

Omar Maniya, MD, MBA, on leaving the frontlines for private practice

AMA's Moving Medicine video series amplifies physician voices and highlights developments and achievements throughout medicine.

Featured topic and speakers

In today's episode of Moving Medicine, a discussion with Omar Maniya, MD, MBA—an emergency physician who went from the frontlines of the pandemic to family practice—about his journey and what private practices can do to stay successful.

Speaker

- Omar Z. Maniya, MD, MBA, CEO, Maniya Health

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we're talking with Dr. Omar Maniya, an emergency physician who went from the frontlines of the pandemic to family practice, about his journey and what private practices can do to stay successful. I'm Todd Unger, AMA's chief experience officer in Chicago. Well, Dr. Maniya, it is a pleasure to have you back. It seems like a million years ago, when we first had you on the COVID-19 Update. You were one of the first voices we heard from telling us what it was really like as an emergency physician on the frontlines, treating COVID patients and you yourself were just recovering from COVID-19. Now you've made a big switch to private practice and I'd love to start by just asking why did you make that decision?

Dr. Maniya: Thanks, Todd, thanks for having me back. And most importantly, for helping to share the physician voices over the last year and a half, which is so important. So let's talk about the switch. I think, to be honest with you, COVID happened, I'm working in the emergency department. I'm helping really sick patients out. And my mom has a primary care practice in Central Jersey and telehealth

becomes a thing. And like most private practice, older doctors, she wasn't trained in and raised in a tech-savvy environment and she needed help implementing telehealth.

And so I came and I helped do that. And then we fixed the phone system and then we fixed the scheduling system and then we made automated reminders. So you don't have to call 60 patients a day and say, "Hey, remember your appointment's tomorrow." And we just started things together. And fast forward a year and a half, I decided to join and really take this on. I think, yes, while I'm currently working in a family practice, what our core thesis is that marrying the two worlds of acute care and chronic care, which historically have lived far apart with a giant river running in between them that has no bridge, marrying those two worlds together can really have a dramatically positive impact on patient care. And that's the experiment that we're currently running.

Unger: I'm curious, why is there a river running through it?

Dr. Maniya: So it's interesting, historically you have your primary care providers who live in the outpatient world and they see their patients at regular cadences. And of course they do some sick visits and treat low to moderate acuity issues. And then, when the patient needs rapid access to labs or diagnostics or specialty consultations or a procedure, they're often sent to the emergency department. And over there, it's a whole different group of docs with a very different skillset who do a totally different thing. And then, the patient gets bounced back. And each of those bounces back and forth, oftentimes results in information being lost, delayed care and things sometimes fall through the cracks.

Now, this is not a knock on emergency physician or primary care physicians. Most, and almost all are awesome, awesome people trying to do the right thing but historically there's been this big structural divide. But that doesn't necessarily make the most sense in 2021. As you and many of the viewers I'm sure know, the vast majority of health care are driven by chronic diseases and it's not from taking Lipitor for your hyperlipidemia. It's from hyperlipidemia not being appropriately managed or not being adequately maximally managed, then leading to XYZ complications. And so, it's these acute exacerbations of chronic disease that I think the current system is not really well designed to deal with. And that's why I think marrying this acute world and the chronic world together can have so much value.

Unger: It's interesting. And that's of course why the AMA is so focused on chronic disease right now for the reason that you mentioned. This issue about kind of unifying those two worlds. You've said that we've got a broken primary care backbone. What do you mean by that?

Dr. Maniya: Yeah. And again, I just want to say every primary care doctor I've met is awesome. They wanted to the right thing and they work their tails off. There's actually an AMA study about pajama time, about how your average primary care doc sees patients all day and then spends two hours writing their chart for every one hour they spent taking care of patients.

And the world is just so backwards if that's the case. So when I talk about a broken primary care backbone, I'm talking about historically the structure of primary care, the way that they're reimbursed less than specialists. And the discontinuity of care, all results in things falling through the cracks and patients have responded. If you survey patients on net promoter score, which is a measure of how happy patients are or customers broadly speaking with any particular type of business, the only thing that ranks worse than going to the doctor is prisons and health insurance companies.

And so that's the world that we're in. And so if patients don't even like going to the doctor, then how can we expect them to be regularly following up on their health issues and making sure that they prevent complications of their disease? So that's sort of what I mean when I talk about a broken primary care system but I think now we're in a really interesting time, particularly over the last decade. I think there have been a lot of really under the radar winds that have happened. And the AMA has been a part of many of them that together, nothing was a silver bullet but, together, all of them I think have really changed the game and will enable the future of private practice and the future particularly of primary care to be really successful and be able to treat patients really well.

Unger: You mentioned a couple of things. The AMA is very focused on, for clear reasons, number one, that just tremendous amount of administrative burden that leads to that kind of pajama time. And the result, significant levels of burnout among physicians due to that. And it's no wonder then that private practices in particular are under a lot of pressure right now.

Your message is, "Hey, we can reimagine this." And one thing you've started to center in on your practice is the use of technology. And what I hear you saying also is like experience, which is an interesting thing to key in on from the patient perspective. Can you talk about what does that mean to reimagine primary care?

Dr. Maniya: Yeah, so I think the first thing is convenience innovations in 2021 should be table stakes. Those are things that customers expect from every other business they interact with. And there's no reason private practice can't afford those things and implement those things. For example, free wifi, that the password is very easily displayed. So people can do something in the waiting room.

Extended hours. That doesn't mean everyone needs to stay late but as long as you stagger shifts, you can make that happen. So for example, we're open 8:00 to 8:00. Guaranteed same day appointments. That doesn't mean you have to hire a new person or create a separate wing. It just means you run the data and you see how many patients do you expect on any given day to call in with a same day complaint and you leave that many appointments empty.

So those are sort of the convenience innovations. We have a couple others, we have a nutritionist, physical therapy, labs on site and radiology because we don't want patients bouncing around but none of these things are rocket science. I think they're all about just looking at the data and building the necessary partnerships to make them happen. So I think convenience is table stakes and should

be table stakes in 2021. I think what's really interesting is, okay, once we've done these convenience innovations to make patients happy about coming to the doctor, now how can we really flex the use of technology to treat them better than the historical standard of care?

And I think this is really where a lot of the AMA supported changes, particularly in the code set and the CPT code set have really, really have the potential to change in the future. So the first and most obvious that everyone's heard of is telehealth being reimbursed without limitations on where the patient is. They don't just have to be in a rural area and hopefully post COVID that goes on. But more so than that, there is chronic care management where you can actually provide care management and patient navigator services to patients to help them find where to go, make their appointment, coordinate transportation, et cetera and really ease those friction points in care.

And that's a billable service now. Additionally, remote patient monitoring. We have, for example, 800 patients on connected blood pressure devices and glucometers, and we're managing their hypertension and their diabetes remotely. We don't have to call them into the office for, "Hey, come in for a blood pressure check," because we already know what it is from their connected device. And it's things like that that I think lower the barriers to entry to seeking care and then result in patients being more proactive and more engaged in their health care.

Unger: It's interesting because telemedicine kind of moving along in a level of innovation at that pace. And then that of course went to 1,000 miles an hour during the pandemic. And what gets pointed out is it's not just a technology problem. There's the reimbursement side, there's the coding side of this. There's both the patient and physician experience side of this, a new skill to learn, new way to support the operation of it. A lot has to come together for that to really work. And from what I hear you saying, you're recommending embracing that system as a way to innovate at the private practice level. Am I hearing you right?

Dr. Maniya: Absolutely. I mean, in biology and evolution, they talk about form follows function but in health care delivery, form follows payment and telehealth has been around for three decades. In rural India, there's an eye clinic that was doing it in the mid 90s. So two-way audio visual communication is by no means new but what's new is now we can bill for it. And I think that is the key for private practices to understand how to use those codes. And AMA has a lot of resources on this. Understand how to use those codes, what the requirements are and then implement it in your practice. Because for the first time now, you can.

Unger: Access has been a big source of discussion, particularly during the pandemic. And some question marks around how technology either enables or hurts that. You have many low and middle income patients, have they embraced these advancements that you're talking about?

Dr. Maniya: Yeah. That's a really interesting question. So yes, our patient population's predominantly low, middle income, a very large Medicaid population and a chunk of uninsured patients. And they, by and large, love the changes that we're making. Because if you have transportation difficulties, being

able to pop on a video call and at least get your medication refill, hear about your lab results and get the next step in the process going is huge. You don't have to delay your appointment by six weeks. But I think one of the key lenses through which to evaluate and implement any of these technological solutions can and should be, is this usable for my patients?

So for example, when you are messaging patients, you can create a fancy app or use a fancy patient portal but there's tons of data out there that patient portals are used by low single digit percentage number of patients because you got to log in, you got to remember your password, you got to download the app, you got to figure out how to use it.

And sure. It might look really fancy but if it's not usable by the end user, it doesn't get used. So in our care management platform, for example, we purposely selected one that only texts the patient. So it shows up just like a text and even grandma knows how to text. And so when we send out a care management check-in, we get over 50% of patients responding same day because they all know how to text. But I'm sure if we did that in app form, that would be 1% or 2%. And so, I think that technology, by and large, can be really well accepted by low and middle income patients and also by older patients but it has to be bite sized for them, not look pretty for us.

Unger: Yeah. These are basic tenets of my world of customer experience. And I love to see them making their way through into medicine. One of your center pieces of that experience is around personalization. Why is that important and how does that look?

Dr. Maniya: Yeah, so I think that there are some easy parts of personalization and then there's some really hard parts. I think the easy parts are as a small practice, we like to play to our strengths and attract patients who speak the languages that we speak. So yes, we have translator services for other languages but we really try to market in certain languages that we speak because there's tons of data that shows that if your provider and the patient speak the same language, better care happens. So that's one of those sort of easier things.

I think what's more exciting about personalization is we have a very regimented empanelment process. So the patient over 90% of the time sees the same person. So they get to know them. And then we have, I think what's even harder is when you have an acute exacerbation of chronic illness, that's really where you can flex that personalization and treat the patient better.

So I'll give you an example because I know I'm speaking in fluffy terms. We had a patient the other day, who's in her 80s. She's on a blood thinner and she woke up with a diaper full of blood. In most circumstances, that phone call, the response is go to the ER. And in the ER, I would get blood counts. I would repeat those blood counts. See if there's active blood coming out of the lower GI tract and maybe even admit that person to get a colonoscopy and see.

We have her baseline blood counts because she's our patient. And we have her most recent colonoscopy records, which show internal hemorrhoids, which is a benign source of bleeding. And we

have her on remote patient monitoring. So we know her vital signs. And we have the ability to send home blood draws to her house. And so, we basically were able to coordinate this whole ER hospital workup in one day as an outpatient because we knew her and we had her prior records, and we had that trust built in with her and were able to follow up with her a couple times during the day.

And in doing so, we're able to avoid a potential hospitalization. And I think that's really where this personalization kicks in. Yes, at the time of the visit, there are some things that can make the patient feel more comfortable and can result in better care but where you can really flex it is when these acute exacerbations happen, you know the patient and you can decide what the best level of care is for them and what exactly they need and then make those things happen.

Unger: I'm curious because you have experience in both large health systems and now in a smaller private practice. And I'm wondering, how did your health system experience inform your approach to patient care where you are right now? Did that help in the transition? Were there things you had to kind of relearn? What's that look like to you?

Dr. Maniya: Yeah, that's a great question. I think health systems, particularly large health systems and big hospital systems are really, really good at high acuity complex care. That's what they specialize in. They make Lamborghinis that are pretty expensive but are some of the fastest cars on earth. But just because you're good at making a Lamborghini doesn't mean you're good at making a fuel efficient car.

And where I think private practice can thrive is in being a Prius, a solid car, affordable. It gets the job done. And it does the bread and butter, going to the grocery store pretty darn well. And so, I think that coming from experience in large health systems, I learned that wow, they're able to do some things that nobody else can do because they require tons of resources and complexity. But now seeing private practice, I see, wow, there are some really interesting strengths here.

You know your patients. There's a magic in when a patient calls and the secretary picks up and they're like, "Oh, Mr. Jones, how's your cousin and your friend? And I saw you at the grocery store last week." That personalized connection, that's magic. That can't be replicated in big systems usually. And then there's also a separate piece here on the physician side. I think being an organization that's small, that's physician controlled, physician run, you can really treat your patients the way you want them to be treated. You don't have to accept things that are unacceptable to you. And I think that's part of the historical allure of private practice and something that is being lost as private practice becomes less and less a smaller and smaller percentage in the market. But that's a real value because you can make sure your patients get treated the way you want them to.

Unger: Well, I'm sure we could play that analogy out a lot but underneath in that Prius, there's a lot of technology in the revolution, in terms of the driving experience. And it's kind of interesting to apply that to your situation right now. You mentioned again, the big issue here about pressure on private practices. When you think about the challenges you're seeing firsthand at this point, what kind of

support do we need to give to physicians in private practice?

Dr. Maniya: So in speaking with many of my colleagues in the local market, I think there is a big knowledge canyon that all of us can help to bridge. And then, there are some actual changes we need to make. So let's start with the knowledge canyon. Over the last 10 years, there have been probably a dozen new code sets which can reimburse private practices for previously unreimbursable time. That we would just call pajama time or I'll just do that for free, whatever. You can get paid for telehealth. You can get paid for telephone visits. You can even get paid for electronic communication. And you can bill for remote patient monitoring and care management and all these things that you were probably doing before because you cared about the patient but you didn't have a 99XXX code to click. So that's part of it.

I think there's also an explosion of technology providers that can help. So historically, if you're charting a lot at home during pajama time, you had only two options. I do it myself or I hire a full-time scribe to walk around with me all day but there's virtual scribes now. There's dictaphones and there's a whole host of services there and you can apply that level of innovation and it has been applied to every one of those examples I just mentioned, telehealth, remote patient monitoring, care management, et cetera.

And so, I think that the awareness of those and a ranking system of usability is pretty hard to find but those are things that can really help private practices thrive. They just need to know about it and then they'll be able to implement it. So I think that's on the knowledge side. And then I think reimbursement structure going forward is going to be really, really important for private of practices. Making sure that if a doctor provides high quality service in a hospital versus a private practice, that they're paid the same because why would it not be fair to do that? Historically, hospitals have been paid more for doing the exact same service and also making sure that some of these innovations that we have and strides we've made during COVID, such as telehealth reimbursement are there for the long term. I think those are two really important things going forward.

Unger: And if you're interested in finding out more about the resources that the AMA has for private practice physicians, check out the AMA website. And also take a look at our new and latest section, the Private Practice Physicians Section or PPPS, which would help to shape health policy. And I encourage you to find out more about that. Well, in closing Dr. Maniya, I'm just curious, what kind of advice that you would have for other residents that are thinking about how they take their career forward and what advice would you give them to support a decision to move into private practice like you have?

Dr. Maniya: Private practice is alive and kicking and it really, really can thrive. You don't have to do everything. You just have to find the right partners to help you do all those things. And it can be tremendously rewarding because you can treat patients the way you want to treat them, not the way that somebody else wants you to treat them.

Unger: Well, thank you so much, Dr. Maniya. It is great to see you in a somewhat different location than where I spoke to you over the last year, in a very different situation. So thanks for being with us and we'll talk to you again down the road. That's it for today's Moving Medicine video and podcast. You can join future episodes of our podcast and video by subscribing at ama-assn.org/podcasts. Thanks for joining us. Please take care.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.