

THE Physicians Report

FALL 2017 | PHYINS.COM

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NAVIGATING CHANGE

THE SPACE BETWEEN CHANGE

Change is often characterized as a bad thing. It's not uncommon to hear statements that "people don't like change." And while there is value to be found in stability and consistency, we know the "change is bad" generalization isn't necessarily true. Few would argue against the life-saving benefits that changes in medicine have brought, such as the contributions of pioneers who discovered new and better ways to treat diseases once thought incurable.

Rather, perhaps, it is the transitional space between changes that is the culprit of this criticism. It is this "in-between space" that can make personal change difficult. But it is almost paradoxical that we are so experienced with personal change (e.g., learning to ride a bicycle, learning to drive, going on a first date, leaving home, taking a first job, buying a home, or having children) and not equal experts at transition itself.

Most of us were not taught transitional skills in school, or given any formal education on how to navigate change, despite the countless shelves of self-help books on the topic. Interestingly, though, transitions between one stage and another are powerful teachers, and influence how we navigate the future.

Thinking back on times when I experienced changes and transitioned through them effectively, I see several common elements in motion:

- I received information on what to expect during the change
- I took time to reflect on and process the change, becoming self-aware regarding what would be easy or challenging
- I framed my thinking around the idea that change was not inherently good or bad, and focused on my own behavior as a result of the change instead

As you read through this edition of *The Physicians Report*, perhaps you'll be reminded of your own change experiences, and read how others view change or navigate their transitions. In these stories and articles, I am confident you'll also agree on one last common element to successful navigations of change: walking alongside someone else. Having a friend, colleague, or community present or lending support is always a plus during these transitional phases—because in the end, no one changes in isolation from others.



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Defining Change Management

WHY IT WORKS AND DOESN'T WORK

By Lisa Goren

Health care transformation, reform, change—all words for a big, unpredictable mess. While the health care industry has always been complicated, it has never been this tumultuous. From the external pressures of new expectations to the internal pressures of burnout, now is inarguably the most uncertain and challenging time to practice medicine.

WHAT WE KNOW ABOUT CHANGE

Several names dominate any extensive review of the change-management literature. From Lewin's change model in the 1940s, to Bridges' transition model in the 1970s, to Kotter's eight-step process in the 1990s, we have seen approaches to change evolve in response to modernization and globalization.

These researchers and their colleagues provide us with clear direction on managing change personally and leading change within an organizational context. Underlying this guidance are four core assumptions:

- Change is hard—harder than you would expect.
- Change is slow—slower than you would expect.
- Change is tiring—more tiring than you would expect.
- Change is scary—scariest than you would expect.

These four assumptions may seem simple, but they represent precisely what puzzles us about successful change management. The truth is, there is no plan or template in the world that can be cross-applied to the myriad changes the average health care organization is juggling on any given day.

IN REAL LIFE

Accepting these assumptions as truth helps build a more realistic foundation for the kind of support that individuals or teams need in order to weather change. Electronic medical record (EMR) implementations provide a perfect context in which to understand the assumptions of change management.

A traditional EMR implementation will likely define success as “going live” on budget, on time, and without major incident. However, organizations that consider the four assumptions of change can define success more meaningfully, aiming at results like these:

- Diverse participation by respected providers on a Physician Advisory Council
- Medical staff adoption of new rules and regulations governing EMR use
- A training and support plan that makes physicians feel prepared while and right after going live
- High rates of computer physician order management (CPOM)

By thoughtfully creating governance structures and mechanisms for engagement, organizations that incorporate the four assumptions acknowledge that change is a complex emotional, psychological,

and political process. In short, spending more time managing the human implications of change will pay off in high levels of engagement, buy-in, and productivity.

CHANGE IS CHANGING

Just as health care is undergoing transformation, the concept of change has in fact changed. Up until recently, the change-management literature centered around models that contain a clear beginning, middle, and end. But the changes facing today's health care executives, physicians, and workforce are complex, integrated, and often without a neat and tidy conclusion.

Paradigm shifts have rooted change in complexity science. Thousands of pages have been written about complex adaptive change, and this article won't do them justice—except to highlight that change may be governed by simple rules, but is anything but simple itself. Change should not be viewed through the lens of a single project or program; rather, one must consider that change is as dynamic as any living organism, and is governed by multiple, integrated systems. Sound familiar?

“Change is not a disease, but is instead a condition regarding which one can build a stronger capacity or resilience through a proactive, disciplined approach.”

One way to think about change is as something similar to the shift from acute disease intervention to chronic disease management. Change is not a disease, but is instead a condition regarding which one can build a stronger capacity or resilience through a proactive, disciplined approach.

SEVEN STRATEGIES

The seven strategies for managing chronic change in health care will not guarantee success, but they should make change-management programs a whole lot easier for those participating in and leading them. Each strategy detailed below is accompanied

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REALIZING THE EHR VISION:

Simple Isn't Always Easy

By Amy Mechley, MD



As a physician executive, I've learned a few solid lessons when it comes to change management. A mantra that serves me well: **We will make this simple, but it is never easy.**

The most important foundational element when managing change is first understanding, and then communicating, the “why.” When talking with clinicians and care-systems personnel about electronic health record (EHR) implementation or fundamental health information technology (HIT) changes, we must remember to articulate the “why” early and often. EHRs touch so much of a clinician's world, the topic is always a hot button, and will trigger strong emotions. Also, through a purely financial lens, it's important to start with the end in mind: What is the REAL sought-after deliverable, and how will we ensure that the deliverable is executed and measured?

GETTING TO THE “WHY”: BEWARE

First, many half-truths, and full untruths, have been promulgated by the EHR industry. Understanding what your clinicians are hearing from EHR vendors can help you better articulate your “why.” The list below presents a few of the most common categories of misleading statements about EHR implementation, and the clinician's perspective on each. (Note: These will likely NOT be the “whys” that you communicate as part of your change-management strategy.)



“Acting on the truth that the data is the patient's, we are merely stewards. And in best serving our patients, we must ensure that the interaction between caregivers and EHRs enhances that experience.”

- **Ability to establish and maintain effective clinical workflows.** REALITY: EHRs, in general, have proven to initially (sometimes permanently) disrupt workflows. If disruptions continue, the patient/doctor relationship is compromised and can diminish.
- **Ability to access records remotely.** REALITY: This functionality can certainly be a bonus if it allows physicians to improve their market reach. But for many clinicians, the ability to access records remotely has led to “Saturday date nights” with their computers and EHRs.
- **Fewer medical errors.** REALITY: Patient safety is always paramount, and EHRs do help reduce errors when it comes to prescriptions and physician orders. But again, from a clinician’s perspective, the increased navigation requirements can be frustrating, resulting in a hunt-and-peck exercise to locate what the clinician wants to order. We have not fully realized the benefit of embedding best-in-class knowledge into workflows inside EHRs, though I have observed some small advances that have resulted in clinician adoption. These successes contribute to my continued support of human-centered design.
- **Improved patient safety.** REALITY: Yes, this could be an effective “why” for all stakeholders. However, when stated without defined case studies and real applications, it becomes noisy rhetoric.
- **Stronger support for clinical decision-making.** REALITY: This is true—provided the data is trusted and reliable. Also, access to data at the point of care is paramount. Many clinicians still spend an inordinate amount of time searching for data they trust, and ensuring that it’s complete.

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Transforming Health Care Culture

Top 10 Considerations for Successful Physician-Hospital Integration

By Allison P. Wilson and Graham Fox

While the tide continues to shift toward physician-practice and health-system integration, many organizations struggle with alignment of culture, goals, and operations. This leads to a cycle of frustration on both sides, and strained or irrevocably damaged relationships.

When both sides take care to define the path to integration at the outset, success is more easily achieved.

The hospital-affiliated-physician model endures, in part, because many physicians remain overwhelmed by the costs and pressures of private practice; they seek employment as a refuge. Further, growth in physician-hospital integration is driven by greater

clinical and data integration and new payment models that include bundled payments, as well as financial incentives for providers to coordinate care to achieve better outcomes at lower costs. Many new physicians favor health-system employment over private practice, due to a perception of lower risk and improved work-life balance. Therefore, it is difficult for private practices to recruit for adequate succession.

▶ Transforming Health Care Culture Case Study

Sky Lakes' Blending of Physician-Hospital Cultures Is an Evolving Challenge



As physician-hospital integration advances, there are many important factors physician practices and hospital administrators should examine to determine if hospital integration would be a long-term successful fit. Practice and hospital leaders should consider the following areas when evaluating a hospital affiliation:

1. **Compensation.** Many independent physicians consider hospital employment an opportunity to attain more consistent, and perhaps higher, compensation levels. While this has historically been a reality for some, many hospitals are scaling back on the proportion of physician compensation that is guaranteed or tied to productivity measures. In fact, compensation plans are shifting to include components (in the form of base requirements, incentives, or performance withholds) for care coordination, clinical transformation, and quality improvement. Therefore, underperforming physicians, or those reluctant to transition from a volume-based mindset, may not see employment benefits in the form of compensation. It will be important for both physicians and hospital leaders to understand and assess proposed compensation models in advance of the transaction. Additionally, using current performance to evaluate compensation under the proposed model will help minimize surprises.
2. **Governance/Leadership.** A key differentiator between private-

practice and hospital employment is governance structure. Often, physicians in private practice are autonomous, and have difficulty transitioning to an environment where they have much less input on the operations and direction of the practice. Therefore, understanding and evaluating the governance of the hospital or hospital system is important. Physicians should seek relationships with hospitals that have physician-leadership roles on the board of directors and in departments such as quality management, information technology, patient safety, and finance. Additionally, incoming physician groups should seek and hospitals should offer joint accountability in strategy, operations, and finance. Committees should include strong representation of physicians, and encourage physician leadership and participation. When physicians become involved in key areas, they are afforded the opportunity to provide feedback in strategy and decision-making that impacts both current and future operations. It also strengthens the integration bonds between the practice and the hospital system, significantly increasing the opportunity for success. (See “Sky Lakes Case Study”.)

3. **Culture.** When transitioning from independent practice to a hospital affiliation, evaluation of hospital culture is critical to long-term success. Cultural discord ranks in the top five reasons for turnover

In 2012, Sky Lakes Medical Center, of Klamath Falls, OR, started transforming itself from a rural acute-care medical center to a small comprehensive health care system. That process, which is still ongoing, has involved the acquisition and establishment of numerous physician practices, so that today the medical center employs a total of 56 primary-care and specialty physicians and 1,400 staff. With the change there has come a shift in focus, as outpatient volume now outpaces inpatient.

The strategic decision to pursue an employed-physician model was made in response to a variety of market and economic pressures, as well as to a lack of physicians in the area (due to retirements and practice closures) and continued difficulty recruiting new physicians. According to both research and anecdotal reports, new physicians are very different from their predecessors in terms of what they want from their careers, their preferences concerning work-life balance, and their tendency to shy away from traditional private practice. This is due to significant financial challenges and less interest in operating what is essentially an entrepreneurial enterprise—and given that most come out of medical training with significant debt.

Other factors influencing the trend toward an employed-physician model among both new and established physicians include continued uncertainty about the ACA, declining reimbursements, and increasing regulatory burdens.

“We didn’t just wake up one day and want to get bigger,” says Grant Kennon, Vice President of Sky Lakes. “We knew we had to do this to stay viable and to serve our community.”

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A LEADER'S ROLE

THREE LEVELS OF CHANGE:
SELF, OTHERS, ORGANIZATION



A LEADER'S ROLE: HOW TO COPE WITH RAPID CHANGE

By Kevin Osborne

Rapid-change events in local, national, and international cultures and economies are challenging traditional expectations in the workplace—and forcing leaders, especially physician leaders, to face the unknown. Countless articles discuss the barrage of disruptions that organizations and people are facing. One of these notes that, in the year studied, one in four organizations undertook a significant change initiative every other month. [ATD/i4cp, “Change Agents: The Role of Organizational Learning in Change Management” (Alexandria, VA: ASTD Press, 2014)] Many have also written (on LinkedIn, Harvard Business Review, FastCo, Forbes, and BizWeek, among others) about the sobering reality that roughly 75 percent of all change efforts fail.

RAPID, DISRUPTIVE CHANGE—NOT THE SAME AS A TECHNICAL CHALLENGE

A Google search for “change management” yields more than 94 million results. Missing from the literature, however, are practical approaches to objectively assessing the types of change organizations face, and the implications for how we respond as leaders. With health care now in a permanent state of disruption, we need ways to understand the nature and types of changes we face, respond to them strategically, and develop tactical solutions accordingly. Physician leaders can help others begin to see change as ongoing, evolutionary, and emergent. This opens the possibility of responding intentionally to change, rather than simply reacting to it.

Thought leaders have identified two distinctly different types of challenges. Originally described by Ronald Heifetz, founding director of the Center for Public Leadership at Harvard University's John F. Kennedy School of Government, technical challenges are relatively easy to define and understand, and you can organize and manage solutions to them as enterprise initiatives. By contrast, adaptive challenges are ambiguous and hard to define, and sometimes even undetectable to the people facing them.

HOW TO RESPOND: METHOD VS. MINDSET

Traditional change management models respond well to technical challenges. At the enterprise level, John Kotter's 8 Steps (or variations on that model) can be effectively used to manage, control, and communicate technical change initiatives both large and small. At the individual level, William Bridges' Transition Model and the Prosci ADKAR Model describe the psychological stages people go through as they face change. These models are important because a frequent cause of failure in change management is a lack of attention to stakeholder reactions or receptivity, as well as misaligned expectations regarding the willingness of people to get on board. Organizations employ these methodologies to manage reactions to change, often using a variety of models in tandem to tackle such technical challenges as an ERP implementation, a re-org, or a facility move.

Many of the changes health care organizations are facing now, however, are adaptive in nature. They require leaders who have developed mindset qualities that do not come naturally, such as introspection and self-governance. Adaptive leadership often requires a change in attitudes and beliefs about what it means to be a leader—deeper work than what is typically involved in a leadership development program focused

“The single biggest failure of leadership is treating adaptive challenges like technical problems.”

—RONALD HEIFETZ

on knowledge and skill development. Yet it is attitudinal development that enables leaders to navigate increasingly complex operating environments and provide critical system-level leadership.

Moreover, when you change deeply held attitudes, beliefs, and notions of purpose and identity, the experience can be richly rewarding and transformative.

WHAT MAKES A GOOD CHANGE LEADER?

This type of complex cognitive development results in more effective and professional leadership, along with a healthy dose of personal fulfillment. Mindset changes are often challenging, complicated, personally difficult, and time-consuming. They require stepping outside of your comfort zone. For many, the emphasis on traditional leadership competencies and effectiveness can create a false sense of security.

While relatively little has been written about the specific competencies change leaders need, there are a few noteworthy exceptions. My colleague Nancy Winship describes several of them in *Meta-Skills for Adaptive/Agile Leadership* in a “VUCA” Landscape. Doug Ready at the International Consortium for Executive Development Research

similarly describes “4 Things Successful Change Leaders Do Well”. Nate Boaz and Erica Ariel Fox at McKinsey & Company make a useful distinction between two types of self-awareness in *Change Leader, Change Thyself*. One of these is an awareness of one's competencies, which serves as a strong foundation for adaptive leadership development.

If physician leaders can improve their awareness and understanding of the types of change they face, they can respond better at a personal level while supporting their organizations' responses to change. The sooner we make distinctions between the types of change we are facing, the sooner we can employ the right tools to address them.

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“Progress is impossible without change, and those who cannot change their minds cannot change anything.”

—GEORGE BERNARD SHAW

among employed physicians. Careful consideration of culture will help ensure that both parties share a similar mission, vision, and values, building the foundation for a long-term relationship. Most successful integrated networks tend to share certain values, such as collegiality, transparency, and a belief that employed physicians are an integral part of the larger health system. The practice should meet with hospital leadership and other physicians affiliated with the hospital to assess culture. Ultimately, the group will need to determine if the current culture is consistent with overall physician values and goals.

4. **Compliance Support.** Increasing compliance risks and the burden of mitigating them are key reasons physicians consider hospital integration. The most onerous of these risks is the risk associated with improper billing, combined with ever-changing coding and documentation rules and guidelines. Many independent practices lack the staff and management support to properly monitor billing and coding compliance, placing themselves at risk for an audit or exposure by a whistleblower. Similarly, HIPAA compliance and proper oversight pose a significant risk to many private practices. While the practices may be fulfilling the basic mandates, such as providing a Notice of Privacy Practices or executing a Business Associates Agreement, many of them are ineffective at addressing all HIPAA security components, including HIPAA Security Risk Assessments and other IT-related requirements. Adding the burden of OSHA, Department of Labor, and IRS regulations, a practice can be consumed with compliance obligations in addition to patient

care. Therefore, it is critical to ensure that hospitals maintain well-established, defined processes and practices to reduce compliance concerns in these areas. Practices should understand the levels of oversight and management within a hospital, and be open to discussing areas of concern with appropriate parties. Practices should also gain an understanding of how the hospital system “operationalizes” these programs in the day-to-day activities of providers and staff to grasp the impact on their daily work lives.

5. **Operational Management Support.** Practices face increasing administrative burdens related to oversight and management of operations. Monthly monitoring of key metrics has become essential to the identification of potential issues and their timely resolution. Additionally, constant changes in the health care industry have made it difficult for physicians to be aware of, and keep up with, all potential areas of impact. For these reasons, having strong management support is attractive to many independent practices. However, groups should ensure the physician enterprise for the prospective hospital has a seasoned, successful leadership team in place for provision of this support. This team is often led by a director of operations for the employed physician enterprise, and is supported by operations managers or coordinators. Understanding the levels of support available and



reporting transparency will be important in the practice’s decision-making process. Because these individuals may not be involved in the negotiating process, it is worthwhile to meet those who would be working with the practice to ensure that the potential for a solid working relationship exists.

6. **Hospital Financial Standing.** Financial strain will impact the viability of any relationship. In a hospital setting, it may increase pressure on physicians to produce, and it may also lead to reduced compensation, benefits, and resources. Ultimately, it may result in a change of hospital ownership. When hospitals are sold, employed physicians may face changes in workflow processes, compensation, culture, and much more. Therefore, physicians should thoroughly investigate the current financial condition of any hospital with which they are contemplating employment.
7. **IT Infrastructure/Support.** Enhanced IT infrastructure is one of the driving forces in the consideration of physician practice-hospital integration. Physicians seek opportunities to improve practice management and EHR systems and reporting capabilities. However, many hospitals are trending toward utilization of a single system platform, or limited number of system platforms, to capture increased efficiency, financial



“A downside of the employed-physician model is that physicians tend to have a reduced sense of ownership. We are working hard to strengthen integration to make sure physicians are connected and engaged.” —GRANT KENNON, V.P., OF SKY LAKES MEDICAL CENTER

(Sky Lakes’ Blending, continued from page 9)

UNIVERSAL HEALTH RECORD INTEGRATION REQUIRES “EPIC” EFFORT

Many new-to-practice physicians, as well as those who have well-established practices, turn to hospital employment for access to big-ticket resources, such as electronic medical records, that would be too costly for them to afford on their own.

When physicians join Sky Lakes, all must integrate their patient records into the EPIC universal health-record platform, and all their workflows must adhere to EPIC requirements. This integration has required countless hours of physician and staff training, and there’s no sugar-coating it: it’s been challenging.

“Everyone struggles. It’s as much a heartache as a benefit, and as much a struggle as a triumph. But we know it’s necessary,” says Kennon.

The EHR has been integral in enabling Sky Lakes to expand its focus from reactive response to illness to prevention through the data-analytics and population-health information the platform offers. This enables the medical center to take a more holistic view of patient and staff wellbeing and the community’s overall health, involving the promotion of healthy

lifestyle choices. Evidence of this commitment to wellness is the medical center’s establishment of a Wellness Center focused on reducing obesity rates, creation of an outpatient Care Management department that utilizes community health workers to improve patient access and outcomes, and designation as a “Blue Zones Worksite” (a population health-improvement model that uses evidence-based practices to influence personal wellness choices).

“We didn’t just wake up one day and want to get bigger. We knew we had to do this to stay viable and to serve our community.”

Other new processes designed to bridge the cultural physician-hospital gap include involving physicians in team problem-solving, including as members of Lean/Six Sigma projects. Sky Lakes executive team meets monthly with each physician, either individually or in small groups according to their specialty. These meetings are a chance to check

in with physicians, share information, and review practice volumes and revenue, while also maintaining strong physician representation and hands-on participation to address a wide array of patient-safety, care-quality improvement, or clinical and systemic issues.

“A downside of the employed-physician model is that physicians tend to have a reduced sense of ownership,” Kennon says, but adds, “We are working hard to strengthen integration to make sure physicians are connected and engaged.”

The regular team meetings have enhanced communication levels and quality, and have helped Sky Lakes build relationships with physicians. Previously, when physicians had independent practices, Kennon says, “I might not talk to a doctor for a year—but that never happens now. We know each other better. Preconceived notions on both sides have changed.”

Another plus of improved relationships with employed physicians is a greater sense of partnership. Michael Turturici, director of risk management at Sky Lakes, says physicians are much more receptive to his counsel when it comes to patient safety and avoiding risks in care delivery. “It used to be, they didn’t like to see

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(Transforming Health Care, continued from page 12)

economies of scale, and improved clinical performance through streamlined communication and coordination with other providers. (These efficiencies directly impact quality and operational performance.) This may be a difficult transition for physicians who have a strong preference for, or aversion to, certain systems, especially electronic medical records. Physicians should inquire about a prospective hospital employer's required or preferred system options, and ensure that they can adapt to them. (See "Realizing the EHR Vision," page 6.)

8. **Clinical Quality Performance.**

With the current transition from volume to value, clinical quality is more important than ever. While physicians are working to continually improve individual quality performance, alignment with a system with similar goals is crucial to optimal performance. Many private practices do not have the resources and expertise to properly capture, analyze, and monitor clinical quality data. Although physicians may avoid direct financial penalties associated with bundled payments and value-based reimbursement through hospital affiliation, as discussed previously, many hospitals are restructuring physician-compensation plans

to include penalties or incentives for performance. Therefore, it is important for practices to evaluate hospital-controlled areas that impact physician quality and cost scores.

For example, a hospital with excessive readmission rates will directly impact the physician's quality and cost scores, and ultimately the physician's public reporting on the Centers for Medicare & Medicaid Services (CMS) and carrier websites (hospital performance rating information may be found on the CMS Hospital Compare website). This should also be a point of discussion with leadership.

9. **Community/Patient Experience.** As health care becomes more consumer-focused, it is important for physicians seeking employment to choose hospitals with high quality ratings and a good community reputation. Brand loyalty can help newly employed physicians build and maintain a solid patient volume. Conversely, practice volume may decrease through affiliation with a hospital where patients have had negative experiences. Physicians should research hospital-patient satisfaction scores and discuss planned or implemented improvements with hospital leadership.

10. **Overhead Costs.** While hospital integration may afford practices additional support, improved IT infrastructure, and resources, these may come at a significant cost. Physicians should inquire about management fees and any additional costs attributed to the practice post-

integration. Although the practice may no longer be directly responsible for certain overhead expenses, these will be charged back to the practice financial statement and compared to revenue. If the practice experiences significant losses on a consistent basis due to overhead costs exceeding revenue, the affiliation may not survive long-term.

While there are practical reasons for continued integration, both parties should undertake the proper due diligence before making this significant transition. Alignment requires significant time and resources; therefore, it is in the interest of all to ensure the integration is successful in the long term. Consideration of the previously outlined areas will provide a solid basis for evaluation, discussion, and transparency, building a foundation for continued communications and collaboration post-integration. With the appropriate initial investment of time, research, and consideration, the partnership will have a greater chance to prosper. ^(PR)



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Graham Fox is a strategy and integration services senior manager with PYA, and specializes in physician-practice/health-system integration.

(Sky Lakes' Blending, continued from page 13)

me coming. It was more adversarial," he says. But now, he adds, "They see me as on their side, and there's more trust that we have a common goal" of quality and reducing the risk of adverse events.

Now, Turturici says, they actively share issues or concerns—and that's much better for everyone.

SHIFTING THE MINDSET FROM INDEPENDENT TO EMPLOYEE

"Independent doctors don't think the same as employees. They're both highly trained and skilled, but their focus is very different," Kennon says.

Communication is key to shifting physicians' mindset—and that means giving clear direction and defining the path to success. It also requires vigilance, to explain again and again the standard processes and why they are needed. This is what it takes for physicians and staff to be as efficient as possible with their time. But, Kennon cautions, "There's no magic here. This is an immature process, and there is still a lot of trial and error."

While all the systems, processes, and meetings help, changing culture is really about people, and inspiring new behaviors.

IF I KNEW THEN...

The transformation of Sky Lakes is still unfolding, but one thing Kennon isn't shy about sharing is that it has been a lot of work. "We didn't know how hard it would be," he says, adding, "It sounded a lot simpler on paper."

Nonetheless, if given the choice, he would do it again. "This (transformation) has helped us deliver better care in an integrated way that puts patients first, and is helping us move our focus to overall wellness—and that's worth its weight in gold."



Transforming Health Care Culture Case Study

Alaska Center for Pediatrics Puts Patients First in Organizational Shift

Alaska Center for Pediatrics, located on the Alaska Regional Hospital campus in Anchorage, has been serving a large and diverse population of pediatric patients from birth through adolescence since 1982.

While many physician groups and hospitals must blend two distinct cultures after a merger or consolidation, ACP recently embarked on a different sort of transformation: the significant undertaking to be recognized as a National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH), an achievement they reached in 2014 (See Defining PCMH related article). A PCMH approaches providing primary care in a manner that puts the patient at the forefront and empowers patients and their families to utilize educational resources and services in order to better understand and manage their health. This team-based approach to care has been recognized and endorsed by the American Academy of Pediatrics.¹

The goal is to provide care that is accessible, compassionate, family-centered, continuous, coordinated, culturally effective, and comprehensive. They plan to maintain this accreditation from the NCQA, and are up for review in 2017.

A CLEAR PURPOSE AND STRONG LEADERSHIP ARE KEY

Paramount to the success of this practice, according to practice administrator Leigh Ann Woodard, is the exceptional commitment of the organization's staff and providers to improvement. "ACP is lucky to have great leadership," shares Woodard, "which has developed great values and a meaningful purpose—'Partnering with families in a medical home where healthy kids can grow!' It is our intention to put patient-family at the center of each decision we make." She adds, "When choosing our team, we make our purpose very clear and find like-minded staff by seeing how they engage with this concept."

Having a staff that is dedicated to serving their patients and the community has been instrumental to the organization's ability to innovate and accommodate changing needs.

New standards have shifted to emphasize how patients are treated, rather than focusing on how their medical information is inputted to the electronic health record (EHR) system. With 10 providers, as well as a practice administrator and other front-line staff including RNs and care coordinators, the practice offers medical care 24 hours a day, seven days a week, through same-day or next-day visits and on-call services. They also offer preventive-care visits to patients from birth through the age of 22, case management of children with chronic illnesses, home visits for newborns and their mothers, and a number of nutrition, child-development, behavioral-health, and specialty-care services for the pediatric population.

The clinic provides care for chronic, acute, and behavioral conditions, as well as addressing issues surrounding the social determinants of health for their young and diverse patient base. One of the challenges they face is the large size of the Medicaid population

(Continued on page 32)

(A Leader's Role, continued from page 11)

A LEADER'S ROLE: INSPIRING OTHERS TO EMBRACE TRANSFORMATION

By Debra Wiggs, FACMPE

HOW CAN A LEADER FACILITATE TRANSFORMATION?

In today's uncertain environment, many health care organizations are looking for solutions to their most pressing issues by implementing large-scale changes in their cultures and launching new processes. Transformation is a series of vision-related changes driving to a much more long-lasting effect. Leading any change is scary for most leaders, and many organizations. While there are several things an individual can do to prepare to lead transformation, in the end, being properly equipped is both a skill and a mindset.

Successful transformation management is reliant upon the attitudes and perspectives of leadership. If leaders see change as an opportunity, not as a burden, and choose to think about it differently, they can lead others in their health care organization by creating a culture of improvement osmosis.

Transformation is rooted in a leader's intention and, in order to obtain support, that intention needs to be an honorable one, demonstrated first and foremost by leaders themselves. Good leaders will actively immerse themselves in the process of transformation, not just the goal. The gradual pace of implementing substantial changes can be particularly challenging for professionals in health care, where there is a sense of urgency and a tendency for providers and management to focus on the goals, anticipating results rather than being active participants in the process.

As Frances Hesselbein said, "Culture does not change because we desire



"Culture does not change because we desire to change it. Culture changes when the organization is transformed; the culture reflects the realities of people working together every day."

to change it. Culture changes when the organization is transformed; the culture reflects the realities of people working together every day."

WHOM SHOULD A LEADER LOOK TO FOR INPUT?

Leadership is often a lonely place to be, especially when implementing change—

resistance and barriers to success surely await. Leaders should engage a trusted team of advisors and stakeholders who will be willing to provide honest feedback or call ideas into question. Wise leaders also seek others who have accomplished the changes they want to achieve, and learn from their experience. Why reinvent the wheel?

Once an intention has been set, a leader can begin to break long-term goals down to a beginning, middle, and end, establishing a path forward. During the initial stages of implementation, engaging others in the strategic planning process will result in a better long-term vision. Without this engagement, managing transformation is very difficult.

Focusing on one or two metrics—related to the value stream—to measure throughout the transformation process, and measuring them the same way every time, is essential. This will help to ensure that the improvement work stays aligned with long-term goals.

HOW CAN LEADERS CREATE BUY-IN?

A leader's willingness to collaboratively engage others in achieving the desired outcome is also critical. Proactively engaging staff in strategic planning sessions will help to achieve and align the "end in mind," and help gain buy-in from the organization and staff.

Another way to create buy-in is to create a compelling story. Many people need data to substantiate reasoning, and data is a puzzle that, once completed, can tell a compelling story. When choosing a value stream to focus on, first listen to what the data is saying. Numbers are a great source of truthful information that should drive the scope and magnitude of the changes being implemented. What story are the data telling? Substantiate quantitative data with qualitative data, and be willing to look at things not normally considered. Consider what opportunities present. What is the cost of not changing? Data modeling tools, such as waterfall charts, are helpful here. Be willing to assemble the story one picture at a time, like a puzzle, and reassess when something doesn't fit.

HOW DO LEADERS GET DETRACTORS AND FENCE-SITTERS ON BOARD?

Engaging skeptics and detractors on the front end of a change can turn them into powerful advocates in the long run. Leaders should focus on educating others about the benefits the change will create, to encourage buy-in. Most importantly, they must show a willingness to listen to concerns. This is also a great way to solicit some creative solutions for the planning process from an alternate perspective. If you include these reluctant participants early on, everything else opens up. Even late adopters can be some of your greatest champions. Your supporters will give you energy and momentum. This bottom-up approach

will create a well-prepared team with a shared vision.

HOW CAN LEADERS BEST ENGAGE THEIR TEAMS?

Self-reflection is essential to leadership. It is important to look at where your strengths are and how to grow, both as a leader and as an organization. Ask your staff, "How can we all grow?" One of the core qualities of a strong leader is the willingness to be in a state of continuous learning and constant improvement.

"Your supporters will give you energy and momentum. This bottom-up approach will create a well-prepared team with a shared vision."

Know your team's strengths. Tap into their skills as key resources in implementing transformation initiatives. Also, be willing to invest in the tools or resources that will make growth and transformation possible. If it is a new Electronic Health Record platform, be sure to customize this tool so that it will alleviate the burden of work, reduce errors, and allow your staff to perform more high-level tasks.

Listen to your team—the people who will be experiencing the changes. Demonstrating a willingness to listen is one of the most important things a leader can do to prepare their collaborators for transformation. Even further, it's important to demonstrate a willingness to engage all members of staff in finding

and creating solutions. Outside the critical, immutable decisions for which a leader may be solely responsible—such as safety or crisis management—most issues are opportunities to solicit input from the individuals who work every day in the environment in question.

Continue to engage others to find solutions. Your staff are often the people best equipped to identify where the obstacles to improvement are, whether these are people or processes. Most often the obstacles are processes that prevent people from maximizing their strengths, so leading transformation also means leading the change of process elements.

Be realistic about resources when planning transformation initiatives. Short-term change is necessary at times to get things started or propel them forward. Do the next right thing today. Small steps made frequently keep the organization agile and in motion. As for a runner in a marathon, each step is important—and though some steps may not seem significant, as a whole, even these small steps will deliver you further toward the goal. Small adjustments continuously applied provide the opportunity for the leader to be a visible, active participant in change and make changing an iterative process over time. Keep in mind: everything that your organization does now was at one point someone else's transformation.

(Part Three Continued on page 24)



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board chair of the national Medical Group Management Association. Deb can be reached through V2V Management Solutions at dwiggs@v2vms.com.

Resources

¹ Frances Hesselbein, "The Key to Cultural Transformation," Leader to Leader, 1999.

“What remains constant is that the process of change, no matter what scale, is less about the science of managing a project and much more about the art of leading people.”

(Defining Change Management, Continued from page 5)

by a stakeholder question to ask of those directly affected by the change.

1. Name the change—This doesn't refer to a clever name, a meaningless acronym, or confusing jargon. As with any baby's name, think carefully about whether you have to work too hard to explain it, or if people will be able to poke fun at it.

Stakeholder question: What do you think we should name the change?

2. Choose a respected champion—Over time, you will build coalitions of champions and supporters, but it starts with one. If that one person isn't respected or liked, the change is at risk of being ignored or resented.

Stakeholder question: Would you walk over hot coals for your change champion?

3. Give everyone a clear role—Even the largest change efforts can be avoided, ignored, and critiqued unless stakeholders know exactly how their voices will be valued and how their unique perspectives will be leveraged.

Stakeholder question: What are the tangible and valuable ways in which you can contribute to the success of the change?

4. Tell the whole story, not just the pretty stuff—It is tempting to frame every purposeful change as entirely positive. After all, why else would it be happening? However, even the best changes are filled with discomfort, strife, and loss, so be sure to acknowledge difficulties that you

anticipate or that are experienced by people who have already engaged in the change in question.

Stakeholder question: What kind of information will help you fully understand the goals, timeline, and expectations of the change?

5. Create safe spaces to talk, vent, or question—Highly educated, competent people like physicians are not quick to admit their fear of learning something new. Since many changes are logistical, operational, or technical, the human side of change is often glossed over, because it's viewed as a difficult can of worms that most people feel unqualified to open.

Stakeholder question: What kind of support structures and access to change champions do you need?

6. Identify success metrics that are meaningful and moving—Change is both a process and a product, and the success of both should be regularly monitored, easily measurable, and highly motivating. As with building any new skill, behavior, or mindset, momentum is built with the accumulation of small, consistent successes.

Stakeholder question: What are all the ways in which you would monitor and define personal, team, and organizational success with this change?

7. Create real mechanisms for re-energizing—With the burnout epidemic

topping 50 percent among physicians, the impact of change (exhaustion, confusion, apathy), cannot be overestimated. It is crucial that change champions fully recognize what type of energy—physical, mental, emotional—is required, and respond by reducing or temporarily eliminating other priorities.

Stakeholder question: What should we temporarily stop doing in order to create the time and space to acclimate to this change?

IN CONCLUSION

While no two changes are exactly the same, the seven strategies for managing ongoing, complex, chronic change can improve any scenario in which people are being asked to do their jobs differently from the ways they're used to doing them. Over the last century, the literature on change has undergone its own transformation from acute care to chronic management. However, what remains constant is that the process of change, no matter what scale, is less about the science of managing a project and much more about the art of leading people. 



Lisa Goren is a health care leadership coach and advisor helping physicians and executives lead effectively and resiliently within a transforming industry. She works with

individuals and leadership teams to create engaging organizational cultures where individuals feel less exhausted and more excited walking through the door each day. Lisa is a frequent conference presenter, and is on the faculty of several health care Master's programs. You can find out more at lisagoren.com.

LIVE EVENT

Assessment, Treatment, and Management of Suicide Educational Program on Tap

Online registration is now open for the live educational program, "Assessment, Treatment, and Management of Suicide," which will be presented by Dr. Daniel Clark of Critical Concepts on October 13, 2017. This event will be hosted by the Washington State Medical Association as a pre-conference program for their annual meeting, which will take place Oct. 14 and 15 at the Hilton Seattle Airport and Conference Center.

This event is free for Physicians Insurance members, as well as all WSMA members. Completion of this activity will meet the Washington State requirement for six hours of suicide prevention training.

The pre-event educational session will be from 10 a.m. to 5 p.m. on Oct. 13, and lunch will be provided.

Additional details are available through WSMA's website on the event's registration page: <https://tinyurl.com/y7qzoupp>

WA Looking for Medical Commissioner Applicants

The WA Department of Health (DOH) is currently accepting applications to fill a vacancy on the Washington State Medical Quality Assurance Commission (MQAC). Application deadline is October 18, 2017.

To learn more, go to <https://tinyurl.com/ydcct822>

Volk v. DeMeerLeer: Your "Duty to Warn" Has Changed

Together with the Washington State Medical Association and the Washington State Hospital Association, we have developed the following guidance on how the "duty to warn" has been altered with this case.

Read more at <https://tinyurl.com/y7d3m6ee>

ONLINE WEBINAR

The Future Is Now: How Physicians Can Thrive Through the Transformation of Health Care Delivery

John Nance, JD, a key thought leader in American healthcare, brings a rich and varied background to the task of helping doctors, administrators, boards, and front-line staff serve and prosper during the most challenging time in modern medicine. Having helped pioneer the Renaissance in patient safety as a founder of the National Patient Safety Foundation in 1997, his efforts and health care publications are dedicated to transforming health care from a reactive response to an effective and safe system of prevention and wellness.

After this one-hour course, participants will be able to cite the challenges they face in transitioning from a fee-for-service model to a value-based, population health-oriented system of care, list the strategies they will use to improve teamwork and care coordination and describe key drivers of change in physician culture to promote accountability.

For more information and to register, go to <https://www.phyins.com/cme/courses/thefutureisnow>

SAVE THE DATE!

2018 Risk Management Summit: Creating a Culture of Respect

A complimentary event for health-care leaders.

Date: April 27, 2018

Time: 8 AM – 4 PM

Cost: Free to Physicians Insurance members; nonmembers can register for \$299

Place: Seattle Airport Marriott
3201 S. 176th St.
SeaTac, WA 98188

All CME is offered at no charge to our members

How Independent Practices Are Staying Viable in Today's Changing Health Care Industry



► Unified Women's Healthcare of Washington Partners with National OB/GYN Group to Address Business Needs

Change is a given in every industry, but most of all in health care. Market forces are driving change and significantly impacting how physicians are doing business. Learning to adapt with new ways of doing things is essential to navigating today's choppy waters.

Unified Women's Healthcare of Washington, a group of three affiliated OB/GYN physician practices located in Bellingham (Bellingham OB/GYN), Bellevue (Bellegrove OB/GYN) and Kirkland (Center for Women), is an example of physicians doing things in a new way by joining forces with other regional practices and partnering with a national group to address business-management needs, such as cost reduction and

resource- and service-sharing, to enable them to thrive and stay independent.

Equally important to maintaining their viability as a business, this affiliation and partnership is designed to let physicians focus on what they know best: taking care of patients.

Starting in 2015, UWH of WA began a partnership with a larger national organization called Unified Women Health (UWH). UWH contracts with Unified Physicians Management (UPM), which consists of some 1,100 OB/GYN physicians and mid-level providers, and is the largest and fastest-growing group of OB/GYNs in the nation.

In addition to its groups in Washington, UWH has state physician groups in Texas, North Carolina, Georgia, and Florida. It is the only private-practice women's health group with a singular vision that is 100 percent physician-governed.

Through UPM, Washington State's UWH has access to what is often described as a "back-office platform." Some of the infrastructure and practice-management tools offered in that platform include:

- **Computers.** UWH uses an Electronic Medical Record system with deep-data analytics and enhanced reporting capabilities, as well as cyber security protection.
- **Contracts.** Working with a group of 30 with solid performance data and a professional negotiator has substantial benefits. Participating providers have a stronger position in contract negotiations with health plans because they represent significantly larger patient populations and, through their EHR, can demonstrate efficiencies and cost savings for health plans, as well as for patients and the practice.
- **Cost containment.** This includes human resources, accounting, legal assistance, health insurance, a 401(k) plan, and medical-professional liability insurance. Group purchasing offers significant cost savings when practices buy in larger volume, and offers vendors the extensive ability to track inventory and supply use, which can enable them to get more favorable pricing.
- **Compliance.** Federal, state, and local regulations for business and medical practices are complex. Having access to professionals focused on this task keeps the process smoother and much less burdensome for providers.

"The back-office platform is worthwhile for many reasons, but there are three key benefits," says Michael Mallory, MD, president of UWH of WA, who has been in practice at Bellingham OB/GYN for 17 years. "The best-in-class Athena EMR platform that is specifically designed for private practice is the top reason." He adds that this caliber of EMR is something most individual practices can't afford.

"We have a great model to help any stable practice survive, optimize, and grow in today's business climate."

The other two key reasons are increased leverage in contracting with payers and access to HR professional expertise and benefits.

While there are many benefits to the back-office platform, there are drawbacks too. Getting consensus is at the top of Dr. Mallory's list of challenges—and this is true for UWH as well as for the larger UPM committee and boards that make strategic and operational decisions.

"We are highly motivated individuals," says Dr. Mallory. He notes that only 5 percent of OB/GYNs are still in private practice in the country, so the trend to affiliate and partner or work for a hospital is almost universal. "We know this affiliation and partnership is valuable," he says. But it's still hard to get agreement. "We've decided to work with this organization to get things done, so we all have to learn to get along."

While decision-making can be a headache, Dr. Mallory considers it a "growing pain" that is very different from the conditions doctors face who run their own practices. "But we all are learning to look at the greater good and think outside our individual practice," he adds.

Mallory estimates that it takes two years to see results from the new platform and partnership, but he's confident that they will pay dividends as long as the focus remains on the things that matter: "How best to take care of patients, how to save money for patients and ourselves, and how to make money as a business."

Sounds like a recipe for success.

UWH participation gives Dr. Mallory and other providers the time and resources to make their practices more efficient.

As far as next steps goes, Dr. Mallory says he would like to see his organization grow. "Washington State is very diverse, geographically and culturally. However, our challenges are the same ones faced by all small practices," he says. "We have a great model to help any stable practice survive, optimize, and grow in today's business climate. Our affiliation with UWH has essentially taken the headaches out of running our practices, and permitted us to focus on the part we enjoy—seeing patients." 



A PERSPECTIVE EHR: WHERE CHANGE MANAGEMENT IS NEEDED MOST

A major source of anxiety in health care today—and a place where the need for change management is often felt most acutely—is the adoption of electronic health-record platforms. Below is a perspective shared by a member of Physicians Insurance.

FROM WASHINGTON UROLOGY ASSOCIATES ON IMPLEMENTING A NEW EHR

Washington Urology Associates is an eight-provider, physician-owned medical practice with multiple offices in the greater Seattle area. The group practice offers complete care for men's and women's pelvic health to the East Puget Sound community. The staff is comprised of an interdisciplinary team of board-certified urologists and gynecologists, three sub-specialty board-certified uro-gynecologists, naturopathic physicians, and ARNPs.

Located at four clinic locations in Kirkland, Bellevue, and Issaquah, as well as at two state-licensed and Medicare-certified Ambulatory Surgery Centers, and providing in-house diagnostic testing, Washington Urology and Urogynecology provides a large array of services on-site to patients, and delivers specialized services at a third of the cost of hospital and hospital-owned physician practices.

Washington Urology Associates first started using Netgain's Greenway (EHR) hosting software in 2010. However, the conversion was implemented without staff training. As a result, the platform was minimally utilized and often not correctly used.

TRAINING

Software training for staff members is essential to ensuring the correct use of the platform and optimizing performance potential. This should be a priority investment for other clinics and practices launching an EHR for the first time.

In June 2017, the practice officially re-launched the implementation of the Netgain Greenway (EHR) Hosting platform—this time with significant training for staff delivered over the months prior to launch.

EHR HIGHLIGHTS

New features allow automated collection of patient information and automatic updates to patients' charts. In addition, the software interfaces directly with clinical lab equipment, so data is captured, reported, filed, and stored immediately at the time of collection from the patient. This new system reduces human error, eliminates the burden of work, and prevents unnecessary staff access to patients' medical information, further protecting practices from breaches of information.

An additional benefit of the platform is that it has greatly streamlined the practice's process of submitting insurance claims. This improved turnaround means that revenue is brought into the practice faster, saving staff time and allowing the practice to run more smoothly.

PERSISTENT CHALLENGES

Mandatory government reporting makes it a requirement to pull specified data sets from patient records. Due to changes in what needs to be reported, these data sets vary from year to year. As a result, each year when reporting is required, the data-collection parameters in the EHR must be changed to reflect new reporting requirements.

KEY TAKEAWAYS

Practice administrator Brenda Carter says that, by and large, training on the software platform was the single most important element of its successful implementation. "It made a world of difference to our staff, who now feel confident in using this new system," says Carter.

(Realizing the EHR Vision, continued from page 7)

- **Improved care coordination.** REALITY: Interoperability is often promoted, but seldom delivered. This must be a central part of any change strategy and execution.
- **Cost savings and efficiencies.** REALITY: Costs and administrative burdens often escalate when implementing EHRs. Any claims that costs are reduced and efficiencies are realized should be thoroughly questioned. One should ask: "How exactly does this EHR save money?" "Do you have any case studies?" "Was it actual money that was saved, or some other attributed value?"
- **Shared best practices.** REALITY: While a worthwhile and lofty goal, shared best practices will only truly be realized with efficient interoperability of data systems and the adoption of a value-based outcome revenue stream.
- **Patient-engagement forum.** REALITY: Ouch! This one can really hurt. EHR patient-portal adoption rates are weak, and for good reason. Most patient portals are an afterthought, with no user-experience focus. Successful forthcoming digital-health models will not be built on a one-size-fits-all solution. According to a New England Journal of Medicine study, a majority (59%) of clinical staff believe the most effective patient-engagement strategy is simply spending more time with patients.

THE HOW: EFFECTIVE MESSAGING

The real issue at hand is the disconnect between "vendor speak" and the realities of the clinicians' experiences with the product. To help answer a clinician's two most pressing questions—"What is in it for me?" and "How does this help my patient?"—the "whys" should be repositioned with the clinicians' point of view in mind. The following practical answers and sample applications can promote clinician buy-in:



- **Access to useful and meaningful data repository and exchange capabilities that can be used for:**

- Improving clinical care of the current population we serve, employing real case studies and metrics. Examples: create registries for a practice's diabetic population; identify women over the age of 50 who have never had a mammogram.

need it, and in a way that is consistent with how they talk with their patients.

- **Third-party interface (such as pharmacy).**

Examples: obtain confirmation that an e-prescription a doctor has placed has been received; access doctors' community health-information exchange, and acquire results from other area clinicians. This functionality provides doctors with the means and information to better care for their patients.

- **Determine whether the vendor invests in user experience, human-centered design, as a development tool.**

- **Invest in scribes, period.** It is irrefutably foolish for the highest revenue-producing staff to spend valuable time on data entry.
- **Invest in knowing your own cost of care,** so you can make rational decisions that will not surprise you.

INTELLIGENT DATA INTEGRATION: EFFECTING MEASURABLE CHANGE

The future of the “quadruple aim”—better patient experience, better health outcomes, smarter spending, and a stable and engaged health workforce—will be brought forth not with data alone, but with intelligent data integration.

We must be able to trust the data as real (high data quality from the best source), and know on what data we should focus (impact distinguished from noise). We can then derive real insights from the resulting analytics, leading to resource allocation for actionable interventions that can be validated, then shared as best practices. All the while, we must keep in mind that we are designing for humans, so “one size fits all” will not be tolerated.

But if you are looking for a simple one-sentence answer to clinical change management with EHR or HIT adoption: Hire and retain a strong, well-trained project manager. [PR](#)



Amy Mechley, MD, is a strategy and integration principal at PYA, a health care management advisory and accounting firm. She also serves with the Ohio Governor's

Office of Health Transformation on the task force for patient-centered medical-homes redesign for Ohio providers.

TAPPING EHR POTENTIAL

The EHR was built, and has been largely used, as an electronic version of a paper-based medical record. Acting on the truth that the data is the patient's, we are merely stewards. And in best serving our patients, we must ensure that the interaction between caregivers and EHRs enhances that experience. In order that we might further realize EHRs' incredible potential, reimbursement models must evolve to support the care of the patient, not the transaction of care. Also, full interoperability must be instituted on a platform with which all electronic health records and health-information exchanges can interface. It is important that we ask the right questions (from a clinician's perspective) of our vendors, and take additional steps like the following to ensure EHR effectiveness:

- **Look for HIT system providers who are investing in interoperability and interface management.** Systems should work with health-information exchanges with open application-programming interfaces (or APIs) and possess capabilities for connecting with other best-in-class systems (e.g., population health management platforms, data warehouses, patient-engagement platforms). System-tech firms should be willing to admit that such systems have an accessible place in the ecosystem; they are not themselves the ecosystem.

“Invest in scribes, period. It is irrefutably foolish for the highest revenue-producing staff to spend valuable time on data entry.”

- End-user reporting for quality improvement. Example: identify and share best practices to determine how other clinics are doing so well on their quality bonuses.
- **More effective payment-revenue capture and improved accounts-receivable performance.** Example: provide patients with an unambiguous financial picture, leading to a clearer understanding of benefits.
- **Clear user interface.** Example: get the information doctors need, when they

(A Leader's Role, continued from page 17)

A LEADER'S ROLE: ORGANIZATIONAL IMPLEMENTATION OF CHANGE

By Steve Gordon, MD., and
Keely Killpack, Ph.D.

IMPLEMENTING MEANINGFUL CHANGE ACROSS THE ORGANIZATION

The degree of recent change in health care delivery is astounding. How should leaders approach initiating change and improvement in this context? What can be learned from the experiences of others, especially when change efforts go sideways? What does success look like?

Recent examples of transformative change impacting physician practices include electronic health records, HIPAA, ICD-10, pay for performance, practice consolidation, ACOs, and now MACRA, superimposed on an explosion of medical research and new treatment options and modalities. Opinions differ as to whether these changes are beneficial, but increasingly, change fatigue itself is recognized as a cause of professional burnout and a growing leadership challenge.

In our experience, change efforts among physicians and providers falter when leadership stumbles into one or more of nine common pitfalls. We use a tool called Change Curve, a conceptual model commonly employed by change-management methodologies to assess and chart people's adoption of a change (Killpack, 2017). We have leveraged this standard tool to illustrate challenges that can occur along the way, including:

- Failure to explain the personal impact to physicians, providers and staff, and to specify exactly what each person is being asked to do
- Failure to accurately describe the problem in the first place, including



the future impact if the problem goes unaddressed

- Failure to ask for help addressing the problem
- Leaping to solve a problem before determining and verifying its root cause
- Confusing the measure with the aim
- Solution bias and over-confidence in a chosen approach
- Inadequate support over the course of the change
- Failure to thank and celebrate
- Failure to consider and align with other concurrent organizational changes

AVOIDING PITFALLS OF CHANGE: HOW TO GET PHYSICIANS AND PROVIDERS ON BOARD

Envisioning a future state is often easier than working through the necessary steps to get there.

The first step is one's own recognition that change is required. This may take the form of an extended period of

consideration, or simply an instance of awareness. Willingness to change is a personal attribute and is a key change enabler, along with humility, curiosity, perseverance, and focus. Leaders should also assess practice culture, including the history of change in the organization, its enablers or barriers, and whether stakeholders expect to be asked or told what to do.

Additional steps to implementing and embracing change include:

ORGANIZATIONAL STEPS

- Identify the specific problem you are trying to solve. Frame it in a way that people understand, and agree on the problem.
- Select which changes to bring to physicians and providers for input or decision-making. Develop instead a tailored approach, focusing on how much and what information to



“The first step is one’s own recognition that change is required. This may take the form of an extended period of consideration, or simply an instance of awareness.”

bring forward, and determining the people to whom that information should be tailored.

- Break large solution initiatives into smaller pieces that are most likely to succeed. Don’t present 18 different initiatives, but four or five that are easily understood.
- Don’t go it alone. Align and partner around change with individuals and groups inside and outside your organization, as well as with professional societies and advocacy groups with similar values. Consider investing in expert change management support for larger, complex initiatives and when change fatigue or physician

burnout is a risk. Use proven data-informed techniques, such as Lean or 6-Sigma, to guide improvement, and partner with providers interested in being involved and learning more about improvement science. Seek out the individuals within your organization who have the most influence, and ensure your messages are resonating with these team members. Describe any steps being taken to monitor and track performance.

- Market the changes to each group. Explain the problem, process, and action items to each group, along with the specific action items required of that group. Don’t provide information that is not relevant to a specific group, as that will only lead to confusion and an overwhelming feeling.

PERSONAL STEPS

- Create open dialogue, and show empathy. Don’t just tell physicians and providers what needs to happen—affirm that you understand the myriad challenges they face, and ask for their advice. Celebrate progress and express your appreciation to individuals, not just for the change at hand, but also for providing compassionate, high-quality care every day.
- Shadow people in their daily work, understand their pain points, and offer assistance when you can. Don’t assume that every physician or group can or should be a top performer right away; pushing too hard or too fast may jeopardize long-term success. Focus on the long-term goals, and be sensitive to overlapping demands for change. Look for the signs and symptoms of burnout, and support those at risk. Implement policies aimed at alleviating burnout, such as paid sabbaticals.
- Focus, focus, focus. Competing priorities are distractions. Help alleviate concerns by providing specific action

items that address what will be needed, and when. Clarify each person’s role as part of the change. Participants without workflow change can nevertheless be impacted secondarily, so awareness matters. We recommend preparing an inventory of roles and customizing a change plan for each.

- Acknowledge the uncertainty that comes with any change. Especially when dealing with external market forces such as MACRA and other new value-based payment models, emphasize that these programs are likely to change over time, but that they are not going away.
- Above all, always keep your eye on the patient. Virtually all providers and staff can agree on a change when the benefit to patient care is clear.

Change is a predictable component of health care delivery. Developing and refining an effective approach to managing change is an essential leadership skill. Recognizing common pitfalls, planning accordingly, and course-correcting effectively will help to inspire others, ensure success, and minimize adverse impact. [PR](#)



Steve Gordon, MD, is a principal consultant with Point B’s health care practice group.

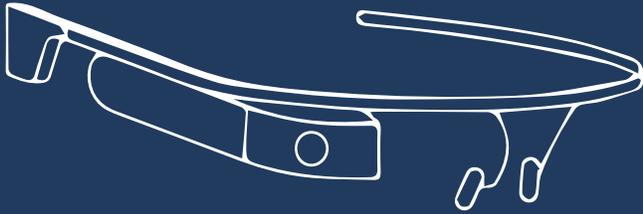


Keely Killpack, a consultant with Point B, is a founding member of the Association of Change Management Professionals (ACMP), holds a PhD in

*Organizational Psychology, and has just finished her first book about change-management strategies, *ChangeRX for Healthcare*.*

Meeting Changing Demands in Health Care

Novel Uses of Technology Are Key



Google Glass Is Ready for Work

EARLY RESULTS SHOW MEDICAL-SCRIBE STREAMLINING AND PHYSICIAN-BURNOUT IMPROVEMENTS

Medical scribes offer physicians a second set of ears to capture patients' concerns, medical histories, and information critical to updating their medical records, while allowing the physician to focus on the delivery of care. But this medical-scribing process isn't always problem-free.

Recently, Edmonds Family Medicine's CEO and practice administrator, Marcy Shimada, decided to offer the Augmedix—a virtual medical-scribe service that connects medical scribes and physicians to practices remotely—to her practice in the hopes that it would relieve some of the burden of charting and medical notes that were keeping doctors at the clinic after hours. The service is utilized through Google Glass, so each of the practice's 33 physicians wear the device during their patient appointments.

Google Glass facilitates a live video feed into the exam room so that the assigned medical scribe can hear and see the medical exam in real time as it is performed by the provider. This allows the provider to focus on the patient rather than worry about getting all the details down in their notes during the patient's visit. The patient experience benefits from this uninterrupted attention, and the doctor can fill in any additional notes they have later when they review the scribe's work. Reducing the hours it takes to capture a patient's medical information offers physicians better work-life balance, and ultimately helps to reduce burnout.

While electronic health record (EHR) interfaces increasingly offer more intuitive ways to integrate with a physician's workflow, errors around data entry or technical issues with the platform can keep them from being fully utilized. Furthermore, many patients feel that their physician is staring at a computer screen more than engaging with them, a huge barrier to patient satisfaction.

In addition, physician burnout—due to a provider shortage and the resulting increasingly long hours and mounting paperwork—has become a growing issue for health care organizations struggling to recruit and retain their physician care providers. According to a recent article in Becker's Hospital Review entitled, "A Burnout Epidemic: 25 Notes on Physician Burnout in the US," "Fifty-one



A Washington State Orthopedist Makes Strides in Cutting-Edge Implants

James W. Pritchett, MD, has been designing joint implants and the surgical tools to place them for more than 30 years. In that time, the goals and expectations of patients have changed dramatically. The average age of a joint-replacement patient is 70 years, with some younger populations of individuals who engage in professional or extreme sports. While in the past a 10-year lifespan for a joint replacement was considered pretty great, orthopedic implants have more than doubled their lifespan, offering patients who receive them considerable freedom and lifestyle flexibility.

Joint replacements in the United States exceed one million per year today, and this number is expected to grow rapidly over the next two decades, with patients under age 65 expected to outnumber those who are older.¹ Athletes in particular have taken advantage of the benefits of joint replacement after injury, with the hopes of performing exactly as they did pre-injury. Dr. Pritchett, who practices in Seattle, has a diverse patient base, including many elite athletes such as NBA players, competitive surfers, and professional golfers and runners. Some discover that they perform in their sport even better after a joint replacement than they did with their natural joint.

MORE SOPHISTICATED EHRS AND BIG DATA BRING IMPLANT IMPROVEMENTS

Improvements in implant design can be attributed to a number of factors. Dr. Pritchett says that more thorough testing, with cyclic loads way beyond that of the body, is the new norm. “Previously, 10 million cycles was

Additionally, the physicians report being very pleased with the scribe service, noting that their scribes had captured all details with great accuracy and quickly gained a sense of their communication or notation style, and that even substitute scribes, filling in when their assigned scribes were out, created a fairly seamless experience.

“I find that I’m saving myself at least a few hours of additional paperwork each night, and the quality of the service has been very high, in my opinion,” shares physician Andrew Thurman, who ramped up his use of the technology over time and now uses it for all his patients. “I feel like it offers time savings. The notes [in the patients’ charts] have more verbiage and are more accurate, which makes it easier to bill correctly.”

While most patients—90 to 95 percent so far—consent to have their physician use the technology during their visit, there are some who fear the risk to privacy, or have other reservations regarding Google Glass or the scribing service. However, “Most patients



“These doctors are getting home in time to have dinner with their families, and feeling less overwhelmed by the volume of paperwork and charting they were previously experiencing.”

—MARCY SHIMADA, CEO, EDMONDS FAMILY MEDICINE

percent of physicians reported experiencing frequent or constant feelings of burnout in 2017, up from forty percent in 2013, according to Medscape’s annual survey.”

Yet, after just a few months, the results of this Augmedix/Google Glass pilot project at Edmonds Family Medicine show promising signs of alleviating fatigue for the providers using the technology.

“These doctors are getting home in time to have dinner with their families, and feeling less overwhelmed by the volume of paperwork and charting they were previously experiencing,” shared Shimada.

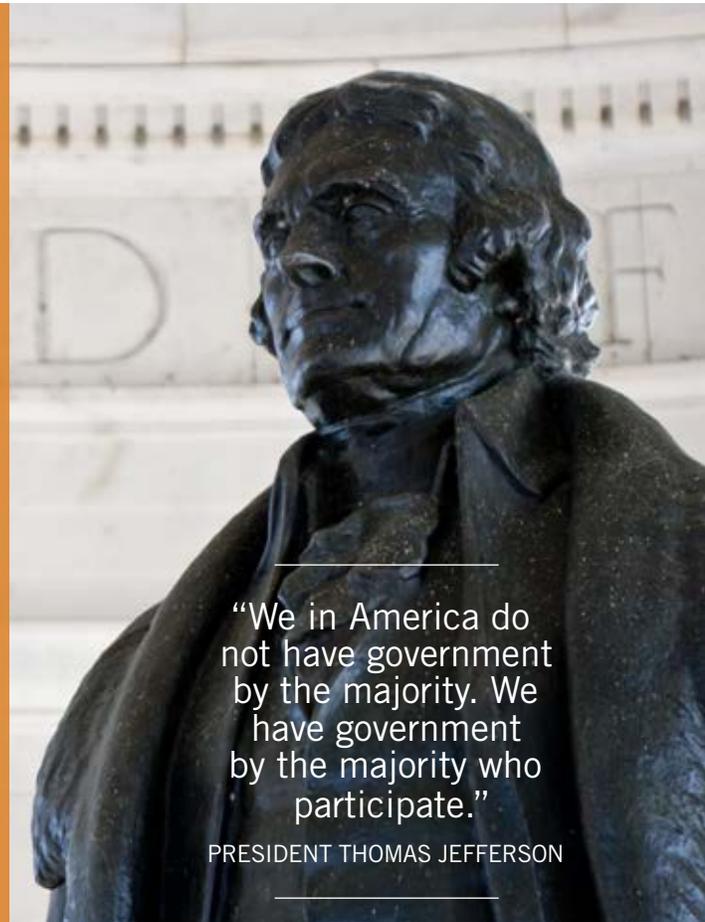
are intrigued,” says Thurman. “The patient can see when the device is in use by the green light on the corner.” If the medical assistant prepares the patient by talking to them about Google Glass use and the reasons behind it, most patients are pleased that their physician is using the technology.

Shimada is pleased that Augmedix continues to slash hours of charting from her provider’s work days. While the organization is not necessarily looking to increase patient volumes, they are reporting a time savings that is creating better work-life balance for the staff and satisfaction in those who are using the service.

(Continued on page 34)

ADVOCATING FOR LAWS THAT IMPACT HEALTH-CARE LIABILITY, INSURANCE, AND PATIENT SAFETY

Government Relations: 2017 Legislative Update



“We in America do not have government by the majority. We have government by the majority who participate.”

PRESIDENT THOMAS JEFFERSON

Effective advocacy is crucial for ensuring that the concerns of our members and their patients are heard by lawmakers at both the state and national level. Anne Bryant, Senior Director of Government Relations and a registered lobbyist in Washington and Oregon, works in close cooperation with many other organizations that pursue similar goals, and establishes Physicians Insurance as a leading advocate for laws that impact health care liability, insurance, and patient safety.

We provide advocacy on challenges to medical and hospital professional liability that create new causes of action against health care professionals, alter the standard of care for physicians, create strict liability for performing or not performing care, and impose onerous or unnecessary duties on insureds. Physicians Insurance supports legislation that improves the liability system, promotes meaningful patient-safety initiatives, and improves communication between health care professionals and patients.

WASHINGTON

The historical legislative environment in the Washington State Senate continued as one Democrat Senator crossed over to caucus with the Senate’s 24 Republicans to create a new Majority Coalition Caucus (MCC) for control of the Senate.

Governor Inslee (D) won his re-election, and the Washington State House slightly increased its Democratic control with 51 D’s and 47 R’s. State budget issues were the main focus of the 2017 legislative session.

We achieved the following:

- Defeated plaintiff trial bar’s proposals to expand wrongful death claimants to include other beneficiaries.
- Defeated plaintiff trial bar’s proposals to expand damages by inflating medical expenses in personal injury medical claims
- Supported proposals to engage in shared decision-making without impacting informed-consent requirements
- Promoted the passage of the interstate medical licensure compact to allow physicians to practice medicine across state borders (<https://tinyurl.com/yaae7t7u>)
- Supported proposals to create an education-based process to remedy minor practice deficiencies through completion of a remediation plan

We continue to partner with the Governor’s Healthier Washington initiative to further improve the health care delivery system through patient empowerment.

FEDERAL MEDICAL LIABILITY REFORM LEGISLATION PASSES THE U.S. HOUSE OF REPRESENTATIVES

OREGON

Governor Brown (D) won her re-election and Democrats maintained control of the Oregon State Senate and House—the Senate with 17 D's and 13 R's; the House with 35 D's and 25 R's. There are two physicians in the Oregon Legislature, one Republican and one Democrat. This, along with bipartisan support, was instrumental in blocking harmful legislative initiatives promoted by the plaintiff trial bar. There was no opportunity for the passage of any meaningful tort reform this 2017 legislative session.

We achieved the following:

- Defeated proposals that add insurance to the Unlawful Trade Practices Act and expand the types of lawsuits that are brought against insurance companies
- Defeated plaintiff trial bar's proposals to increase the \$500,000 cap on non-economic damages recoverable in wrongful death and personal injury actions
- Effectively worked with coalition partners on strategies to assure tort reforms were not eroded by the plaintiff bar

We continue to participate in the Oregon Rural medical professional liability premium subsidy plan, which pays part of the premium by reimbursing participating providers. In addition, we continue to partner with the Oregon Patient Safety Commission to further improve communications between health care professionals and patients, and promote patient empowerment.

IDAHO AND WYOMING

Both states hold strong Republican majorities in the Senate and the House and have Republican Governors. The 2017 legislative sessions were relatively quiet, with limited challenges to medical and hospital professional liability, our insureds, and their patients.

On June 28, 2017, the U.S. House of Representatives passed the Protecting Access to Care Act (H.R. 1215), the first comprehensive medical liability reform legislation to be passed by either chamber of Congress in more than five years. (<https://tinyurl.com/ya9sn6h2>) The bill passed 218-210.

H.R. 1215 ensures fair and timely compensation to injured patients, improves access to patient care and promotes affordable and accessible medical liability insurance coverage to providers. Specific provisions include unlimited compensation for economic losses, caps on subjective non-economic damages, limits on attorney contingency fees, periodic payment of future damages, and a statute of limitations.

Unlike previous federal bills introduced, H.R. 1215 is focused solely on health

care professionals and entities, includes more flexibility for states, and applies only to medical liability claims involving care provided through the expenditure of federal dollars, including federal tax benefits.

A companion bill will be introduced in the U.S. Senate to improve H.R. 1215. For example, reform will apply to all medical liability claims, regardless of whether the care is provided through the expenditure of federal dollars. Medical liability reform faces significant challenges in the U.S. Senate, given that not all Republicans support reform through federal edict.

We will continue to engage our lobbying efforts and work in close collaboration with PIAA, our national trade association, to promote national comprehensive medical liability reform.

FEDERAL

We continue to support and work closely with PIAA, our national trade association, and its renewed effort to push for national legislation to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system. Anne Bryant, Senior Director of Government Relations, is the current Chair of PIAA Government Relations Committee.

To date, we have achieved the following:

- Promoted Accessible Care by Curbing Excessive Lawsuits (ACCESS) Act—similar to California's Medical Injury Compensation Reform Act (MICRA)—comprehensive legislation that improves the liability system and promotes meaningful patient safety initiatives (See "Federal Medical Liability Reform" article)
- Continued to support the Affordable Care Act's provision that no new standard of care for medical liability

claims is created by the ACA

- Promoted the Crisis Standard of Care and Good Samaritan Act, which provides liability protection for health care professionals and facilities providing uncompensated services to victims of federally declared disasters
- Supported the framework for potential legislation that addresses telemedicine liability as telemedicine services expand

We continue to be a trusted, reliable source for our members and key members of Congress, state legislatures, and state executive branches, and serve them with a fair, balanced, and solution-centered approach. 

If you would like to participate in our effort, please contact Anne E. Bryant, Senior Director of Government Relations at Physicians Insurance, at anne@phyins.com.

The Spine Institute of Idaho

The Backbone of Treasure Valley

by Clint Kelly

Close-knit Practice Offers Full Gamut of Simple and Complex Spine and Neck Care



In Idaho's Treasure Valley region, midway between the state's two largest cities of Boise and Meridian, a growing number of spinal pain sufferers are placing their trust in the medical team at The Spine Institute of Idaho in Meridian, Idaho. A vast number have returned to work and active play. Elderly patients and those with major spinal problems have regained significant functionality.

Samuel Jorgenson, M.D., acting medical director, sees the full range of issues, both simple and complex, from 60 to 80 patients each week. He performs about 350 spinal surgeries a year—between five and 10 per week—and says he dedicated his life to this branch of medicine “because the spine is so complex and all-encompassing.”

“The field is so technical, and the skill set so specialized, that it would be hard to do other medical procedures not associated with the spine,” he says.

He sees a broad range of ailments that can impact the quality of life—herniated discs, osteoarthritis, spinal fractures, sciatica, cervical fractures, and more.

Jorgenson and his team of four orthopedic spine surgeons, two physiatrists, two nurse practitioners, three physician assistants, a physical therapist, and office medical assistants serve patients from across a broad geographical area that, besides Idaho, includes parts of Nevada, Oregon, and Washington.

Among the Institute's surgical specialties are cervical (neck) surgery, minimally invasive surgery, the correction of previous failed back/neck surgery, and reconstructive spine surgery. “Our patients come to us from farm communities and cosmopolitan cities,” says Jorgenson. “Our office is close-knit and highly collaborative when it comes to our patients and their problems.” He also enjoys a strong relationship with St. Luke's Regional Medical Center, St. Alphonsus Regional Medical Center, West Valley Medical Center, and Boise VA Medical Center, area hospitals where he performs most of his surgeries.

Following nine years of practicing spine surgery at the University of Southern California Medical Center and affiliated hospitals in Los Angeles, California, Jorgenson joined The Spine Institute of Idaho in 2002. The decision to move there was in part to raise a family in a healthy, outdoor lifestyle.

He, his wife of 26 years, and their three children have thrived in Idaho, where they have vacationed at Sun Valley, hiked the Boise foothills, and kept exercise at the forefront of their personal health focus. Their youngest child, a son, pursues competitive cycling; their middle child, also a son, is at Columbia University in New York, poised for a career in computer science; and the oldest, a daughter, is a graduate of Colorado College and considering medical school.

FAST FACTS

LOCATIONS: Two sites: one in Meridian and the other in Caldwell, Idaho

MEDICAL STAFF: Four surgeons, two physiatrists, two nurse practitioners, three physician assistants, a physical therapist, and office medical assistants

GEOGRAPHIC AREA: Besides Idaho, includes parts of Nevada, Oregon, and Washington



“The field is so technical and the skill set so specialized that it would be hard to do other medical procedures not associated with the spine.”

SAMUEL JORGENSON, MD, ACTING MEDICAL DIRECTOR, THE SPINE INSTITUTE OF IDAHO

surgery is his way of doing so. “Anyone with a spine problem can come to the Institute and find options to help them,” he says. “We offer a full range of treatments, and will refer for the most appropriate means of providing for them.”

Part of Jorgenson’s job is to educate patients who have no clinical knowledge. They frequently come to his office with inaccurate assumptions. “A patient might say, ‘Oh, my uncle had back surgery and is doing great,’ and think that one form of treatment fits all,” he says. “You’d be surprised at the number of people we talk out of surgery for their own benefit.”

Jorgenson is ever mindful of the dangers of spinal surgery. Cardiac function can be compromised when a patient is asleep for long periods. Pneumonia and blood clots are other potential risks, as are

disc causes the disc space to collapse, creating a bone-on-bone situation and abnormal wear on the joints.

What brings joy to Jorgenson is helping people through a difficult time to be able to pursue the life they want to live, to return to work, and to enjoy their families again. He sees them through the struggle and is there for them in the healing process. “It’s challenging to keep up on changing technology, to constantly educate yourself and stay current,” says Jorgenson, who has performed minimally invasive surgeries as well as 10- to 12-hour surgical marathons. His skills include microscopic surgeries and major reconstructive surgery for scoliosis.

“It’s rare to have one office provide the full spectrum of operative and non-operative treatments,” he adds. And not only that, but the Institute’s board-certified and

In his medical practice, the issues Jorgenson most often sees are tied to aging and degeneration in the spinal region. But he quickly discovered the depth of passion a number of his patients had for outdoor recreation. It was satisfying to help those more athletic and adventurous patients recover from back injuries and return to the slopes.

“Though I’ve never taken up hunting, some of my patients live for hunting season, and are just miserable if an injury prevents them from getting out there,” Jorgenson says. He takes great satisfaction in repairing spinal injuries that keep his patients down, and in providing therapies to restore their back strength and range of motion so they can again do the things they love most.

For Jorgenson, one of life’s biggest payoffs is in the personal satisfaction of caring for people in crisis, and focusing on spinal

nerve injuries, fractures, and removing too much bone or tissue, which can result in destabilized bone structure where stabilization was intended. Consequently, the Institute’s professional standards require Jorgenson and his team to not only spend time and energy training for surgery, but also to optimize the overall health of their patients to get them ready for surgery—and to teach them how to minimize the chances of the problem ever happening again through exercise and the maintenance of a healthy lifestyle routine.

Another discovery some patients make in seeking help from the Institute is that smoking is bad for your back. Because it diminishes nutrition and hydration to the spinal discs, smoking is a risk factor for degenerative disc disease. The lack of nutrition and hydration to the

fellowship-trained physicians and orthopedic spine surgeons have developed innovative techniques now standard in spinal medicine. “We have designed and tested implants commonly used in spinal surgery today,” he notes. These include a cervical plate for giving increased stability to the spine following surgery, which helps provide an earlier return to normal function.

The comprehensive array of spine treatments offered, and the skilled staff to employ them, are what make the Institute such a valuable asset to the community. It’s clear all of its team members believe in making a difference in people’s lives.

From patient care to office operations, The Spine Institute of Idaho provides for the community and for its own. You could say they have the backbone to run a health care practice the way it ought to be run. 



(Alaska Center, continued from page 15)

they serve, many of whom require costly care and high utilization. Additionally, they serve a large number of teenage patients as well as a large population of infants in their NICU, and are working to offer services for maternal depression to mothers. They are also working to expand their preventive and social services by offering teen classes on self-esteem, and have implemented a parenting class for families with toddlers based on “The Incredible Years” curriculum. The clinic serves a diverse community, and has improved its screening methods by offering service in more than 43 different primary languages.

Maintaining financial wellbeing has, at times, been a struggle for the practice. Alaska doesn’t have any managed-care or health-maintenance organizations,

which places an added burden on many practices. Alaska Center for Pediatrics has responded by taking up an integrated preventive-care model and approach to best serve their patients.

TEAM-BASED CARE DRIVES SUCCESS

“Shifting to team-based care was crucial to our success,” says Woodard. “ACP believes whole-heartedly that partnering with families and outside agencies is extremely important in providing global care for our patients, and we work hard to maintain trusting relationships to ensure that this can be achieved.”

ACP has cultivated a good relationship with the state of Alaska, and has received a grant from the Alaska Primary Care Association focused on integrating

behavioral health into the medical home. Currently, they are working on an initial behavioral-health assessment and intervention. They have also participated in value-based contracting since 2016.

“I would say that you have to have both a well-defined purpose and engaged leadership,” says Woodard. “When all decisions that are made put the patient and his or her family at the forefront, then this automatically empowers us to make decisions that are respectful of our families, staff, and community. At the end of the day, it feels really good to walk away from meaningful work that drives a positive culture.” 

Resources

¹ “Guiding Principles for Team-Based Pediatric Care,” PEDIATRICS, Volume 14D, Number 2, August 2017, The American Academy of Pediatrics.

DEFINING THE PRIMARY CARE MEDICAL HOME

The medical-home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.

The medical home encompasses five functions and attributes:

1. Comprehensive Care

The primary-care medical home is accountable for meeting the large majority of each patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician

assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators.

2. Patient-Centered

The primary-care medical home provides health care that is relationship-based, with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient’s unique needs, culture, values, and preferences.

3. Coordinated Care

The primary-care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital.

4. Accessible Services

The primary-care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care.

5. Quality and Safety

The primary-care medical home demonstrates a commitment to quality and quality improvement through ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision-making with patients and families, and engaging in performance measurement and improvement.

You can also view a list of foundational articles on the PCMH. To find these articles and more information, go to the AHRQ website at <https://tinyurl.com/ycj5oxjw>.

Trial Results



The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact health-care professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.



ALLEGED CONTRAINDICATED LEVAQUIN PRESCRIPTION

SPECIALTY: Internal Medicine

ALLEGATION: An 80-year-old female alleged ongoing Achilles-tendon injury after taking 500 mg of Levaquin for a urinary-tract infection in 2009. Plaintiff alleged, first, that the provider should not have prescribed any antibiotic for the patient's confirmed urinary-tract infection; and second, that the provider failed to inform her of the risks associated with Levaquin and the alternatives to that medication. The patient claimed a myriad of ongoing symptoms and decreased mobility caused by the Levaquin.

PLAINTIFF ATTORNEY: John Walsh

PLAINTIFF EXPERT: Peggy Goldman, MD, Internal Medicine/Emergency Medicine, Seattle, WA

DEFENSE ATTORNEYS: Tim Ashcraft, Fain Anderson VanDerhoef Rosendahl O'Halloran Spillane, Seattle, WA

DEFENSE EXPERTS: Peter McGough, MD, Family Practice, Seattle, WA, T. Scott Woll, MD, Orthopedics, Vancouver, WA

RESULT: Defense Verdict

IMPROPER INTERPRETATION OF ANKLE X-RAY IN FAILURE TO DIAGNOSE TENDON INJURY

SPECIALTY: Radiology

ALLEGATION: The patient presented to the Emergency Department with a complaint of moderate right-dorsal foot pain after stepping off a stool and landing awkwardly. The provider who conducted the exam noted a pink contusion and swelling crossing obliquely from the head of the third metatarsal to the first metatarsal, tender to palpation. A standard three-view X-ray suite was ordered.

The radiologist interpreted the X-rays that same day, and noted that the joints were normal with no significant arthritic disease or effusion. Ankle mortise was symmetric. Soft tissue appeared to be normal, and the overall impression was of a normal right foot. As a result of this interpretation, the patient was instructed on the use of crutches, ice, elevation, and rest, and was sent home to follow up with a primary care physician, or return if pain worsened.

A year later, the patient presented to the Emergency Department with complaints of foot pain. An X-ray was taken, which revealed a lateral subluxation at the base of the

second metatarsal, suggestive of a Lisfranc ligament injury with no attendant fracture. In comparing this X-ray with the prior X-ray, the radiologist noted the possibility of a much smaller Lisfranc ligament injury on one view of the prior films.

Subsequently, the patient underwent a medial column stabilization surgery, which included a fusion of the first, second, and third tarsometatarsal joints, as well as medial-to-middle cuneiform and middle-to-lateral cuneiform joints, for ongoing complaints of pain and inability to bear weight.

It was alleged that had the radiologist identified and reported the Lisfranc tendon injury on the 2012 X-ray, surgery would have been avoided.

PLAINTIFF ATTORNEYS: Jeff Donchez and Mercedes Donchez

PLAINTIFF EXPERT: Glen Curda, DPM, Bellevue, WA

DEFENSE ATTORNEY: Chris Anderson

DEFENSE EXPERT: Jonathan Berlin, MD, Radiology, Chicago, IL

RESULT: Defense Verdict; Private Trial 



“Traditionally, in medicine, doctors reported outcomes that were based on their own scientific interests. Now feedback is collected around the issues that matter most to the patients.”

(Meeting Changing Demands, continued from page 27)

considered standard, which equates to about a 10-year lifespan for a joint,” he says. “Now, 30 million cycles has become standard, adding 30 more active years on the joint. More sophisticated electronic health records and big data sets also offer a better measure of how joint replacements perform over a full range of time as patients age.”

Additionally, hip implants are being made to look and function more like a natural hip joint. The new implants can match the exact ball diameter of the patient’s hip, and are attached to the skeleton with a new porous metal that the bone grows into, creating a permanent bond. This is a big step up from the cement that was used previously. Finally, the old joint replacement used to act like a hinge, but now a more exact match of the ball joint allows for a complete range of motion.

Improved reporting of patient outcomes in medicine at large has also delivered unique insights and better informed design choices. According to Pritchett, “Traditionally, in medicine, doctors reported outcomes that were based on their own scientific interests. Now feedback is collected around the issues that matter most to the patients.”

For example, when Dr. Pritchett began to ask his patients about their sexual function after their hip replacement—a topic that was nowhere to be found in existing medical journals—he discovered that there was indeed a design shortcoming in this area. This feedback informed the design of a new, more stable hip. The goal is to not place any

limitations on the activities a patient can enjoy after surgery. In the past, undergoing a joint replacement still meant that you would likely have long-term limitations on motion and activity. That is no longer the case.

However, to this day the patient story that stands out most to Dr. Pritchett is that of a patient who was neither middle-aged nor athletic. Coerced by a friend to come in, the 31-year-old female patient was suffering debilitating hip pain, causing her to stay home outside of work. “She has no life,” her concerned friend reported to Pritchett. The young woman’s only hope was of pain relief. She said that she didn’t think she would ever have a family. Pritchett convinced her to have the surgery.

After the surgery, which had gone beautifully, Dr. Pritchett noticed the young woman’s mother in the hallway crying. Concerned that something had gone wrong with his patient, Pritchett headed into the patient’s room, and checked to see how her recovery was coming along. Everything looked great. He then approached the patient’s mother and asked, “What is the matter?” to which she responded, “This is the first time I’ve seen my daughter walk normally her entire life.” At that moment, Dr. Pritchett realized that the joint replacement had not only offered the patient a chance to alleviate her chronic pain, but had changed her entire life—and her mother’s life, too.

Living a normal life was something the young woman had never envisioned for herself, and today, she is the mother of four children. For many of the athletes who come in to Dr. Pritchett’s office, getting “back in the game” is usually the primary goal. Yet for the young

woman, simply not being handicapped by pain, and feeling normal, was the goal.

This experience has stayed with Dr. Pritchett as a humbling reminder of the importance of continuing to advance the design and surgical replacement of joints. The goal, according to Pritchett, is that each patient “is not prevented from realizing their potential, whatever that is.”

Dr. Pritchett has contributed to the body of knowledge in this area through his original research and over 160 published scientific papers. The extensive experience of his practice stands out in the Pacific Northwest. They have performed more than 5,200 cross-linked polyethylene and metal joint-resurfacing procedures, with patients using their new joints as soon as the effects of anesthesia wear off.

Carena Virtual Health: A Way to Extend House Calls

Carena, a telemedicine startup based in Seattle, was founded in 2000 to provide on-demand care to patients by partnering with larger health organizations, as well as through employee health programs. In order to provide virtual house calls as an extension of their existing care-delivery system, the company began development in 2007 and successfully launched their very first virtual-services platform in 2010.

Virtual care, for Carena's leaders, seemed like a natural extension of the traditional "house calls" that have been a form of medical care delivery, performed in cultures around the world, for hundreds of years. The opportunity to bring the consumer's experience back to a high level of access and personalization could not be better timed, given a health care environment where many patients' access to care is being increasingly limited.

The first clinic to adopt their virtual-care services was a Franciscan hospital in Seattle in 2012, which integrated the technology into their regular care without issue. They have since grown rapidly and now work with over 120 hospitals across the United States, offering services to 18 million people. Their services allow the partnering hospital's clinical team to redefine care delivery and extend consumer access, particularly among rural populations. Among the benefits reported by Carena's partnerships are:

- Lower hospital readmission rates
- Improved patient outcomes
- Decreases in physician burnout

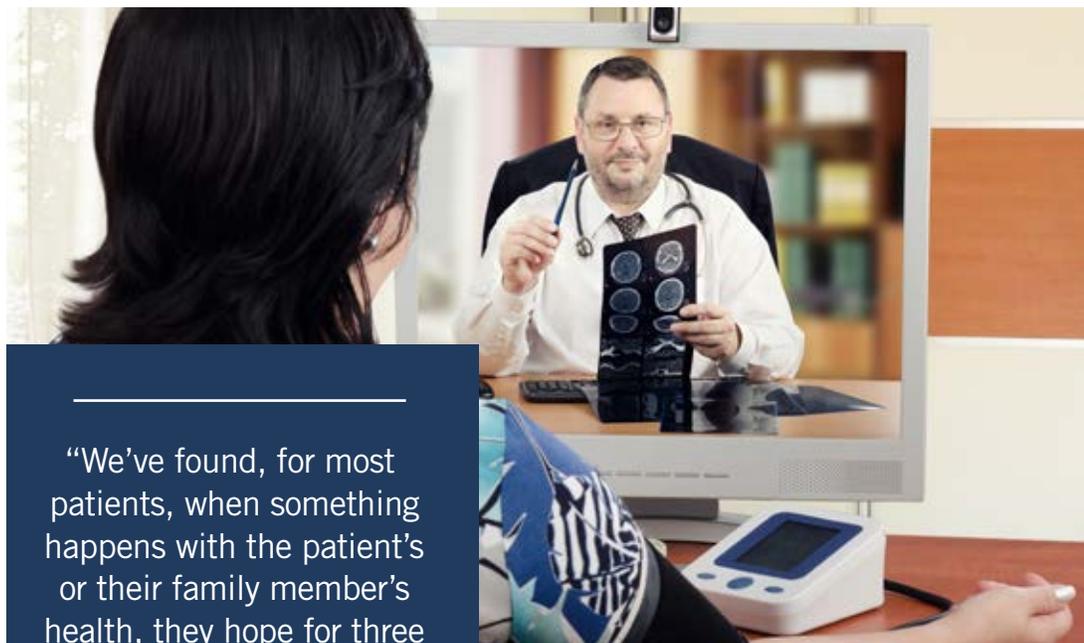
Patients report high levels of satisfaction with the 10 to 15 minutes on average that it takes to talk to a doctor. For example, parents who are up late at night with sick children can have their anxieties and questions addressed without an unnecessary trip to an emergency department. The cost of a Carena patient visit is \$10 to \$35. The majority of the negative feedback they receive from patients focuses on access to medication, as Carena providers are cautious prescribers.

"We've found, for most patients, when something happens with the patient's or their family member's health, they hope for three things: I hope it's not serious; I hope I can see my doctor; I hope it is paid for," says president and CEO Ralph Derrickson. Often patients simply need to speak to someone medically licensed who can answer their questions or concerns.

A VALUE-ADD TO THE PATIENT EXPERIENCE

The care Carena offers has benefited Derrickson personally. He became one of Carena's first patients when he contracted shingles on a trip and needed urgent medical instructions while in a remote location. Most of the time, Carena patients want to talk to a provider more to discuss anxieties about their health than to address an actual urgent medical condition. But in addition, Carena serves in an urgent-care capacity, offering an important alternative to the emergency

department. However, the road to providing these services to patients is not without barriers. Medicare patients are not always covered to receive virtual care, as parity laws lower reimbursement rates. For some of these patients the emergency department is covered, while virtual care—the most cost-effective option—is not. Additionally, variations in state licensure requirements, and the absence of a national standard of licensure for practicing virtual medicine, presents challenges and red-tape barriers for the company.



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department. "This is a tremendous value-add to the patient-experience component that health systems provide to their enrolled patient populations," says Derrickson.

Patients with chronic conditions often find benefit in access to virtual-care services. Additionally, for patients who have been recently discharged from the hospital, virtual care can be critical to preventing hospital readmission.

Yet the Carena model is working. Companies such as Microsoft, Costco, and Boeing are using Carena to supplement their self-insured plans to help keep costs down. And hospital and health systems are using Carena to support their employee populations and as a way to extend the primary-care arm of their systems, as well as market to new patients.

But the key is, virtual care protects the sanctity of the office visit and doesn't change who patients see—just how consumers access their care. And for health care providers, teaming up with a virtual care provider extends their ability to care for patients without having to pack more patients into their already full schedule. [PR](#)



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WELCOME TO OUR NEW MEMBERS!

**MEDICAL PROFESSIONAL
LIABILITY**

**McMinnville Imaging
Associates**
McMinnville, OR

Dena'ina Wellness Center
Kenai, AK

**Anchorage Neighborhood
Health Center**
Anchorage, AK

**Sunshine Community
Health Center**
Talkeetna, AK

**Iliuliuk Family and Health
Services**
Unalaska, AK

**HOSPITAL
PROFESSIONAL LIABILITY**

Confluence Health
Wenatchee, WA

EvergreenHealth
Monroe, WA

Fork Community Hospital,
Forks, WA

Klickitat Valley Hospital
Goldendale, WA

Mason General Hospital
Shelton, WA

Mountain View Hospital
Idaho Falls, ID

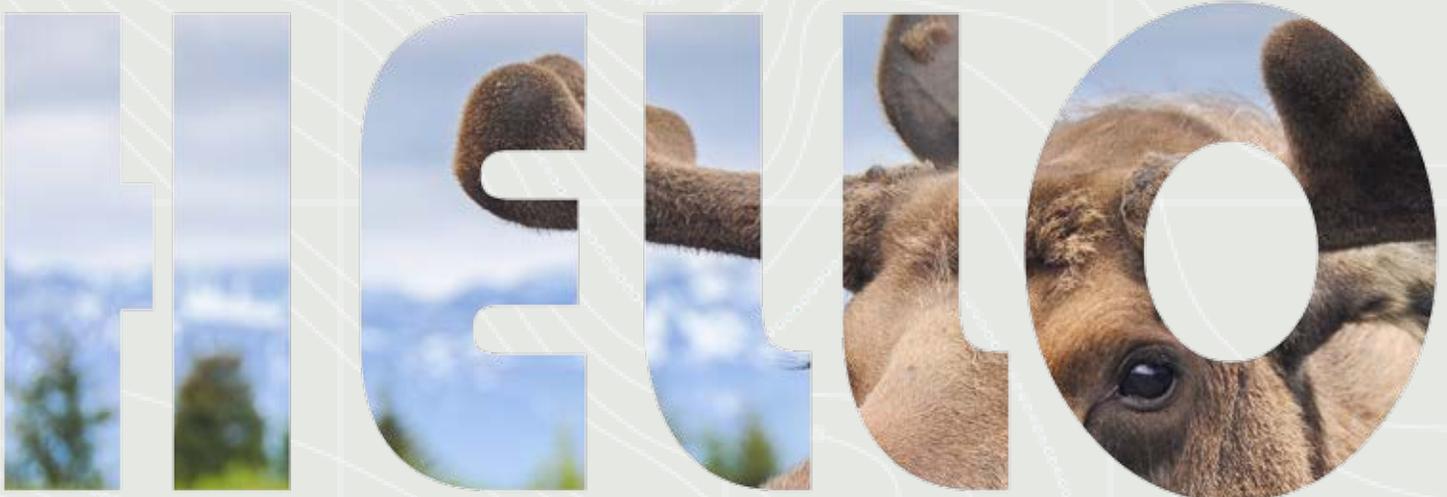
**Newport Hospital (Pend
Oreille #1) & Health
Services**
Newport, WA

Prosser Memorial Hospital
Prosser, WA

Skyline Hospital
White Salmon, WA

Willapa Harbor Hospital
South Bend, WA

WELCOME TO OUR NEWEST MEMBERS IN ALASKA



We recently started serving Alaska. So we offer a special welcome to our new members from that state. We are happy to be a part of your medical community.