIT/DISCHARGE SAME CALENDAR DATE:

Code	MDM	Time
99234	Straightforward or Low	45 minutes met or exceeded
99235	Moderate	70 minutes met or exceeded
99236	High	85 minutes met or exceeded

If services exceed the highest time threshold in each category, there is the ability to add prolonged service codes. Prolonged services can only be used with time-based coding and only apply to CPT codes 99223, 99233, 99236, 99255, 93306 and 93310.

For example, if the time is 90 minutes or longer for an initial service (99223), the provider would use CPT 99418 for commercial carriers, and G0316 for Medicare. If the time is 65 minutes or longer for a subsequent service (99233), the provider would use CPT 99418 for commercial carriers, and G0316 for Medicare.

Complexity is the first element on the new MDM table. New guidelines emphasize "the number and complexity of problems that are addressed during the encounter". Multiple new or established conditions or problems may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis, and each symptom is not necessarily a unique condition or problem. For example, if a patient presents with a cough, runny nose, fever, and a sore throat and the final diagnosis is determined to be influenza, the presenting signs and symptoms should not be counted as unique conditions or problems. Co-morbidities are not considered when selecting a level of service unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed, or increases the risk of complications and/or morbidity or mortality of patient management. Documentation of the assessment of any comorbidities will be important as comorbidities listed without further elaboration will not be considered towards the level of complexity.

There are four levels of condition complexity:

- Minimal, which includes 1 self-limited or minor problem,
- Low, which includes 2 or more self-limited or minor problems OR 1 stable chronic illness OR 1 acute, uncompleted illness or injury,
- Moderate, which includes 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment OR 2 or more stable chronic illnesses OR 1 undiagnosed new problem with uncertain prognosis OR 1 acute illness with systemic symptoms OR 1 acute complicated injury,
- High, which includes 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment OR 1 acute chronic illness

2023 Hospital Services: Admit/DC Same Calendar Date

Code	MDM	Time
99234	Straightforward or Low	45 minutes met or exceeded
99235	Moderate	70 minutes met or exceeded
99236	High	85 minutes met or exceeded

• Require two or more encounters on the same date, of which one of these encounters is an initial admission encounter and another encounter and antoher encounter being a discharge encounter.

• Commercial carriers: If service is 100 minutes or longer, use prolonged service code 99418

• Medicare: If service is 125 minutes or longer, use prolonged service code G0316

• Prolonged is only applicable when billing based on time

• Prolonged service code only applies to CPT 99236

or injury that poses a threat to life or bodily function.

There are also four levels of amount/complexity that apply to the data to be reviewed and analyzed:

• Minimal or none. This level does not require any data to be reviewed. It is also the default level if the encounter does not meet a more advanced level.
• Limited or low. Must meet the requirements of at least 1 of 2 categories:
  o Category 1 includes tests and documents. There must be a combination of 2 from the following: review of prior external note(s) from each unique source, review of the result(s) of each unique test, and ordering of each unique test
  o Category 2 includes an assessment requiring an independent historian(s)
• Moderate. Must meet the requirements of at least 1 of three categories:
  o Category 1: tests and documents (any combination of 3 of the following): review of prior external note(s) from each unique source, review of the result(s) of each unique test, ordering of each unique test and/or assessment requiring an independent historian(s).
  o Category 2: Independent interpretation of test (test was performed by another physician and not reported separately)
  o Category 3: discussion of management or test interpretation with external physician and/or appropriate source
• Extensive. Must meet the requirement of at least 2 of 3 categories:
  o Category 1: Tests and documents, any combination of three from the following: review of prior external note(s) from each unique source, review of the result(s) of each unique test, ordering of each unique test, assessment requiring an independent historian(s).
  o Category 2: independent interpretation of test (performed by another physician and not reported separately)
  o Category 3: discussion of management or test interpretation with external physician and/or appropriate source

The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. There are four levels of risk: minimal, low, moderate and high. The level of risk is determined by the risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), and treatment(s). This includes the possible management options selected and those considered but not selected, after shared medical decision making with the patient an/or the patient's family.

Examples of moderate risk provided by the AMA are: prescription drug management, decision regarding minor surgery with identified patient or procedure risk factors, decision regarding elective major surgery without identified patient or procedure risk factors, or diagnosis or treatment significantly limited by social determinants of health.

Examples of high risk provided by the AMA: drug therapy requiring intensive monitoring for toxicity, decision regarding elective major surgery with identified patient or procedure risk factors, decision regarding emergency major surgery, decision regarding hospitalization, or decision not to resuscitate or to de-escalate care because of poor prognosis.

The following tables show how to put all the risk and complexity determinations together to formulate a level of service.

SUMMARY

E&M coding is a complex and highly regulated aspect of physician billing. Failure to comply with accurate coding and billing practices may leave physicians open to audits and even charge recovery from payors. All providers should try to educate themselves on the new changes and consult their facility coding experts and champions for questions on how to apply the risk and complexity determinations together to formulate a level of service.

MDM: Putting It All Together (Inpt/Obs)

Example:

If complexity = high, data to review = moderate and risk = low, the correct level of service would be level two.

		Must Meet Two of the Three Elements		
MDM Level	**Level**	**Complexty**	**Data to Review**	**Risk**
Straightforward Low	Level One	Low	Limited	Low
Moderate	Level Two	Moderate	Moderate	Moderate
High	Level Three	High	Extensive	High

CPT codes: 99221, 99231 and 99234 encompass straightforward or low MDM
CPT codes: 99242, 99252 encompass straightforward MDM
CPT codes: 99243, 99253 encompass low MDM
CPT codes: 99222, 99232, 99235, 99244 & 99254 encompass moderate MDM
CPT codes: 99223, 99233, 99236, 99245 & 99255 encompass high MDM

Critical Care Services (Concurrent & Shared)

Critical Care services are time-based codes:

- Minimum of 31 minutes must be documented
- Do not use "approximate", "about" or "greater than" for time statements
- Do not use the code description as a time statement
- Documentation should reflect what was done and what you did that was critcal for patient.

Critical Care services are split or shared:

- Presumption is who is signing and submitting a code performed the substantive portion of the visit
- Time must be documented by both parties
- Provider with the higher time documented along with what was personally performed for the patient should be signing and submitting a code.

Critical Care Services & Global Procedures

- Critical care services may be paid separately in addition to a procedure within a global surgical period **IF** the critcal care service is unrelated to the surgical procedure.
- Preoperative and/or postoperative critcal care may be paid in addition to the procedure **IF** the patient is critically ill (critical care definition) and requres the full attention of the physician.
- Critical care must be unrelated to the specific anatomic injury or general surgical procedure performed.
- If care is **FULLY transferred** for the surgeon to an intensivist (critical care is unrelated to the procedure), appropriate modifiers must be reported to indicate the transfer of care.
- **Continued for 2023: Modifier FT** needs to be included on the claim regardless if care was transferred to another provider.
- Identifies critical care is unrelated to the surgical procedure

Physician Burnout: A Rising Epidemic

by Bernardo Gonzalez, MS3, and Izi Obokhare, MD
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INTRODUCTION

Physician burnout is a far too common cause of job dissatisfaction, medical error, symptoms of anxiety and depression—and, worst of all, suicide—among medical practitioners. Burnout has reached an alarmingly high rate, with more than half of practicing physicians in the United States reporting significant symptoms (1,2). Some professionals are more susceptible than others, as it is related to each person's degree of conflict, financial problems, work overload and organizational stress. Healthcare workers in stressful or productivity-based working environments, especially when dealing with the critically ill, shoulder more responsibility and are at increased risk, as seen during the COVID-19 pandemic.

Burnout is defined as a syndrome brought upon by chronic stress and characterized by a sense of emotional exhaustion, decreased sense of accomplishment, and cynicism or depersonalization. This widely accepted conceptualization of the syndrome, initially described by Maslach and Jackson in 1981 (3), established three dimensions (Table 1):

CONSEQUENCES

Burnout syndrome is a mental health condition. It is progressive and, if not recognized and addressed promptly, can worsen and lead to devastating outcomes for the individual and those around them. For the physicians themselves, it can lead to depression and anxiety symptoms, as well as alcohol and substance use, in an attempt to relieve these symptoms; in the worst cases, it can even lead to suicide. As many as 400 U.S. physicians die by suicide every year (2).

The physician experiencing burnout can also make the job of their peers more stressful and less enjoyable, as those who are burned out are commonly impatient, irritable, and less mindful of other's concerns. Furthermore, burnout significantly impairs the level of care patients receive; when the physician experiences cynicism or depersonalization, it becomes difficult for them to connect with patients and to express empathy. Studies have shown that patients of physicians exhibiting high exhaustion and high depersonalization had significantly lower patient satisfaction scores on surveys by insurers (4). In addition, poor communication from the physician leads to a 19% risk increase in treatment non-adherence in patients (5). Clinical reasoning can also be impaired, as demonstrated by the clear association between burnout and medical error and malpractice lawsuits, as well as worse patient outcomes (6,7).

CAUSES

Burnout develops through an interaction between organizational and individual factors. The former refers to the conditions created by the healthcare system and the physician's employer in the workplace, including but not limited to: work hours, level of autonomy/influence, social support, and perception of injustice (8). The latter is made up of the individual's traits and characteristics, some of which can be protective, while others represent risk factors. Table 2 below highlights common individual factors.

Table 1. Dimensions of Burnout

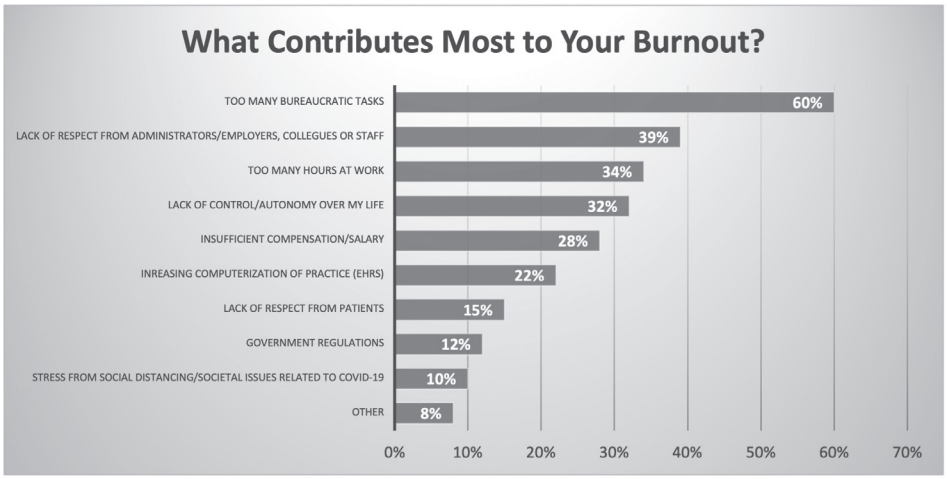
Dimension	Definition	Time
Emotional exhaustion	State of being emotionally depleted due to the accumulated stress from the excessive demands of one's work and/or personal life.	40 minutes met or exceeded
Cynicism or depersonalization	A response of detachment, indifference or apathy towards one's work or the people who receive it.	55 minutes met or exceeded
Reduced personal achievement	The tendency to negatively evaluate one's own work, doubting one's ability to proficiently perform their work and producing low professional self-esteem.	75 minutes met or exceeded

Table 2. Individual traits that Influence burnout

Protectors	Risk Factors
Agreeability	Neuroticism
Meticulousness	External locus of control
Extroversion	Impatience
Open-mindedness	Agnosia
Problem-focused coping	Emotion-focused coping

The 2022 edition of Medscape's annual Physician Burnout & Depression Report (9), which surveys physicians from around the country, revealed the following to be the most common responses when asked "What contributes most to your burnout?" (Figure 1):

Figure 1. Results from the 2022 edition of Medscape's Annual Physician Burnout & Depression Report



MEASUREMENT/ASSESSMENT

Several instruments have been developed for the assessment of burnout. The most commonly used and validated is Maslach's Burnout Inventory (3), a generic instrument that assesses for the syndrome. However, more specific instruments have also been developed to evaluate individuals in particular professions. For physicians, the Physician Burnout Questionnaire – PhBQ (10) – is a 17-item instrument that provides four subscales: burnout syndrome, antecedents, consequences and personal resources.

MANAGEMENT AND PREVENTION

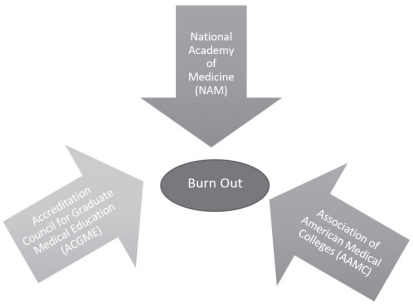
Regular use of such instruments by organizations (i.e., hospital systems) to monitor burnout levels among individuals and to identify patterns based on department, location, and job duties can be particularly valuable, as it enables organizations to pinpoint a root cause of distress among workers before it leads to further downstream effects on the individuals and eventually the organization. Typically, functional impairment begins in the psychological realm, then progresses to biological/physical and ultimately behavioral consequences, which impact those around the individual and ultimately the organization (11).

Effective measures have also been demonstrated at the individual level to combat burnout and improve overall physical, mental, and emotional wellbeing: physical exercise (12,13), practicing mindfulness (14), self-observation and monitoring signs/symptoms, learning skills to enhance resilience, creating personal space for self-care, emotional and physical distancing from work, among others (Figure 2). By cultivating the following practices into their daily life, professionals can effectively prevent burnout: exercise, meditation, cognitive reframing to help reduce ruminative thoughts, deep breathing, yoga, relaxation, sleep and diet habits, setting boundaries in the workplace and taking time to maintain connections with friends and family, fostering emotional awareness, emotional intelligence, self-compassion, and mindfulness.

Figure 2. Effective practices to prevent burnout

Another often overlooked driver of burnout is physician financial well-being. According to the Association of American Medical Colleges (AAMC), the median medical student-loan debt for 2021 graduates was $200,000 (15). That number doesn't take into account debt from their undergraduate studies or the accumulated interest after graduation while living off residency wages. In reality, it is common for medical students to owe over $300,000 in student loans. This can be incredibly stressful for physicians, particularly early in their career, and often forces them to work overtime and accept jobs with unsustainable hours to pay off this debt. Most physicians live paycheck to paycheck, which makes taking time away from the job difficult despite protracted illness, pregnancy and other health concerns. Incorporating financial education and retirement planning into the medical curriculum would afford physicians the opportunity to practice medicine on their terms with the hours they want.

Figure 3. The NAM, AAMC and ACGME are working together, with the support of many others, in the efforts against physician burnout.



If the burnout has already advanced and is impairing one's ability to perform job duties or other activities of daily life, psychotherapeutic intervention is indicated and is typically based on principles of cognitive behavioral therapy (16, 17). If a doctor doesn't feel safe talking about what they're going through, they can ask for help directly through the physician support line at 1-888-409-0141. This resource was created during COVID to offer free and confidential peer support to American physicians and medical students, by creating a safe space to discuss immediate life stressors with volunteer psychiatrists who are uniquely trained in mental health and understand many of the shared difficulties among healthcare professionals.

OPTIMISM: MOVING FORWARD

Physician burnout is a public health crisis. The good news is that our healthcare community recognizes it as a great concern, and there is a wide consensus about its severity and the urgency for change. Leaders and governing bodies are eager to collectively work towards combating it.

In January 2017, the National Academy of Medicine (NAM), in collaboration with the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME), launched a nation-wide collaborative effort to improve clinician well-being and resilience (Figure 3) They endorse four central goals:

1.Increasing visibility of clinician burnout.
2.Improving healthcare organizations' understanding of challenges to clinician well-being.
3.Identifying evidence-based solutions.
4.Monitoring efficacy of solutions implemented.

Since then, the collaborative has grown to 55 core organizations, plus an expanding network of over 80 additional ones consisting of clinician groups, government agencies, research institutions, technology companies, etc. (18).

There is reason to believe that positive change is coming. The NAM has a proven track record of bringing about systemic change. Notably, in 2000, when it was known as the Institute of Medicine (IOM), this group released the report To Err is Human: Building a Safer Health System, which broke the silence about medical errors and set forth a national agenda to reduce them and improve patient safety by changing the system. The report then catalyzed system-wide changes that have improved safety and quality of care (19).

Their commitment, along with that of the AAMC, ACGME and over 100 powerful organizations nationwide, has established clinician welfare as an utmost priority for the leaders of our country and healthcare industry. By reducing physician burnout, we not only improve the health of the individual physicians, but also their workplace environment and the quality of the care given to their patients.

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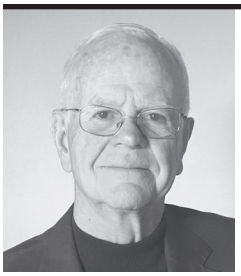
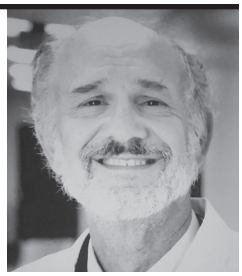


Retiring from Medical Practice

by Dick McKay, MD and Steve Urban, MD



After decades of arduous training and (hopefully) rewarding medical practice, you will some day face the prospect of retirement. Presumably, you have been able to accrue sufficient assets for a comfortable and happy retirement. Before riding off into the sunset, however, there are a few remaining hurdles to surmount. The purpose of this essay is to review some (but not all) of the requirements that you should address before retirement.

The issues involved vary from situation to situation--for instance, retiring from solo practice entails items (evaluating and selling your building and equipment, for instance) that will not confront the doctor who is retiring from a group or corporately-owned practice. Many of the topics that we will review require counsel with a lawyer or CPA. We won't even address complicated or contentious situations (such as being asked to leave practice under duress, or the death or incapacity of an active physician). Fortunately, many resources are available to get the conversation started. For instance, the Texas Medical Association (www.texmed.org) offers an excellent and detailed CME course (free for TMA members, $325 for non-members) that covers the issues we will discuss (and more) in detail. The Texas Medical Board website (www.tmb.state.tx.us) contains up-to-date rules and regulations and is quite well organized. It has an entire section on retirement, containing useful FAQs as well as forms for transferring custody of medical records, sample letters for discontinuing practice, etc. The Texas Medical Liability Trust website (www.tmlt.org) has a succinct 2-page fact sheet regarding retirement and insurance coverage.

ENSURING CONTINUITY OF CARE

The first priority to consider as retirement approaches is the welfare of your patients. All patients should be provided for, but especially patients with active problems that you are in the process of evaluating or managing. For instance, you should make a list of important pending laboratory studies, biopsy reports, etc. and make sure that a clear chain of responsibility exists to check on these results and to contact the patient. Failure to make these provisions may constitute patient abandonment, which, besides being unethical, carries potential legal implications.

Your minimum responsibility is to make sure that your patients have sufficient time and notification to arrange care with another practitioner (see "notification" section below). This is a greater problem for a retiring solo practitioner, since most doctors in a private group or in a corporate practice will turn their patients over to one of their continuing partners or associates. (of course, the patient has the right to transfer care to another practice if they choose). Many solo practitioners will make arrangements with another doctor of their specialty to assume care of their patients—this can either be a formal transfer of records and care (often entailing selling the practice) or a more informal arrangement until the patients have re-established care. Since most primary care practitioners in this day and time use hospitalist services to manage their inpatients, the care of acute hospitalized patients is not as big a problem as it once was, but doctors who have hospitalized patients at the time of retirement will obviously need to arrange continuing hospital-based care for their patients.

NOTIFICATION

A corollary of ensuring continuing care is the need to notify your patients of your impending retirement. Amazingly specific and somewhat complicated rules govern this process, and we will just give an outline of the necessary notification procedures. For a complete account of your responsibilities, again, go to the TMB website or seek legal counsel.

First of all, there are certain groups of physicians that are not required to notify their patients if they retire or leave town. In 2014, the TMB held that locum tenens practitioners who have been in a given location for less than 6 months are not required to notify. Then, in 2019, the TMB absolved the following categories of doctors from the need to notify: (1) doctors who only treated patients in a hospital, an emergency department, a birthing center, or an ambulatory surgery center and (2) physicians who only provided anesthesia, pathology, or diagnostic radiology services. So, most practitioners without direct patient care responsibilities are no longer required to notify their patients; all other practitioners should inform their patients that they are leaving practice.

Which patients do you need to notify? For most practices, the answer is that any patient whom you have seen or done professional services for (i.e., refilled prescriptions) in the past 2 years should be notified.

How much lead time do you need to give your patients? The answer is at least 30 days. You can imagine certain circumstances where this would be problematic—i.e., the sudden death of a physician, the sudden termination of a physician's privileges; these situations are beyond the scope of this brief article.

How should I contact all these patients? The answer is that you need to use at least three separate modes of communication. This is not an optional "best practices" recommendation; it is specified by the TMB. The 3 means are: (1). posting notice either on the practice website or in the local newspaper ("the newspaper of greatest general circulation in each county in which the physician practices or has practiced", to be specific) (2) a written notice prominently displayed at the doctor's office and (3) sending a letter or email to all active patients.

A final note about notification. It is important to emphasize that the legal responsibility for the notification devolves to the retiring physician—not the practice itself. In most circumstances, if you are retiring from a multi-member practice, management will take care of notifying your patients. But, ultimately, it is the retiring practitioner's responsibility. In the (hopefully rare) circumstance when a physician is retiring under duress, some practices are reluctant to let the leaving doctor have access to the addresses of his or her former patients. In almost all circumstances, this is a violation of statute. In order for physicians (whose responsibility this is) to contact their patients to report that they are leaving the group (perhaps to a new locus of practice?), physicians must be given their patient list with addresses.

AVAILABILITY OF MEDICAL RECORDS

When you retire, you will need to make certain that your patient records will remain available to your patients. Patients are empowered to view their own records and/or to have them transferred to a new physician of their choice. In most cases where a physician retires from a group or corporate practice, the practice itself will maintain the records and, for a reasonable fee (see below), provide copies (either electronic or paper copies—it is the patient's choice). An 8-page white paper that details best practices is available on the TMA website. (on the Retirement or Sale of Practice" checklist)

Most solo practitioners will employ a professional firm to be custodian of their medical records. Again, there are numerous specific requirements for the management and storage of medical records (concerning safety, ease of availability, HPIPA compliance, etc.). A reliable medical records custodian will know all the rules and regulations, which are listed in Chapter 165 of the TMB rules and regulations. The TMA medical service bureau maintains a list of medical records management and storage services that are active in the state of Texas (http://www.medicalservicebureau.com/contact.htm) (phone number 512-467-0520).

As a general rule, medical records must be maintained for 7 years—in the case of minors or obstetric patients, the records must be maintained until the patient reaches or would have reached age 21. (This stipulation holds for deceased patients as well.) Medical records need to be available to patients within 15 working days after receipt of a valid letter of consent and a "reasonable" fee. (The TMB currently specifies that the maximum reasonable fee for copying paper records is $25 for the first 20 pages and $0.50 per page thereafter. For electronic records, the specified maximum reasonable fee is $25 for the first 500 pages and $50 for more than 500 pages). One final point to make about medical records: it is NOT the responsibility of your electronic medical record vendor to be the default custodian of your medical records. The company will make sure that the records are available to your chosen custodian, but they will not manage your records for you.

WHO ELSE DO I NEED TO CONTACT TO INFORM OF MY RETIREMENT?

In addition to your patients, you should notify the **Texas Medical Board** to inform them of your retirement. TMB rules require that you notify them of a change in address or departure and closure of practice within 30 days of the change. Besides its essential role as a repository of about a million rules and regulations, the TMB website is a good source of sample forms including a Notification of Departure or Closure of Practice.

You should contact the **Drug Enforcement Administration** at least 6 weeks in advance of any practice location change. You will need to follow their rules about disposal of any controlled substances that you have in the office. If you do not plan to renew your DEA certification, you will need to return your official controlled substance prescription forms to the DEA in a carefully prescribed manner.

Just a note here: retirement does not automatically abrogate your medical license nor your DEA certificate, but, at the time of the next renewal, you will have to decide whether you want to renew your license to practice medicine and your DEA certificate or not. This will be an individual choice and will depend on your particular circumstance. Some doctors want to keep their options open and maintain the ability to do pro bono work, to do locum tenens work, or to get back into the swing of things if their circumstances change. Others want to be able to write antibiotic prescriptions for their family members, etc., but we think this is a bad idea. Not only are you required to keep records of your encounters, but you would also be ensuring that your family members are getting substandard care. When our family members get sick, we think it best that they see a currently practicing, up-to-date, and actively engaged doctor!

If you do decide to keep up your medical license, remember that you will have to keep up with your CME, medical ethics CME, and other requirements. The going fee for medical license renewal is $468 every 2 years, and for DEA renewal is almost $900 for a 3 year certificate. If you want to provide charity care only, the licensure fee is waived, but you still have to keep your license up to date (including keeping track of your CMEs).

Small Practices Can Take Advantage of Little Known Group Health Options

In today's group health insurance market, a small practice owner may feel they have limited options. If you feel this way, it may be because you're not being offered all your options.

TMA Insurance Trust is different. Our mission is to provide insurance strategies that help practice owners meet their needs best. Here are examples of how we help small practice owners:

- Practice owners can get "group of one" PPO coverage just for themselves and their family, and it may cost less than an individual HMO plan.
- **Physicians who have or establish an LLC** may be eligible for group PPO health insurance for just themselves, regardless of whether they have employees or not. (Partnership documentation and the company's Schedule K-1/Form 1065 are required.)
- As a practice owner, you can upgrade your personal coverage to a PPO plan while offering a more affordable HMO plan to your employees.
- We work with leading carriers to provide the best group and individual plan options.
- If you're thinking of opening your own practice, we can help you find and start your own group plan.

If you want to know all your options, call us at **1-800-880-8181** to speak with an advisor, **Monday to Friday, 7:30 to 5:30 CST** or visit us online at **tmait.org**. It will be our privilege to serve you.

TMA INSURANCE TRUST
Exclusively Endorsed by the Texas Medical Association

LIFE ★ HEALTH ★ INCOME ★ PRACTICE

You should send a written notification of your retirement to **Medicare and Medicaid** if you have been participating in these programs. You can do this via internet through the Medicare Provider, Enrollment, Chain, and Ownership System (PECOS) site (https://pecos.cms.hhs.gov/pecos/login) or by paper to JH (Part A&B) Provider Enrollment Services P.O. Box 3095 Mechanicsburg PA 17055-1813.

You will need to contact your **malpractice insurance carrier** and inform them of your retirement as well. Remember that, if you have a claims-made policy, you will need to make sure that you are covered for suits that you are not aware of but that may fall within the statute of limitations. Your insurance carrier should be able to inform you if you need to purchase a "tail" for your policy or not.

If you have X-ray equipment (including DEXA scanning or mammogram equipment) in your office, you will need to report transfer or disposal of the equipment to the **Texas Department of State Health Services Radiation Control** Department MC 2835 PO Box 149347 Austin TX 78714-9347.

If you have participated in organized medicine, you can get a dues reduction when you retire. The best way to inform them about this is to contact your **local medical society** (i.e., the Potter-Randall County Medical Society at 806-355-6854). They will contact the Texas Medical Association for you; that way, both organizations will know. If you are a member of the **American Medical Association**, you will need to contact them directly.

Several others should be contacted, not because of statute but because it is the professional thing to do. You should, of course, inform **your employees** of your retirement decision as soon as you can. If you are a solo practitioner, you will have to anticipate that some employees will probably start looking for a new job right away. You may have to hire temporary help to tide you over until your retirement day. In addition, you should contact the **hospitals** where you have privileges and your **referring physicians,** so that new referral arrangements can be made. If you are renting office space, you will need to contact your **landlord**; if you own the property but still have a mortgage, you will need to contact t**he carrier of your loans**. It would be thoughtful to contact **vendors** that you have used over the years. **If you are a PA (Professional Association)** you will either need to file an Article of Dissolution, or, if the PA will continue without you, a formal transfer of partnership interest. A health care lawyer can help you with these filings.

WHAT ABOUT SELLING MY PRACTICE OR MY OFFICE, EQUIPMENT AND SUPPLIES?

Evaluating a practice is a complicated process and involves that assessment of the particular community, the demand for your services, etc. Several accounting and legal firms have departments that deal specifically with the evaluation and sale of medical practices. You can access a list of these companies through the TMA. These firms can also help you assess the value of your equipment if you are planning sell it to a colleague, hospital, etc.

APPROACHING RETIREMENT

Perhaps as important as all the business and professional aspects of retirement are the personal and psychological issues involved. Retirement is a bittersweet time. In a sense, you have been working toward this day for the past 30 to 50 years of your professional life. This is what (hopefully) you have been saving your money for. And yet—this is how you have been spending much of your time over these past decades. If you have been in a patient care specialty, you will miss patient contact. Most of us enjoyed almost all of our patients, and the ones we didn't really love all that much we could tolerate because the others were so rewarding to care for. The role of being in the healing arts has been important to your self-image and your self-assessment. You have spent tens of thousands of hours learning how take care of patients, and you will miss this. You will miss interactions with your colleagues—your partners, your referring doctors, the nurses and even your hospital administrators.

We can't tell you how to live your lives after retirement, but here are some thoughts. In the fall of 2016, Panhandle Health published an issue whose articles were all written by retiring or retired doctors. You might profit from looking back over the ideas about retirement from thoughtful doctors like Lowell Chaffin or Mitch Jones, Chuck Rimmer or Phil Periman (go to the Potter-Randall County Medical society website, click the "Magazine" tab, and scroll back through the old issues).

One of our most important recommendations is to be intentional about your retirement, just as you were intentional about your training and your practice life. Don't plan to drift off into retirement and just see what turns up. We have seen many retirees (not just doctors) who floated off into retirement and soon found themselves floating off into depression. Have a plan for retirement. Keep physically and mentally active. Jump feet first into activities at your place of worship, your civic club, at the symphony or the little theater. There are scores of volunteer activities that will give you a reason to get up in the morning. You need to actively cultivate meaning and purpose in your life, even if the way you find meaning has changed.

Retirement for a medical practitioner can be sobering, but it can also be invigorating. You can see from the first part of this essay that the legal and bureaucratic requirements can be arduous. You will need to grind out this part; study the TMB website and engage legal advice from a healthcare attorney to make sure that the i's are all dotted. But, once you have plowed through the legal and ethical requirements associated with the process of retirement, you are finally ready to really embark on the adventure of creating a productive, meaningful, and fruitful retirement life for yourself.

The History of Health Insurance in the United States

by Rouzbeh K Kordestani, MD, MPH

INTRODUCTION

The history of medical insurance in the United States is a story filled with the needs of the population and the eventual response/reaction of the industry. This story begins in the early 1900's, when the growth of industry in the US showed the need for some sort of protection, not only against disease but also against the pitfalls of industrialization, namely injuries. As industrial "protection" grew, other segments of the population were left out. They in turn began to develop products to protect themselves from the ever-increasing costs of hospitalization. Soon, other segments of the population (both physicians and patients) reacted to the wave and interest. Also, as the patient population began to grow, segments of the population seemed to be left out, namely the elderly and the indigent. This is where Medicare and Medicaid were born. And as time has gone on, additional permutations of these health systems have developed. The health care system in the US is a telling story of growth, profit, need and wants.

THE EARLY HISTORY OF HEALTH INSURANCE: "SICKNESS" FUNDS

In the early 1900s, most of the population received health care sparingly. In fact, very few patients sought care in actual hospitals. Most care and most surgeries or procedures were performed in the patients' homes. The greatest worry for the patient was the loss of income when they were sick or when they were recovering from an injury. For this reason, most early "insurances" were financial products developed by banks or credit unions to help patients set aside money to cover their lost wages.

INJURY AND THE RISE OF WORKERS COMPENSATION INSURANCE

Since the early insurance products were based on "sickness" funds, it soon became obvious that a significant number of people were uncovered for the most common malady of the day, on the job injury. In the industrial age, injuries during industrial heavy labor could be and often were catastrophic. To protect themselves and their workers, companies soon began to develop products to insure themselves against the long-term costs of workers' injuries. These products often varied from company to company. A company would set aside a certain amount of funds and would make a deal with a group of physicians to help care for their workers. In this way, the company would save money in the long term and the workers felt safer because their medical needs were addressed. This push was also spurred on by the unionization movement. Representing large numbers of workers, these Workers Compensation funds became important bargaining chips in labor negotiations, since they allowed health care costs and needs to be built into contracts for workers.

The first federal law that mandated coverage was enacted in 1908 in the form of the Federal Employers Liability Act (FELA). The law as written applied specifically to railroad workers and workers dealing with interstate commerce, namely truckers. Other workers were not specifically protected. The law was designed to protect workers from injury or sickness related to their work, if it was thought that the injury was work-related, and if the employer was deemed partially responsible. Other industries soon followed suit. By 1915, a total of 32 states had enacted legislation covering workers and allowing companies/employers to buy protection for their workers, mostly through the state and governmental mechanisms.

THE BEGINNING OF PRIVATE HEALTH INSURANCE: BLUE CROSS VS BLUE SHIELD AND BEYOND

As workers compensation funds grew, other groups of workers not involved in heavy industries or trucking seemed to be left out. They in turn began to develop plans to cover themselves and their health care needs. The first recorded non-industrial health plan or "arrangement" was started in 1929 by a group of teachers in the Dallas area with the help of the Baylor Hospital systems. These teachers decided to pay into a health plan at a rate of 50 cents per member per month. This "health plan" allowed teachers access to the hospital for up to 21 days of care at no cost. This method of pooling resources and pooling risks worked well and brought hospitalization insurance to a group of workers that were not heavy industry related. This plan was eventually named "Blue Cross."

An interesting fact is that the "Blue Cross" arrangement was between a group of workers (teachers) and the hospital systems. It did not include any physicians. The patients needed this as an insurance policy. The hospitals needed this to secure use of their facilities and to ensure patients (it began during the Great Depression when hospital revenues were plummeting). Because they felt slighted by their exclusion from this arrangement, groups of primary physicians decided to develop their own system to circumvent the Blue Cross arrangement. They named their group "Blue Shield".

In a similar situation in the Northwest of the United States, the Kaiser companies founded an arrangement with a group of physicians to handle the needs of their employees in the shipyards (and their families). This was initially an in-company health plan. As the company began to expand into Washington, Oregon, and California, so did its health coverage for workers and their families. The plan expanded to cover Kaiser's steel mills, railroads, and shipyards before WWII and for years after. Years later, as the industrial aspects of the company have faded, the health care systems (the Kaiser Permanente Health Systems and the Kaiser Health Care Foundation) are alive and well.

WORLD WAR II AND THE WAR ACT

As the United States and the rest of the world became embroiled in World War II, it became obvious that companies were in desperate need of workers. Unfortunately, based on the laws at the time, no company could offer more pay for workers than its competitors; salaries and wages were basically capped. This was felt by many to be an unfair business practice. In order to justify health insurance, however, in 1943 the War Labor Board decided that insurance and insurance products were "not a part of wages" and could therefore not be taxed as such. This decision was a windfall for the affected companies. Soon, companies were able to offer health care benefits to their workers without incurring taxes. Most importantly, without resorting to increasing wages, which would be deemed illegal during the war, they could effectively give their workers better benefits. Because of this change, between 1941 and 1960, the percentage of insured workers in the United States population exploded from approximately 9% to over 60%.

THE RISE OF PRIVATE INSURANCE

Private insurance groups began to flourish in the '40s, '50s and '60s. However, most of the population continued to receive their insurance through their work. Private arrangements were simply customized to allow certain groups to develop their own products. Again, most of these "products" were like Blue Cross in that they were arrangements with specific hospitals or hospital systems or like Blue Shield in that they were arrangements between groups of companies and groups of physicians. These plans helped to fill gaps between the employer-driven plans.

MEDICARE AND MEDICAID

While a significant number of the patient population was covered by employers, it soon became obvious that parts of the population--the groups with the highest risks--were in fact not covered or poorly covered. This referenced the elderly and the poor. The elderly were often those who were no longer employed but who had the highest risk for disease processes like diabetes and heart disease. In order to cover this segment of the population from sickness and to afford them adequate health coverage, Medicare was enacted. Similar products had been advocated as far back as the late 1930's by President Franklin Delano Roosevelt and later by President Truman, but the political support was not there to pass these programs through a divided Congress. One of the outside groups that fought sternly against the approval of Medicare was the American Medical Association (AMA). This organization felt that these products would threaten the freedom and the autonomy of doctors and the doctor-patient relationship. Fortunately, with the emergence of a Democratic congress and a Democratic president in Lyndon B. Johnson, Medicare was eventually pushed through and made a reality. With Medicare, the elderly had full coverage for their health care needs. This product did much to curb poverty among elderly patients in the United States. In many cases, their medical needs had pushed them into bankruptcy and desperation. With Medicare, this sad ending for many elderly Americans was mitigated.

In similar fashion, the other high-risk group was low-income Americans, many of whom had no jobs or were disabled. As part of the Medicare protection plan, Medicaid was born to help this neglected

group of patients. Unfortunately, the political power was not paramount here. States were allowed the option of deciding how much money they wished to allocate to the Medicaid program. In this way, each individual state had the ability to decide on how it wished to cover its Medicaid-worthy patients. It is for this reason that we now see such a patchy participation in the Medicaid program throughout the United States, while Medicare coverage is much more comprehensive.

THE RISE OF HMO AND PPOS

In the early '60s and '70s, the cost of providing health care began to increase. This was in part due to the actual cost of health care delivery and in part due to costs of expansion and technology. Unfortunately, as the total cost of health care began to increase in these decades, the actual amount of coverage and the actual number of individuals covered began to fall. Also, the number of uninsured and under-insured began to increase dramatically. To stave off this shift, health care groups began to delve into risk analysis and stratification. Insurers began to analyze their populations to decide who to cover and who not to cover. In this way, health care companies soon began to become far more able to understand their products, their populations and its needs, as well as health care consumption in general. Because of this increase in the administrative analysis and the complexity of heath care companies, there was a notable increase in the cost of administering care.

As insurance products became more complex, America saw the birth of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These two specific types of products were the pinnacle of stratification of the new health care systems. They were on different sides of the same spectrum. Some health care groups began to try to limit the use of products (health care) by the institution of HMOs. This model was the most limited version of managed care. HMOs forced members to use only certain groups of providers, certain groups of pharmacies and certain hospitals. In order to cap off ever increasing costs, HMOs tried to hold patients within a circle of product use. On the other side of the spectrum were the PPOs. Within PPOs, the patients and many companies that were self-insured were allowed to pick and choose providers and provider networks, hospitals, and pharmacies. This allowed them a great deal of choice but also came at a higher cost. This model did not maximize cost savings but gave insured patients more choice.

THE STATE OF INSURANCE IN THE LAST 30 YEARS

As health care has become more complex, costs of care have spiraled; despite this, we have seen an ever-increasing number of uninsured patients. So, we have this paradox: as costs have increased, health care benefits have decreased and the number of the uninsured and under-insured have dramatically ballooned. Not surprisingly, most of the population is left confused about what exactly is going on, and multiple political attempts/stabs have been made to find an effective solution.

In the early 1990s, there was an effort to bring forth revolutionary health care reform. The Clinton administration initiated efforts to start a Health Care Security Act. This was championed by first lady Hillary Clinton. The basics of the plan mandated that employers pay for about 80% of an employee's health costs. This, of course, pushed the burden of insurance towards the employer. However, with the spiraling costs of health care, this was deemed unfavorable to business and in many ways politically unfeasible. This plan never reached its fruition.

A less grandiose plan saw the light of day in the state of Massachusetts. Under Governor Mitt Romney, a comprehensive health care plan was enacted in 2006. This plan effectively guaranteed citizens of Massachusetts universal healthcare. It required all citizens above the age of 18 to obtain health insurance. It provided employer insurance to employees and fined those employers that did not offer insurance as per the state guidelines. The Massachusetts plan provided subsidies for employer-sponsored health coverage. With these simple rules, it stratified all members of the state to enroll in one system of insurance and, by pooling their risks, covered all the patients in the state, giving them effective health care with access to all health care products.

Only a few years later, a combination of the axioms of RomneyCare and those of the original Health Care Security Act was enacted as the Affordable Care Act, signed into law under President Obama. Many of the mandates of RomneyCare were kept as essential components. Additional rules and mandates were also enacted. These were not state specific but were federal.

As most are aware, the ACA has increased the number of patients who are covered under health insurance in the United States. Unfortunately, the numbers of uncovered or uninsured are still staggering by any metric. By recent counts, as many as 9% of the population (or about 33 million Americans) continue to have little or no coverage. Even though the ACA has been instrumental in increasing the number of insured Americans and has been a life saver to many, the system continues to be overburdened by its own costs and the costs of health care delivery.

WHAT MAY THE FUTURE HOLD?

As the tally of history of the American health care system shows, it is rather colorful and complex. It has seen its ups and downs. Now, as it has matured, it faces its most harrowing challenges. We continue to be plagued by overwhelming costs in products, hospital costs, costs of health care administration and delivery, while we are not seeing much improvement in actual health care quality—in other words, we are paying more and more for less and less. This trend cannot continue. As modernization continues to advance, it is hoped that cost-saving products, more efficient manufacturing, telehealth and systems of modernization in internet health care delivery, along with a new focus on health care prevention models, will help save the system.

No Boundaries International: Resources for Trafficked Persons

by Traci Rogers, PhD

Editor's note: This is a supplement to an article by Dr. Rogers in the Spring 2023 issue ("Human Trafficking") of Panhandle Health.

INTRODUCTION

Human trafficking does not always cross borders. In order to best serve each victim and those impacted, we must have community collaboration. We are much stronger together! Here are just a few points to remember as you serve those impacted by human trafficking.

REPORTING OBLIGATIONS

If there is an incident involving a minor, Texas is a mandatory reporting state. You are required to report alleged or suspected abuse or neglect of a child, elderly or persons with disabilities that has occurred or may occur. Texas law requires that a report be made within 48 hours of a healthcare provider first suspecting abuse or neglect of a minor. You cannot delegate this task to another person. Reporting must be done to a local or state law enforcement agency, the Department of Family and Protective Services, or the state agency that operates the facility in which abuse happened.

For definitions of abuse and neglect, and further reporting requirement detail, please see Texas Family Code, Chapter 261. See Human Resources Code 48 for additional detail regarding abuse to elderly and persons with disabilities.

The National Human Trafficking Hotline can help you assess a situation and determine a current level of danger.

- Call 911 for emergencies and/or life-threatening situations | Amarillo Police Department: 806-378-3038

- The National Human Trafficking Hotline: 888-373-7888

- Texas Abuse Hotline: Non-Emergency – txabusehotline.org; Urgent (needs to be investigated within 24 hours): 800-252-5400

INTERPRETERS

Make plans ahead of time. Know what your agency's policies are. Many use a translation line, which is great if your agency has the budget for that. For NBI, we prefer to have a network of individuals that we can call that have been trained and are prepared to deal with trafficking victims. Our concern has always been that, when you just use a translation line, you really have no way of knowing the heart of the translator or even if they are truly sharing what you or the victim have said. We do understand that, depending on the language, this might not always be an option.

COMMUNITY PARTNERS

It's critical for you as an agency to be working with a variety of partners. It takes time to develop those relationships. If you do not have these already in place, get started today. Find out what agencies are in your area and develop a relationship with them. Here's a few places to look:

- Shelters/Housing
- Mental Health
- STD Testing
- Food Pantries
- Clothes Closets
- Medical Clinics
- Rehab Facility
- Crisis Centers
- Foster Care
- Law Enforcement
- Employment Opportunities
- GED Programs
- Tattoo Removal
- Counseling Services
- Social Security/Birth Certificates/ID
- Victim Services

Typically, a trafficking victim has no resources and no means to pay for any type of services. Everything has been stripped from them. It's also important to realize that, if you simply hand them a list of resources, they are more than likely going to be overwhelmed and not follow through. They will need your assistance on where to begin.

AMARILLO AREA RESOURCES

This is not an extensive list, but will at least provide you with a starting point.

VICTIM SERVICES

No Boundaries International
Traci Rogers, Executive Director
Kaytlin Wyatt, Victim Services Coordinator
Amber Coppock, Executive Assistant
806-576-2501 Victim Hotline: 806-673-1598 (call or text)
www.nbiamarillo.org

Family Support Services
806-342-2500
Victim Hotline: 806-374-5433
www.fss-ama.org

SHELTERS

Salvation Army
806-373-6631
www.salvationarmytexas.org/amarillo/

Faith City Mission
806-373-6402
www.faithcity.org

Domestic Violence Shelter
806-374-5433
www.fss-ama.org

Martha's Home
806-372-4035
www.marthashome.org

MENTAL HEALTH

Texas Panhandle Centers (TPC)
806-358-1681 (office)
806-359-6699 (crisis hotline)
www.texaspanhandlecenters.org

STD TESTING

Amarillo Public Health Department
806-378-6300
www.amarillo.gov/departments/communityservices/ public-health

FOOD PANTRIES

No Boundaries International
806-576-2501
www.nbiamarillo.org

Bethesda Outreach Center
806-383-6990

Catholic Charities
806-376-4571
www.cctxp.org

MEDICAL CLINICS

Heal the City
806-231-0364
www.healthecityamarillo.com

Haven Health Clinic
806-322-3599
www.havenhealthamarillo.com

JO Wyatt Clinic
806-351-7200
www.nwtpg.com

REHAB FACILITIES

Cenikor
888-236-4567
www.cenikor.org

DOCUMENTATION

It is important to understand the complexity of documenting appropriate and required information. Documentation of medical history and information/guidance provided to a patient could be used in legal situations. Be cautious of documenting anything that could incriminate your patient. Consult local legal guidance, state and local laws to determine best documentation practices for your agency. For additional information, please refer to **Procedures Regarding Documentation** and **Guidelines for Forensic Examination** in the **HEAL Trafficking Protocol Toolkit.**

https://healtrafficking.org/protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-health-care-settings/

ADDITIONAL RESOURCES

Use the additional resources listed below to create a solid plan for your agency and provide educational information to agency members and patients.

HEAL Trafficking Protocol Toolkit

Designed to assist with creating a protocol in health care settings:

https://healtrafficking.org/protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-healthcare-settings/

Human Trafficking: Guidelines for Healthcare Providers

https://www.mhaonline.org/docs/default-source/resources/human-trafficking/human-trafficking-guidelinesfor-healthcare-providers-v2.pdf?sfvrsn=7bbed60d_8

Human Trafficking Response Program Shared Learnings Manual

Designed to assist in creating a protocol for health care settings:

https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:30b5c15b-210e-4392-adc1-1227041a1ce6

Customizable Human Trafficking Educational Brochures for Patients
Available in 20 Languages!

Offered by HEAL Trafficking
healtrafficking.org

Beginning in 2020, in collaboration with the Greater New Orleans Human Trafficking Task Force, HEAL Trafficking created educational patient brochures for use in health systems which serve as a trafficking self-assessment for literate patients. The brochures are available as Canva templates, and are intended to be customized to include local resources depending upon where these brochures are being distributed.

The customizable brochures are available in 20 languages: English, French, Spanish, Arabic, Simplified Cantonese, Simplified Mandarin, Traditional Cantonese, Tagalog, Indonesian, Hindi, Malay, Swahili, Vietnamese, Haitian Creole, Armenian, Korean, Russian, Khmer, Punjabi, and Hmong.

Visit the following link to request the brochure:

https://healtrafficking.org/2021/09/customizable-human-trafficking-educational-brochures-for-patientsavailable-in-20-languages/

Victim-Centered and Trauma-Informed care tool

The PEARR (Provide Privacy, Education, Ask, Respect, Respond) Tool can assist healthcare providers with conversation advice. Visit the Dignity Health website for more information:

https://www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed

What to Look for During a Medical Exam

A resource provided by the National Human Trafficking Resource Center to help identify victims:

https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:b520f112-033e-4691-be19-20e9ddb19a72

AUTHOR BIO

Traci Rogers, PhD is the executive director of the Amarillo chapter of No Boundaries, International., providing structural and spiritual oversight with programs for sex trafficking victims.

A Case Report of Glycogenic Hepatopathy in a Newly Diagnosed Type 2 Diabetes Patient, with Emphasis on Addressing Social Determinants of Health and Language Barriers

by Basak Basbayraktar PGY1, Adrian Mola PGY2, Kelly McMaster MD
Department of Internal Medicine, Texas Tech University School of Medicine, Amarillo TX

BACKGROUND
Glycogenic hepatopathy (GH) was first described by Pierre Mauriac in 1930, regarding a pediatric patient with poorly controlled type 1 diabetes (brittle diabetes) who presented with hepatomegaly, cushingoid features, and poor growth (a condition now known as Mauriac syndrome). Since then, many cases have been reported, variously termed hepatic glycogenosis, glycogen storage hepatomegaly, and hepatic glycogen storage disease. In 2006, Torbenson and colleagues coined the term "glycogenic hepatopathy," which has been universally adopted (1).

Glycogenic hepatopathy (GH) is a rare cause of serum transaminase and alkaline phosphatase (ALP) elevations in the presence of diabetes mellitus (DM). We describe the case of a patient with recently diagnosed, poorly controlled type 2 DM who presented with hepatomegaly and an alkaline phosphatase (ALP) level >1000.

CASE REPORT
A 34-year-old Hispanic male with a past medical history of type 2 DM presented with hypoglycemia due to accidental insulin overdose. He had experienced 60 pound weight loss in the preceding 6 months. He had recently been diagnosed with DM at another facility when he presented with hyperglycemia and episodes of loss of consciousness; her had been discharged with insulin and levetiracetam. Due to a language barrier (he spoke Q'eqchi', a Mayan/Spanish dialect from Guatemala), he misunderstood how to use his insulin and had accidentally administered an entire vial. On presentation, he was tachycardic, diaphoretic, and dizzy. Labs were significant for white blood cell count of 21.9/μL, hemoglobin 9.8 g/dL, ALP 958 U/L, gamma-glutamyl transferase 1298 U/L, alanine aminotransferase 873 U/L, aspartate aminotransferase 529 U/L, albumin 1.9 g/dL, and blood glucose level in the 60s. Physical exam was unremarkable except for hepatomegaly, which was confirmed with ultrasound and MRI. MRI showed right liver lobe measuring about 22 cm craniocaudal. His hypoglycemia was corrected with dextrose, but his liver enzymes remained elevated, especially ALP >1000. Gastroenterology was consulted and recommended a liver biopsy, which showed hepatocellular swelling and abundant cytoplasmic glycogen on the Periodic acid-Schiff stain. GH due to poorly controlled diabetes was diagnosed.

DISCUSSION
GH can cause severe, reversible elevations of serum transaminase levels in patients with poorly controlled diabetes due to liver glycogen accumulation. It is important to distinguish GH from non-alcoholic fatty liver disease because the treatment and prognosis differ (2). Especially in patients with marked transaminase elevations, liver biopsy should be considered. Awareness of GH will cause less diagnostic delay and more insight into the prevalence of this completely reversible disorder (3).

DISCUSSION
Glycogenic hepatopathy is caused by glycogen accumulation due to severe fluctuations in both glucose and insulin. Despite severe laboratory abnormalities, it does not cause liver cirrhosis. Treatment consists of improving glycemic control.

In addition, this case highlights the critical role of addressing social determinants of health (SDOH)--such as language barriers, access to healthcare, and insurance status--in improving health outcomes and reducing health disparities in vulnerable populations.

Recent studies have highlighted the critical role of SDOH. A study published in JAMA Internal Medicine in 2017 found that uninsured or Medicaid-insured patients with diabetes had a 25% higher risk of hospitalization and were 6% less likely to achieve glycemic control, when compared to those with private insurance (4). Similarly, another study published in Health Affairs in 2018 found that Medicaid expansion under the Affordable Care Act was associated with a significant improvement in access to primary care, resulting in a decrease in preventable hospitalizations, particularly among racial and ethnic minorities (5).

Moreover, a systematic review published in the Journal of General Internal Medicine in 2018 found that interventions targeting social determinants of health were associated with improved health outcomes, such as a 23% reduction in hospitalizations and a 19% reduction in emergency department visits. Specifically, providing language services to patients with limited English proficiency and addressing housing insecurity were the most effective interventions (6).

A recent study published in the Journal of Immigrant and Minority Health in 2021 highlights the challenges faced by patients speaking Spanish or Mayan dialects (particularly Guatemalan refugees) in accessing and understanding healthcare in the United States (7). The study surveyed 135 patients in a primary care clinic in the Midwest and found that nearly two-thirds reported limited English proficiency and over half reported

low health literacy. The study also found that patients from indigenous dialect regions had unique cultural beliefs and health practices that impacted their ability to engage in the US healthcare system. These challenges led to misunderstandings, poorer health outcomes, and increased healthcare costs. The study highlights the importance of providing culturally and linguistically appropriate healthcare services, such as interpreter services and translated materials, to ensure that these patients, particularly those from vulnerable populations, can access and engage in healthcare effectively (7).

Several interventions have been shown to improve outcomes for Spanish-speaking patients with limited English proficiency (LEP). In a randomized controlled trial of 180 Spanish-speaking patients with diabetes published in the Journal of General Internal Medicine in 2019, a bilingual nurse intervention was found to improve glycemic control, blood pressure, and cholesterol levels compared to usual care (8). Another study published in Diabetes Care in 2019 found that the use of a bilingual diabetes education program improved diabetes self-management behaviors and glycemic control in 195 Hispanic patients with diabetes (9). Interpreter services have also been shown to improve healthcare utilization and patient satisfaction. A study of 1,302 Spanish-speaking patients published in the Journal of General Internal Medicine in 2020 found that the use of interpreter services was associated with higher rates of preventive care, better medication adherence, and greater patient satisfaction compared to patients who did not receive interpreter services (10).

In the Journal of Racial and Ethnic Health Disparities in 2020, Wang et al. examined the relationship between language barriers and diabetes outcomes among Chinese immigrants in the United States. The study found that patients who experienced language barriers were less likely to receive recommended diabetes care and had worse diabetes control compared to those who did not experience language barriers. The study highlights the importance of addressing language barriers in healthcare to improve outcomes for immigrant populations (11).

Providing professional interpreter services to Spanish-speaking patients with LEP can improve healthcare utilization and outcomes, while the use of ad-hoc interpreters may not be sufficient. Health systems should prioritize the provision of linguistically and culturally appropriate services to improve access to care and reduce health disparities for vulnerable populations.

States have implemented a range of policies to improve access to healthcare for uninsured patients. For example, several states have expanded Medicaid under the Affordable Care Act, which has increased access to primary care and reduced preventable hospitalizations among vulnerable populations. Other states have

established health insurance marketplaces, which allow uninsured individuals to purchase affordable health insurance plans with the help of tax credits and subsidies.

Some states have implemented specific programs to provide healthcare services to refugees and other vulnerable populations. For example, Minnesota has established the Refugee Health Program, which provides comprehensive healthcare services to refugees, including primary care, mental health services, and interpreter services. Similarly, California has implemented the Refugee Assistance Program, which provides healthcare services and other support services to refugees and other immigrants.

Healthcare providers can take steps to improve outcomes for uninsured patients. For example, providers can offer discounted or sliding-scale fees for uninsured patients, provide free or low-cost medications, and provide referrals to community health clinics and other resources for uninsured patients.

According to a recent report by the Kaiser Family Foundation, several states have implemented SDOH interventions, such as providing Medicaid coverage for non-medical services like housing and transportation, to address the needs of low-income and vulnerable populations. California has launched the Whole Person Care program, which provides coordinated care for Medi-Cal beneficiaries with complex medical and social needs, including housing, food, and transportation assistance. Similarly, Oregon has implemented Medicaid-funded Coordinated Care Organizations that provide integrated physical, behavioral, and dental health services and also address social determinants of health.

In Texas, several initiatives have been implemented to address the issue of uninsured patients and to improve access to healthcare for vulnerable populations. Although Texas has not expanded Medicaid under the Affordable Care Act, it has implemented other programs to increase access to healthcare for uninsured patients.

The Texas Women's Health Program provides family planning and preventive healthcare services to low-income women who are not eligible for Medicaid. The program is funded by the state and federal governments and is available to women who meet income and residency requirements.

Texas participates in the Children's Health Insurance Program (CHIP), which provides low-cost or free healthcare coverage to children in low-income families who are not eligible for Medicaid (i.e., the family earns too much to qualify for Medicaid). The program covers a range of services, including doctor visits, hospital care, prescription drugs, and dental care.

Several safety net clinics and community health centers operate throughout Texas to provide affordable healthcare services to uninsured and underinsured patients. These clinics offer a range of services, including primary care, dental care, mental health services, and specialty care.

In recent years, Texas has also implemented telemedicine programs to increase access to healthcare for patients in rural and underserved areas. These programs allow patients to receive medical care and consultation from healthcare providers via video conferencing and other virtual technologies.

Texas has implemented several additional initiatives to address SDOH. The state's Medicaid program offers the Delivery System Reform Incentive Payment (DSRIP) program, which provides incentive payments to hospitals and other healthcare providers for implementing innovative programs to improve quality of care and address health disparities, including those related to social determinants of health. The state's Department of State Health Services has implemented the Promotor(a) or Community Health Worker program, which trains and deploys community health workers to provide culturally appropriate health education and navigation services to underserved populations, including Spanish-speaking immigrants and refugees.

Several nonprofit organizations in Texas, such as the Texas Association of Community Health Centers and the Texas Health Institute, are working to address social determinants of health through advocacy, research, and community engagement initiatives. These organizations collaborate with healthcare providers, policymakers, and community stakeholders to promote health equity and reduce health disparities in the state.

Despite these initiatives, Texas still has one of the highest rates of uninsured residents in the country, with approximately 18% of the population lacking health insurance coverage. This highlights the ongoing need for efforts to improve access to healthcare for vulnerable populations, including uninsured patients and refugees.

Overall, improving access to healthcare for uninsured patients requires a multifaceted approach that involves policy changes at the state and federal levels, as well as efforts by healthcare providers to offer affordable and accessible healthcare services to uninsured patients. States and healthcare providers can implement innovative programs and interventions to address SDOH and promote health equity in their communities.

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