

THE Physicians Report

SPRING 2019 PHYINS.COM

RESPONDING TO THE EVOLVING BUSINESS OF HEALTHCARE



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Business of Healthcare

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Ability to Adapt Key to Navigating Change in Healthcare

When the Greek philosopher Heraclitus introduced the concept of constant change, I know he wasn't talking about reimbursements, EMRs, or healthcare technology—but he certainly could have been.

Over time, it has become clear to me that people and organizations that recognize the inevitability of change fare better, whether by adapting to changing regulations, shifting from fee-based to value-based care, or transforming organizational culture to attract and retain top talent.

This forward-thinking philosophy to prepare for the future, and open up to new ways of operating, is among the reasons I was recently attracted to join EvergreenHealth as its CEO. Over its 47-year history, our health system has continually demonstrated its willingness to embrace change, while keeping patients, providers, and the community at the center of every decision.

Two examples demonstrate this commitment.

First, we are all aware of the recent significant consolidation in healthcare. In some cases, when health systems merge it makes great sense. In others, though, mergers can create issues stemming from duplicative services and difficulties with system integration, leading to closures that force patients to travel further for care.

EvergreenHealth has approached the issue by creating affiliations and strategic alliances—like our partnerships with the Seattle Cancer Care Alliance and Overlake Medical Center and Clinics—that enable our organization to remain independent while partnering with like-minded groups, leveraging one another's strengths without the growing pains mergers can create.

The second example is EvergreenHealth's leadership in forming clinically integrated networks, a model that enables independent providers and hospital-employed physicians to partner to achieve common goals and, ultimately, to improve population health. This leadership started with our creation of the region's first clinically integrated network, EvergreenHealth Partners, and we've built upon it ever since. Most recently we formed the Eastside Health Network, our new clinically integrated network in partnership with Overlake Medical Center and Clinics and hundreds of independent providers.

Today, more than half of the providers in Eastside Health Network are independent providers—a diversity we believe is critical to the success of the network. It covers nearly 50,000 community members, offering a more coordinated experience and better outcomes for patients, along with a system for providers to develop and implement evidence-based, data-driven clinical initiatives to increase efficiency and reduce costs. And all of this is achieved while also reducing the administrative burden of independent practices, to help support their long-term viability through initiatives such as medical-malpractice cost improvements and the creation of medical-benefit insurance options for employees.

We cannot stop the pace of change; we simply must adapt. This means pursuing alternative ways to grow through strategic partnerships and leading the region in clinical integration with independent providers to make navigating the changing business of healthcare possible.



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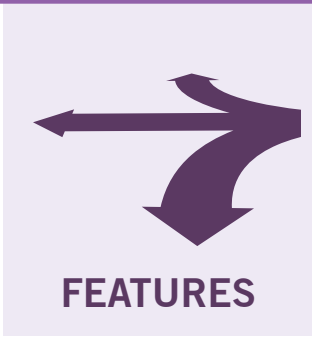
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The Trends Shaping the Business of Healthcare

CONSOLIDATION, COST, AND COMPENSATION DRIVING EVOLUTION OF THE PHYSICIAN ROLE IN HEALTHCARE

The days of independent-physician practices focused on volume-based models in the American healthcare system are far from over, but the landscape looks drastically different from how it did just a few years ago.

Strong waves of consolidation via mergers, acquisitions, and new affiliation/partnership models have concentrated the ownership of healthcare delivery organizations (HDOs) in ways akin to mega-mergers seen in other industries.¹ Similarly, major players across other areas of the U.S. economy—names such as Amazon, Apple, and Walmart—have made strategic acquisitions and investments toward securing space in the healthcare industry.

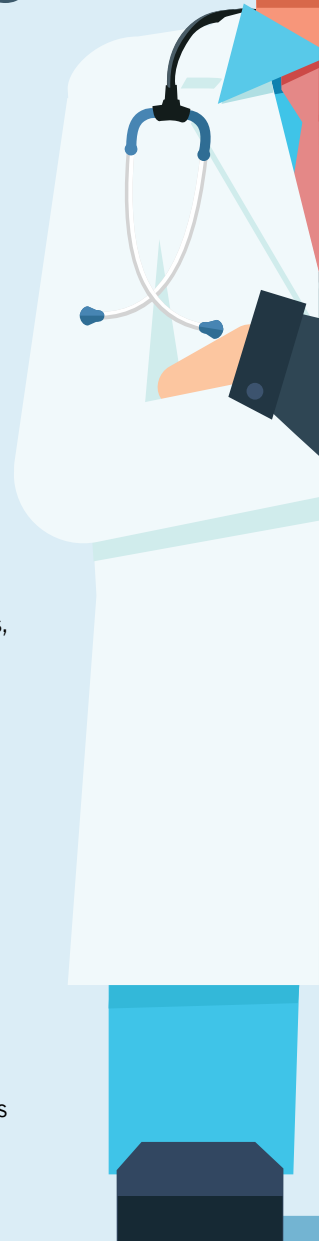
However, this “corporatization of medicine” is not a blanket trend for all HDOs. Even among physician practices that will attract private equity (P.E.) interest, practice acquisition and arbitrage is being driven by size, with larger practices being valued at eight to 12 times earnings before interest, taxes, depreciation, and amortization (EBITDA) and smaller organizations at two to four times EBITDA.² Those larger “platform practices” are often viewed by investors as safer bets to provide about 20 percent or more in annual returns to the P.E. firm, as well as providing an attractive home for physicians looking to sell a smaller practice, which increases the value of the new entity before a firm sells sometime in the following three to seven years.

Medical specialists have been of particular interest to P.E. firms, including dermatology, anesthesiology, pain, radiology and eye care, as well as platform investments in orthopedics, gastroenterology, and urology.³

While this strategy for going after the metaphorical big fish—to then swallow up smaller HDOs—has been popular, there remain other strategic options that physician groups have considered amid the recent M&A craze, including:

1. Join, or be acquired by, a hospital or hospital-affiliated medical group:

Particularly popular in primary care, cardiology and oncology, this change is not as lucrative for physician owners. Physicians often complain that hospitals do a poor job of managing acquired physician practices,





and hospitals pay very little for medical-group acquisitions, due to regulatory limitations.⁴

2. Join, or be acquired by, a “mega-physician group”:

Mega-physician groups remain under the control of physicians, though valuations of practices are normally at book value.

As the big players carve out new efficiencies, thousands of HDOs remain significantly unchanged in governance and structure while facing the same pressures they have in the past decade in the wake of major healthcare-reform legislation, including:

- Quality-reporting requirements from both governmental and commercial insurers
- Securing the information-technology infrastructure to collect, track, and analyze metrics for payers and quality-of-care initiatives
- Meeting the rising demands of increased patient consumerism and an aging population that requires higher-acuity care
- Managing costs in an era of stagnating reimbursement and higher patient financial responsibility
- Maintaining or replacing a provider workforce that reports growing levels of burnout and professional dissatisfaction



“I don’t think it’s in the physician’s best interests to be in solo practice. I think in order to participate in the new healthcare, physicians need to learn to aggregate, to network, and to optimize their own situation.”

MICHAEL NACHOMOVITZ, MD

THE DEMISE OF INDEPENDENT PRACTICE IS GREATLY EXAGGERATED

The grappling of independent-physician practices with the prevailing trends that medical groups have faced in recent years testifies to a space for the physician practice to move forward, despite larger trends toward consolidation.

This is one of the key messages presented recently at the MGMA 2018 Annual Conference by Michael Nachomovitz, MD, former senior vice president and chief clinical integration and network development officer at New York-Presbyterian Healthcare’s Physician Services Division.

During his speech in Boston, he noted that the impending demise of the independent practice is greatly exaggerated. “I don’t think that this is an either/or [situation],” he said.

While physician-practice ownership lost its majority in the past few years,⁵ the same surveys that show growth in hospital employment of physicians and hospital ownership of practices also show that the average practice size has not drastically scaled up because of mergers, acquisitions, and other ownership/structural changes.⁶

While many longtime industry observers might lament the decline in the solo-practitioner model, Nachomovitz says that this is not a bad trend for independent medical practices. “I don’t think it’s in the physician’s best interests to be in solo practice,” he said. “I think in order to participate in the new healthcare, physicians need to learn to aggregate, to network, and to optimize their own situation.”

To that end, large, integrated physician groups have seen success in recent years, largely as a result of a flagship group (often primary care–dominant) bringing contracting, data, and administrative benefits to a smaller practice. This model allows practices to remain flexible on compensation and embrace quality care programs that would otherwise be difficult or impossible to manage without more robust analytics platforms made possible through shared data and IT infrastructure.⁷

Transforming Contract Challenges Into Opportunities

Innovation, Collaboration, and Creative Problem-Solving Pave the Way

As changes in the healthcare industry drive a shift from volume-based to value-based payer and provider contracts, the way in which all payers work with providers is undergoing transformation as well.

Successfully navigating this transition means overcoming challenges large and small, from scrutinizing minute details buried deep in payer contracts, to sidestepping potential conflicts that can derail provider-payer relationships.

But these challenges can be transformed into opportunities when providers harness innovation, collaboration, and creative problem-solving. In a competitive, changing market, skillful contracting

can define revenue expectations, facilitate timely reimbursement, and prevent costly legal battles.

Just as importantly, creating effective contracts can help provider organizations define and understand their own market value. Through the contract process, providers can also harness and build negotiation skills.

“Providers may not realize how many aspects of payer contracts are negotiable,” says Siân Williams, payer contract manager for Oregon Anesthesia Group (OAG), an Oregon-based anesthesiologist group that contracts with every major insurance carrier. “Often, something that appears to be a problem can be an opportunity for negotiation.”

While the new healthcare landscape presents real challenges, providers can adapt and thrive by approaching contracts with an eye toward preventing conflict, optimizing partnerships, and building strong, resilient relationships.

Williams shares her point of view on these issues.





“Providers may not realize how many aspects of payer contracts are negotiable. Often, something that appears to be a problem can be an opportunity for negotiation.”

SIÂN WILLIAMS
PAYER CONTRACT MANAGER,
OREGON ANESTHESIA GROUP



CHALLENGE

An Increasingly Competitive, Cost-Conscious Healthcare Market

OPPORTUNITY

Partner with Payers to Maximize Market Value

Clinicians are increasingly incentivized to provide the highest-quality care at the lowest cost. As payers compete for large employers, providers must understand their own market value to create effective partnerships.

SW: One of the major trends I'm seeing is how involved employers have become in employee health. Large employers are demanding tailored health plans, setting up clinics for their employees, and competing with payers to manage healthcare costs, so we now have payer contracts for specific employer groups with their own set of requirements. This has driven a lot of

change and complexity around how payers organize and market their networks: payers are becoming more and more competitive in order to attract large-employer business. From a provider perspective, we think about what we can offer the plan to help them market to the employer.

Providers can work with payers to market to employers by demonstrating where providers help payers manage costs. Providers can also build cost-saving measures into contracts. These can include quality-assurance initiatives, shared-savings programs, and bundled services.



CHALLENGE

Complicated Contracts That Invite Conflict

OPPORTUNITY

Create Clearly Defined Contracts That Optimize Value

Contracts that fail to define key terms or include vital subsections can spark conflict. The most effective contracts foresee and prevent potential conflicts, and provide a framework for conflict resolution.

SW: Conflicts can arise over a number of components in a payer contract, and it's important to consider the smaller reimbursement components of the contract as well as the larger. For example, while anesthesia is our key reimbursement component, we may have carve-outs for subspecialty services that can impact revenue expectations. It's important to specify how reimbursement will be managed for each subsection of the contract to prevent future problems. For example, there might be conflict over reimbursement on a subset of CPT codes.

While these codes may not be a major reimbursement component of the contract, they can create conflict when they're not well-defined.

The management and timing of reimbursements can also be a source of conflict in contracts with payers. When a contract fails to define all of the reimbursement methodologies, billing procedures, and collection timelines, it can encourage disagreement.

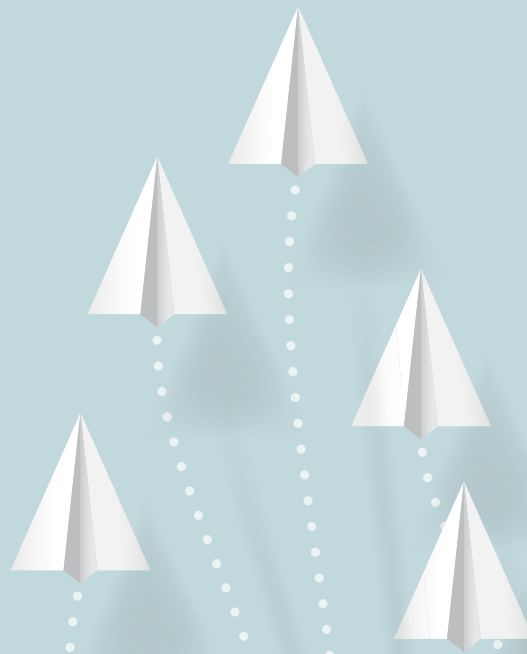
When contracting with a payer offering a high-deductible plan, providers can run into challenges with collections, so it's important to take those plans into account in the contracting process. One strategy is to consider the gap between the allowed amount and

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To BE or Not to BE (An Independent Practice) It's a Matter of DEGREE

Creative Alternatives
to Mergers And Acquisitions

By Martie Ross and David McMillan, PYA, P.C.



Consolidation has been a trend dominating healthcare over the past few years, and there is every indication that mergers and acquisitions will continue at an aggressive clip in 2019.

Last year, hospital deals grabbed headlines due to the sheer size of some of the transactions. For example, the merger of Dignity Health and Catholic Health Initiatives to form Common Spirit Health will create the nation's largest not-for-profit hospital system once the deal closes.


The news in 2019 also focused on newer buyers in the physician-practice marketplace. Hospitals have continued to expand their ranks of employed physicians, but private equity firms and payers are now even more in the market to acquire physician practices as well.

Independent physician practices are overwhelmed by increasingly complex regulatory requirements, continuing reductions in reimbursement, exclusion from provider networks, or the uncertainty associated with the transition to value-based payments. Many physicians tired of these challenges are intrigued by opportunities to sell their practices.

Physicians simply wanting to rid themselves of the business headaches of a private practice may seek some form of economic affiliation, which would relieve them of that burden. However, they should be mindful that it is possible to manage these challenges without ceding all control to a third party.

For example, physicians merely seeking access to value-based payment systems may participate in **clinical integration**, joining a clinically integrated network (CIN) while maintaining their economic independence. By signing the CIN's **participation agreement**, the physicians obligate themselves to adhere to evidence-based practices and to implement the performance-improvement initiatives outlined therein to enhance practice efficacy. The CIN may then pursue risk-based contracts on behalf of the participating physicians, absent the need to economically integrate the physicians into the system.

Nevertheless, hospital systems, payers, and other for-profit ventures remain in the market to purchase or economically align with physician practices in a continuing effort to gain control of patient populations. And physicians may still find some form of economic integration attractive.



When considering consolidation, physicians should strive to ensure that the resulting business structure allows the professionals to retain control of clinical processes.

There are various types of **economic integration** to consider when contemplating new business relationships, and they should only require integration to the degree necessary to achieve the physicians' goal, such as relief from some or all business concerns, access to fee-for-service contracts, or greater economic certainty.

When considering consolidation, physicians should strive to ensure that the resulting business structure allows the professionals to retain control of clinical processes. Doing so will maintain some degree of professional satisfaction and posture the practice to successfully compete in the emerging value-based reimbursement world.

At one end of the business structure spectrum is **economic independence**, in which the practice enjoys self-determination and clinical independence but is solely responsible for securing and managing all necessary resources. At the other end of the spectrum is **economic dependence**, in which a third party makes all decisions—be they business or clinical relationships—and enjoys the economic benefits of the arrangement, but also assumes the economic risk and responsibility for all necessary resources.

Increasing economic integration gradually alters the amount of professional autonomy of the practice's physicians. The degree of autonomy can and should be negotiated alongside the economic arrangement, to achieve a desirable balance of professional control and satisfaction within what is hopefully a more manageable business environment. Discerning and implementing this balance defines the art of designing these transactions.

The following describes different forms of **economic integration** other than the traditional employment model, including the advantages and disadvantages of each and the impact on the professional relationship among the physicians in the practice. Keep in mind that there are numerous variations on these generic arrangements, and each relationship must be fine-tuned to meet all parties' specific objectives.

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(To Be or Not to Be, continued from page 9)

BUSINESS STRUCTURE COMPARISON			
	Characteristics	Advantages	Disadvantages
Clinical Services Agreement	System reimburses practice a set fee for specific services (e.g., medical directorships, clinical co-management, call coverage)	Practice retains full autonomy for clinical and business operations	Practice does not receive any help with the business aspects of practice management
	Practice retains all business and clinical control	System obtains needed clinical expertise to supplement its operations	System does not receive any marketing advantage from its relationship with the practice
	System receives physician direction and control over clinical aspects of its business operations	System and practice are able to manage adherence to evidence-based clinical practices	System foregoes any economic gain from controlling patient referrals or a recognized relationship with a quality practice
	Practice receives supplemental income for services performed for the system (which may have been previously performed gratis as a requirement of staff membership)	Practice receives a predictable supplement to its revenue	
Global Payment Professional Services Agreement	System ¹ contracts with practice to provide professional services in exchange for global fee payment	Physicians are relieved of the worrisome aspects of billing and collections, and physicians' exposure to rate reductions may be minimized	Practice forgoes the economic advantages of a successful business year, rate increases, or other revenue enhancements (e.g., care management, shared savings)
	System reimburses practice for fixed and variable overhead costs	Physicians receive predictable revenue from professional services	Practice relinquishes full autonomy in business-practice decisions
	Parties may form a joint-management committee to supervise their overall relationship	Practice has access to business acumen and management expertise	
	Practice largely retains control over clinical staff and operations	Physicians retain control of clinical operations, the ability to maintain adherence to clinical protocol and evidence-based practices, and the professional-satisfaction aspects of practice	
Third-Party Management Company	Independent, for-profit company (may be supported by private equity) contracts to manage practice	Practice surrenders day-to-day business operations to management company	Practice relinquishes some degree of operational and professional-practice control to management company
	Management company provides a limited menu of "packaged" services, which can range from C-suite personnel placement to consultation	Physicians relieved of business matters can focus on clinical practice	Practice must monitor management company and compliance with contract
	Physicians retain control through oversight of management company	Physicians retain control of clinical practice and the ability to monitor adherence to evidence-based protocol	Management company usually brings minimal clinical-consulting expertise
		Practice retains brand and appearance of independence	Potential conflicts arise when business operations performed by management company conflict with physicians' clinical-practice styles
			Management company is not likely to infuse capital
Member-Owned Management Company	Company is owned by the providers it manages; otherwise, it is the same as a third-party management company	Physicians delegate business operations to a physician-run management committee, freeing remaining physicians to focus on clinical practice	Practice may find it challenging to find and retain business talent
	Multiple providers must commit to organize and operate management company	Physicians retain a greater degree of control than with an independent management company	Physicians must exert time and effort in overseeing the management company
		Member-owned company is more responsive to physician-members' needs	Physicians receive minimal help with system relationships
			Physicians receive minimal assistance with additional funding or contracting

¹ In this example, we refer to the entity with which the physician practice contracts as a "system." However, a practice may pursue a similar arrangement with a private equity firm or payer.

BUSINESS STRUCTURE COMPARISON, CONT.			
	Characteristics	Advantages	Disadvantages
Third-Party Owned Subscription Services	Unrelated for-profit or not-for-profit company offers contracted a-la-carte services for a set fee; otherwise, it shares member-owned subscription-service characteristics	Practices receive turnkey solutions	Practices answer to outside investors
	Relationships among subscription-services customers are few	Practices retain control	Practices must manage contract relationship with a third-party subscription company
	Operations often focus on “the latest thing”	Practices only purchase needed services	Services are often not “one-size-fits-all” solutions
	Services generally supplement, but do not supplant, practice operations	Practice receives a predictable supplement to its revenue	Practices receive minimal or no hands-on assistance
	Arrangements are generally short-term	Physicians experience minimal risk or time-drain from their professional practice	No relationship exists among members, and there is no provider network or joint-contracting opportunity
			Practices control their own adherence to evidence-based protocols
Member-Owned Subscription Services	Several member practices jointly own infrastructure to provide hub-and-spoke services, such as third-party billing companies, health-information technology, and data analytics	Physicians retain control of practice, and their independence	Management-member physicians compete for time for day jobs
	Member practices govern operations through a representative board comprised of member-physicians	Practices can purchase only those services needed, affording flexibility	Member practices must come to a consensus regarding expanding offerings and activities
	Professional management is accountable to the member board	Member practices determine the type and scope of offered services, based on identified needs	Member-owned subscribers are self-sustaining and have razor-thin margins
	Services are made available on an a-la-carte basis and are charged as a division of shared costs	Physicians can leverage business expertise to supplement independent practice capabilities in a non-threatening manner	A-la-carte services do not afford bargaining power
	Member practices use services as a cost-savings strategy, not as a profit center (unless services are marketed to non-member practices)	Management is delegated to employed executive staff	Membership is difficult to grow, given the risk of losing members to other forms of economic integration
		Physicians maintain adherence to evidence-based protocol within their individual practices, although a clinically integrated system can also be established among the participating practices	Arrangement results in more commiseration than collaboration
		No provider network or joint-contracting opportunities exist unless a clinically integrated system is established among the participating practices	
		No opportunity for capital infusion	

In pursuing value-based contracting, physicians should ultimately evaluate opportunities based on supporting infrastructure and on the strength of the clinical continuum of care.

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STILL KEEN ON CONSOLIDATING? THREE KEY DEAL POINTS TO CONSIDER IN NEGOTIATIONS

If, after careful consideration, you conclude that consolidation offers you the best opportunity going forward, the following key deal points, at minimum, should be carefully considered during your negotiations with a health system, payer, or private equity firm.

1. Autonomy. In our experience, the primary motivation for physicians selling their practices and pursuing employment is their desire to practice medicine without the burden of running a business. Handing over operational responsibility, however, always means losing some level of autonomy.

For example, staffing in private practice, both clinical and operational, may vary significantly based on individual physician preferences, long-standing employees, and specific community needs. The physician's new employer, however, may require different staffing in the practice because of greater efficiency expectations or other factors. Although these changes may directly impact how the physician practices, he or she may no longer be able to unilaterally direct staffing—even clinical staffing. Generally speaking, staffing decisions are made by the one responsible for the practice's financial performance.

In anticipation of negotiations with a potential buyer and/or employer, take stock of those operational matters over which you want to maintain some level of control, such as clinical staff, patient scheduling, and referrals for diagnostic

services. Be prepared to make your case for being part of the decision-making process. In striking a deal, strive to maintain a level of autonomy that ensures your professional satisfaction.

2. Compensation. Productivity-based arrangements continue to dominate the landscape, but payment adjustments based on specific performance metrics are becoming increasingly common. And more employers are considering straight-salary arrangements.

Be sure you have a complete and thorough understanding of the compensation formula before signing any employment agreement. For example, calculate future compensation based on past performance. Consider how circumstances beyond your control could negatively impact compensation (e.g., the health system's decision not to contract with a specific payer) and negotiate for safeguards to protect your interests.


If an employer proposes to tie some compensation to quality performance, ask questions (and demand answers!) regarding how the metrics are selected, how data is gathered and evaluated, and whether your patients' acuity levels are considered. Also, understand how often, and by what process, performance metrics are evaluated and recalibrated.

Carefully consider the benefits package offered by the employer, including insurance coverages, vacation and sick leave, and expense reimbursement.

Evaluate how the compensation package compares to the overall market. A valuation expert can provide the data and analysis needed for such comparison, thus strengthening your negotiating position.

3. Purchase price. You can significantly improve your negotiating position by securing the opinion of a valuation expert regarding the value of practice assets. Otherwise, your options will be limited to nit-picking the potential purchaser's valuation. As necessary, determine whether the purchaser will honor previously negotiated ownership buy-outs and retirement planning.

Determining fair market value, understanding the underlying approaches and application to your practice, and looking ahead to the impact of a future compensation structure—and its potential effect on the practice valuation—are all important economic principles that a buyer will consider. Physicians who take the time, and make the effort, to dig into this information before the transaction negotiations begin may save themselves, their partners, their employees, and their legal counsel significant heartache, frustration, time, and expense.

The circumstances of every deal are unique, but focusing on these three deal points—and making sure all questions are adequately answered prior to signing on the dotted line—significantly increases the likelihood that consolidation will be beneficial to all parties. 



Physicians and advanced clinicians spend years mastering their profession,

and dedicate their lives to using these skills to help others. But in their years of rigorous training, most will never take a course in negotiation, business law, or contract management.

When it comes to protecting their own interests during a merger, acquisition, or partnership agreement, providers benefit from outside guidance and support, says physician mentor and consultant Tom Davis, MD, FAAFP. Davis, a physician advocate who coaches practitioners through career transitions and practice mergers, offers the following guidelines to help physicians minimize unpleasant surprises during and after contract negotiations.

1. GET YOUR VALUE UP FRONT

“The most important guideline for the smaller practice is to seek the entire value of the acquisition up front. Often during these negotiations, the larger entity will offer a certain percentage of the acquisition’s total value up front, like 50 percent, and the rest of the value is said to come from joining the network. Those types of contracts tend to be less beneficial for the solo provider or the smaller practice. Even if the full value of the acquisition is

paid over several years or partly held in escrow and paid later, seeking as much value as possible up front protects the interests of the smaller practice.”


2. SEEK UNBIASED ADVICE

“In any consolidating industry, including healthcare, the larger entities have considerable influence over the legal resources in their region. This means that physicians or physician groups in contract negotiations with a large healthcare organization may have trouble finding unbiased legal representation in their area. This may cause them to settle for a lawyer without the expertise they need. The best tactic is to go outside your area and find a high-quality attorney who specializes in arbitration. The fact is, physicians are at a tremendous disadvantage in negotiations with an acquiring entity. Get somebody in your corner.”

3. MIND YOUR PSA

“As a physician, you’re bringing your skills and talent to any organization you join, which is factored into your contract in the personal-services agreement (PSA) that is usually part of any merger or acquisition. But you need to decide how long you want to commit to working for the organization, because you don’t know yet if it will be a good fit. Do you really want to commit to working for the organization for five to seven years, for example? Would you be willing to take less money up front in

exchange for a shorter PSA? Know the financial value of your time, and factor that into your negotiation. Make sure the non-compete agreement aligns with your goals: if you want to continue practicing in your local area, you may want to negotiate a shorter non-compete so that you’re not prevented from practicing locally if you decide to leave. But if you’re flexible on your location, you may be able to use a longer non-compete agreement as leverage.”

In conclusion, Davis recommends the DVD set *Negotiating Skills for Physicians*, produced by educational publisher SEAK Inc. “This should be mandatory for any physician entering contract negotiations,” he notes. “It provides a real-world view and demonstrates the subtleties that any skilled physician is smart enough to acquire, but may not have had the time to study. After viewing this set, physicians will have a better idea of the counsel they’ll need during the negotiation process. Because you don’t know what you don’t know.” 



Mentor, author, and speaker Tom Davis, MD, consults on contracting, practice mergers, care-system design and Medicare Advantage performance. Learn more about him at tomdavisconsulting.com.



CONTRACTING 101

Key Items to Consider When Negotiating Vendor Contracts

Reviewing vendor contracts can be a tedious and time-consuming process for healthcare provider organizations. Taking the time to decipher complex, small-print legalese in a contract can seem like a thankless job without much benefit. However, signing an unfavorable vendor contract can put a provider organization at significant risk of potential liability. Below are a few key terms in vendor contracts that should be reviewed before a signature is provided. Please note that this list does not include all of the important terms in a vendor contract, but it can be used as a starting point for contract review.

TERM AND TERMINATION

When reviewing a vendor contract, the first questions to ask are: (1) what is the term of the contract, and (2) how can it be terminated? Many contracts include terms that span multiple years and only allow a provider organization to terminate the contract upon the vendor's breach of the contract or prior to the renewal of a contract's term.

INDEMNIFICATION

Indemnification refers to the responsibility of a party to a contract (known as the "indemnifying party") to compensate the other contracted party for damages, including losses, attorneys' fees, and other costs, caused by the indemnifying party. For example, if a vendor causes a breach of a provider

organization's confidential information, a vendor contract should require the vendor to compensate the organization for any damages related to the breach. Indemnification provisions can be very complicated, so it is important to review them closely to ensure that they are broad enough to cover the most likely damages that the organization could sustain from the acts or omissions of the vendor. Especially in contracts between healthcare providers, great care should be taken to ascertain whether one of the contracting providers is obligated to pay damages and costs in situations involving alleged malpractice.

LIMITATION OF LIABILITY

A provider organization's negotiation of a strong indemnification provision means very little if the contract has an extensive "limitation of liability" clause that limits the potential liability of the vendor to the organization. For example, many vendors attempt to limit their total liability under a contract to the fees paid by the provider organization within the twelve-month period preceding the incident giving rise to the claim. Depending on the amount of fees payable under the contract, this type of language can pose significant risks to the organization if the vendor engages in conduct that causes the organization to incur damages.

WARRANTIES

A warranty is a guarantee that the

services performed by the vendor will meet certain conditions. Vendors commonly try to disclaim all warranties, but depending on the scope of services, provider organizations should push for the vendor to warrant that its services will be performed in accordance with certain standards, including that the vendor will perform the services: (1) in a "workmanlike manner," (2) in a manner consistent with industry standards and applicable law, and (3) in accordance with the terms of the contract and any documentation provided to the organization by the vendor. Additional warranties that are important in the context of information-technology services include warranties that the services will not infringe on the intellectual property rights of other third parties and that any software provided by the vendor will be free from viruses and other malware.

GOVERNING LAW AND VENUE

If the vendor fails to perform under the contract, the provider organization needs to have an efficient way to obtain relief from a court or an arbitrator. For example, in Washington State a provider organization should push for contractual language requiring the governing law and venue for any dispute to be Washington State. It is common for out-of-state vendors to propose their home state as the governing law and venue, but a provider organization's obligation to bring a claim in a venue located outside



CONTRACTING TERMS

Defining the Evolution of Healthcare

of Washington State can significantly increase litigation costs and time spent in the venue litigating the matter.

HIPAA

When reviewing a proposed contract with a vendor, it is critical that provider organizations understand the requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that “covered entities,” including certain healthcare providers, enter into a special type of contract known as a “Business Associate Agreement” if they engage a vendor to provide a service requiring the use or disclosure of protected health information, as defined in HIPAA. For example, a provider organization likely needs to enter into a Business Associate Agreement with a vendor who performs medical-billing services.

To reduce potential risks, Business Associate Agreements should be reviewed to ensure that they contain strong privacy and security obligations by the vendor. The Business Associate Agreement should include the ability for the provider organization to terminate the Business Associate Agreement upon the vendor’s breach of the Agreement, notification obligations on the vendor where there has been an incident involving a possible breach of security or privacy, and requirements for the return or destruction of healthcare information after the underlying contract terminates.

CONCLUSION

Reviewing vendor contracts is not anyone’s idea of a good time. However, taking a moment to read the contractual language and propose necessary modifications can help to reduce the risk of significant future liability for provider organizations. [PR](#)

Source

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Feel like you need to take “Business as a Second Language,” or some other crash course, to learn the language of contracting? Here are a few definitions to get you started.

Accountable Care Organizations (ACOs):

Groups of providers and hospitals who jointly provide coordinated care to Medicare beneficiaries.

Alternative Payment Models: Emerging reimbursement models, like bundled payments, designed to streamline revenue-cycle management as healthcare transitions to value-based care.

Bundled Payment: An alternative payment model in which a group of providers receives a single payment for one episode of coordinated care.

Clean Claim: A claim that is complete, legible, and accurate, according to the requirements of the Center for Medicare and Medicaid Services, and that requires no additional investigation or delay in reimbursement.

Credentialing: The process of verifying physicians’ professional records. The ACA has significantly increased credentialing requirements for physicians, which can impact payer reimbursements.

Management Services Organization

(MSO): A healthcare-specific organization created to perform administrative and management services that align with the delivery of coordinated care.

Non-compete Clause: A contractual agreement in which a provider agrees not to practice medicine in a certain geographic area for a specified period. Sometimes called “restrictive covenants.”

Professional Services Agreement (PSA):

A contractual agreement between a healthcare entity and a physician group or individual provider, in which a provider or provider group agrees to employment terms for a specified period.

Quality-assurance Plans: Programs or activities designed to assure quality improvement in a medical setting, including quality evaluations, problem assessment, improvement measures, and follow-up monitoring.

Shared-savings Programs: An alternative payment model developed to move Medicaid and Medicare payments to a system based on values and outcomes by promoting accountability, coordinated care, and investment in high-quality, efficient services.

Timely Filing Guideline: A payer’s time limit on claims submissions.

Value-based Contracting: A contract with a provider that ties physician compensation to cost-efficiency and/or quality-performance measures.

Volume-based Contracting: A payment system that compensates physicians for each service a patient needs.

Wraparound Services: Programs that help coordinate health services for children, families, or individuals with complex behavioral and mental-health needs.

Sources:

Centers for Medicare & Medicaid Services; US Department of Health & Human Services; Healthcare.gov; Healthcare Financial Management Association; United Healthcare; National Committee for Quality Assurance; PYA, P.C.; Washington State Health Care Authority.



STRONGER TOGETHER

Rural Hospitals Uniting for Success

Anyone traveling outside Washington State's major population centers knows that the region is as geographically diverse as they come.

From the lavender-scented San Juan islands in the west to the forested peaks and valleys flanking the Pend Oreille River on the east, the state's rural towns are as unique as their picturesque surroundings.

The small independent hospitals in these communities, staffed by caring local providers with a deep knowledge of the local culture, reflect the values of the regions they serve. It makes sense, then, that these rural hospitals would

want to maintain their independence, even as the changing healthcare environment brings new challenges for independent hospitals and clinics.

Fifteen years ago, eight of Washington's independent rural hospitals came together to address that challenge, asking: As rural providers become fewer and farther between, how can independent hospitals continue to serve their communities while also controlling risk, retaining staff, and improving outcomes?

The result was the Washington Rural Health Collaborative (WRHC), now comprised of 15 federally designated rural Critical Access Hospitals. Each member of the collaborative is a

separately governed entity serving rural areas in Washington state, from Jefferson Healthcare in Port Townsend to Goldendale's Klickitat Valley Health.

"Interdependence and independence are not contradictory," states WRHC Executive Director Holly Greenwood. "Interdependence helps our member hospitals remain independent while addressing some of the key challenges faced by rural hospitals."

MOVE FROM VOLUME TO VALUE INCREASES CONTRACTING COMPLEXITY

Chief among these challenges is contracting, something Greenwood says has become increasingly complex in the past five years. "Payer contracting is



more complex in today's environment," she says. "The move from volume- and encounter-based reimbursement to value-based reimbursement with an emphasis on quality and reducing costs has accelerated the complexity."

Additionally, she notes, today's focus on whole-person health means that providers and payers must contract with more trained staff who have increasingly diverse credentials, further ramping up contract complexity. "The focus on wellness in healthcare often requires hospitals to have additional trained staff like care coordinators, which is something you would not have seen five years ago," she says.

Recruiting and retaining these skilled providers is yet another challenge for rural hospitals. "There's been pressure for the rural hospital systems to fill non-traditional gaps like dental, behavioral health, and care coordination in rural communities," says Greenwood. "But with newer payment models, not only is it difficult to recruit skilled part-time staff, but there is often no payment mechanism to support these new roles."

These transitions can increase risks for providers unless key infrastructure investments are made—a burden that may weigh disproportionately on independent rural hospitals. It's no surprise that individual rural health systems struggle to recruit the talent, support, and infrastructure they need to thrive.

In this highly complex, constantly changing industry, Greenwood says, WRHC has supported physicians and hospitals in their transformation through collective action, leveraging of resources, sharing, and learning from one another.

One way WRHC has helped member hospitals is through collective "upside only" payer contracts that mitigate risk and control costs, with potential

"Interdependence and independence are not contradictory. Interdependence helps our member hospitals remain independent while addressing some of the key challenges faced by rural hospitals."

HOLLY GREENWOOD
EXECUTIVE DIRECTOR,
WASHINGTON RURAL
HEALTH COLLABORATIVE

for shared savings. Helping hospitals negotiate value-based payer contracts through Medicaid/Medicare and training providers to maximize reimbursement helps support recruitment, retention, and provider satisfaction. Shared staffing models and telemedicine programs help address the need for part-time providers and local care.


ADDRESSING ADMINISTRATIVE CHALLENGES

Along with front-line providers, hospital administrators are strained, and WRHC helps address managerial challenges like the ever-expanding need for more specialized technical skills. As electronic medical records gobble up data storage and create demand for analytics and coding expertise, WRHC is working to develop a centralized data warehouse and analytics team. Member hospitals also benefit from specialized grant-writing expertise; the WRHC pursues collective

grants through the Department of Health and Health Resources and Services Administration to help rural communities serve specific local needs and fill healthcare gaps.

Hospital leaders meet regularly to share best practices and report financial outcomes and quality measures. Sharing information with other small hospitals, sometimes across hundreds of miles, translates into healthier bottom lines for all. Last year, WRHC member hospital's direct savings increased by more than \$200,000, with an average ROI of \$8.21 for each dollar spent. Since tracking direct member savings began in 2014, WRHC has saved its members an estimated \$6.4 million.

Stronger and more financially sound, WRHC hospitals are better able to serve the needs of their communities, and are positioned to continue improving outcomes for years to come. "It's been a difficult journey for independent rural health systems, and physicians both employed and independent, to maximize value and to make the value base care transformation independently," notes Greenwood. But bridging the gap between independence and interdependence allows WRHC members to thrive, individually and collectively.

"Over the last five years, we have proven that we are better together," she says. "Our vision to support rural health systems in achieving service excellence through collaboration and innovation is at the heart of everything we do. If the sentence starts with 'all WRHC hospitals have a need,' then there's an opportunity to leverage WRHC's power." 



Holly Greenwood,
Executive Director,
Washington Rural
Health Collaborative



Medical Practice Management

A Way Out of the Conundrum

Doctors become
doctors because
they love medicine,
because they're called
to treat disease and
make people well.

And obviously,
doctors go to medical
school to learn how
to be doctors.

Yet many doctors—the ones who want an independent practice, anyway—end up being business owners too, running companies that generate hundreds of thousands of dollars, if not millions of dollars, a year.

But most doctors do this without any business training—and in some cases, without much interest in business at all.

So the very nature of an independent medical practice has always been a conundrum, even when such practices were more common and less complicated than they are today. Layer on increasingly complex regulations, technology, and payer negotiations, as well as growing competition from urgent-care and retail clinics, and you have a recipe for more doctors selling their practices simply so they can do what they do best—while working reasonable hours for a predictable paycheck. According to a 2018 *New York Times* article, big hospital groups employed 43 percent of the country's primary-care doctors in 2016, up from 23 percent in 2010.

There are still a lot of doctors who want the independence of their own practice, though. High-achievers like physicians tend to have an in-charge personality type, one that's often unsatisfied by working for someone else.

And there's research to suggest that it's in everyone's best interests for single doctor's offices and small-group practices to stick around. While you might think that economies of scale would lower overall costs when a large healthcare system buys out an independent practice, researchers at Northwestern University's Kellogg School of Management have found that prices for doctors' services have climbed while mergers and acquisitions in healthcare have increased. After all, as monopolies form, there's

less competition—and there are disparities in how Medicare pays out to independent doctors versus hospitals.

Besides selling out, there is another way out of the operational morass that often bogs down physicians and their

“Doctors have an extraordinary responsibility to their patients, and they’re seeing so many a day, they don’t have time for anything else. They have to be able to trust their administrators.”

JESSE ARNOLDSON
BUSINESS DEVELOPMENT
DIRECTOR, MEDMAN

administrators to the point of detracting from patient care and their own success and happiness: turning over the business side of a practice to practice-management experts.

ONE-STOP SHOP

In contrast to the rest of the consolidating healthcare sector these

days, the practice-management field is highly fragmented and includes a scattering of regional accounting firms, billing companies, and technology providers to which practices can outsource specific business functions.

Then there's MedMan, a Boise, Idaho-based company that provides comprehensive, ongoing practice management. MedMan helps physicians and their administrators respond to the evolving business of healthcare—including contracting, regulatory compliance, and mergers and acquisitions—and ensure their practices thrive. The 42-year-old company is, to its partners' knowledge, the only single-focused business of its kind.

“In terms of the business operations of a practice, there's nothing we don't get involved in,” says Randy Evaro, MedMan's president and CEO. “Physicians take care of patients, and we take care of the business,” he adds—from the front office to long-term strategic planning.

How does MedMan do it? Through a contract with an onsite, MedMan-employed manager and/or an array of consulting products. The company works with doctor-owned groups on insurance agreements, negotiations, governance, physician compensation, and customer service. It measures and plans for financial performance on metrics including reimbursement, revenue cycle, and expense management. It also helps doctors establish new private practices.

Mary Ferguson, CEO of Glens Ferry Health Center in Mountain Home, Idaho, says that since partnering with MedMan, “we have a more confident staff now. Before, it felt like we were feeling our way through the dark. Today, the staff feel empowered because they're equipped with the knowledge they need.

(Continued on page 20)



“We help them act out of their best interests instead of fear. And we provide them with resources and recommendations from experts who have no dog in the fight.”

RANDY EVARO
PRESIDENT AND CEO, MEDMAN



(Medical Practice Management, continued from page 19)

MedMan is not going to come in and do their work and leave, leaving you to go back to business as usual.”

Dr. Kristine Traustason, managing partner at Orion Eye in Bend, Oregon, sought out MedMan four years ago, at a critical time when her practice was facing challenges that compromised its future. “The clinic was going through, I have to say, one of its lowest points,” she recalls. “The practice had been open for about 20 years, and run as a mom-and-pop shop—and that worked for about 20 years. We ended up in a crisis situation. We had no idea what was going on financially with the practice. It was unsustainable, and we didn’t know if we could even keep our doors open.”

The physicians at Orion Eye reached out to MedMan and started to see

immediate results following their initial consultation. “Within a month, we were solvent,” Dr. Traustason says. “Within two months, we decided we wanted to make MedMan a permanent partner. It’s the single best decision I’ve made as a practice owner.”

MedMan currently manages 14 practices directly and does project work for another six. Some of its clients include Seasons Medical in Rexburg, Idaho; Valley OBGYN in Spokane Valley and Liberty Lake, Washington; Cabinet Peaks Family Medicine and Urgent Care in Libby, Montana; Campbell County Health in Gillette, Wyoming; and Krueger and Lenox Oral and Maxillofacial Surgery in Bend, Oregon.

HANDS-ON HELP

According to Jesse Arnoldson, MedMan’s business development director, there’s usually a triggering event that brings

practitioners to MedMan. It could be the loss of a manager, high staff turnover, the opening of a satellite office, an adverse regulatory action, or general financial instability. “Clinics usually come to us in crisis mode,” he says. “Then—it’s like peeling an onion—you find other issues.”

Human resources, he says, is the area where practices get tripped up the most. For example, he says, “There are people in place who shouldn’t be there. Job descriptions aren’t defined. Morale is low. There’s a vacuum of leadership.”

That’s where a MedMan-placed administrator can make a difference. “Doctors have an extraordinary responsibility to their patients, and they’re seeing so many a day, they don’t have time for anything else,” Arnoldson says. “They have to be able to trust their administrators.”

MedMan currently employs 18 people, including onsite administrators and home-office staff, and works with additional independent contractors. The administrators report to both the lead physician at the group and to MedMan. “The doctors like that we are monitoring their manager for them, comparing the performance to industry benchmarks, assessing the clinic every year and making an annual plan to address opportunities and execute an improvement cycle,” Evaro says. “The whole thing spirals upward.”

What’s more, MedMan administrators are backed up by MedMan’s experts in coding, accounting, compliance, and legal matters, whom they can tap whenever need be. The MedMan administrators at the various clinics also turn to each other for help and “vigorously share information, whether it’s a tech problem or a compliance issue,” Evaro says.

MedMan administrators stay with a practice for an average of seven years, though some stay for 10 or more. Because of this relationship longevity and the high level of accountability that results, the company doesn’t like to consider itself a consultancy.


FLOURISHING FUTURE

Sometimes, a practice will decide to permanently hire its MedMan administrator and “graduate” from the company. “For us, losing a client is natural growth,” Evaro says. “When you have such an active management agreement as ours, there’s a life cycle to it. Clients can stay with us, with a legacy-level contract, as a senior clinic, with a different level of support that still includes annual planning.”

Other times, a practitioner will decide to merge or be acquired, after all—and MedMan helps with that process too. Most practitioners only go through that

once in a lifetime, but MedMan has done it for clients over four decades and can provide experienced counsel.

Evaro likens MedMan’s merger-advisory role—in fittingly medical terms—to that of an objective therapist. “We help them think the decision through, pushing back when they’re acting out of stress or duress—or because a hospital is waving a big paycheck at them,” he says. “We help them act out of their best interests instead of fear. And we provide them with resources and recommendations from experts who have no dog in the fight.”

For those practitioners who stay with MedMan, having their business managed well takes concern out of the equation and enables them to remain independent while being part of the MedMan network of clinics. It’s less lonely being part of a robust group of groups that leverages the strength of that larger knowledge base. The company’s goal, Arnoldson says, is to continue to be a highly relevant partner to independent doctors, and improve their lives so they can come to work happier and focus on providing continuity and quality of care to more—and hopefully more satisfied—patients. 




Randy Evaro
President and CEO,
MedMan



Jesse Arnoldson,
Business Development
Director, MedMan

(To Be or Not to Be, continued from page 11)

This is certainly not an exhaustive list of possible economic arrangements that may provide relief for physician practices seeking help with the business aspects of the practice of medicine. But the options described do offer varying levels of economic integration and relief from the headaches of business concerns, while preserving physicians’ control over the professional aspects of their practice.

Health systems and other consolidators of physician practices may claim that economic integration is essential to achieving the clinical integration required to compete for value-based contracts. However, some of the most successful clinically integrated networks are comprised of independent physician practices. Also, numerous health systems have formed networks with local physicians without requiring any degree of economic integration with their practices. In pursuing value-based contracting, physicians should ultimately evaluate opportunities based on supporting infrastructure and on the strength of the clinical continuum of care. 

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For more information, please visit www.pyapc.com.



(Trends Shaping Business of Healthcare, continued from page 5)

COST, QUALITY, AND GOVERNMENT PROGRAMS

The push toward boosting quality of care and securing cost savings along the way has been a major driver for HDOs, especially as more private commercial payers have embraced quality incentive programs in the wake of governmental payer programs, such as the voluntary Medicare Shared Savings Program (MSSP).

When it comes to the shifts between physician and hospital ownership of practices, a 2018 study that compared changes in Medicare spending for patients in accountable care organizations (ACOs) before and after MSSP participation found that:

- Physician-led ACOs saved Medicare money incrementally
- Hospital-led ACOs did not produce savings for Medicare, on average
- Incentives to lower spending were stronger for physician-led practices⁸

This year marks the beginning of the third performance year of the Merit-based Incentive Payment System (MIPS) and the reporting period for year two (2018) performance data. To help MIPS and Alternative Payment Model (APM)-eligible clinicians participate this year and report data from last year, the Quality Payment Program (QPP) website has been updated with additional resources and improved searchability.

The Centers for Medicare and Medicaid Services (CMS) have also rolled out a new account-management system for QPP called “HARP”—HCQIS Access

Roles and Profile System. Previously, QPP participants would use their EIDM, (the acronym for CMS's Enterprise Identity Management system) accounts to access the system to report MIPS data, check eligibility, and review scores. Users with an existing EIDM account should already have a HARP account created automatically on their behalf.

MSSP and ACOs

In December, CMS published a final rule that redesigns MSSP, including an accelerated pace for participating ACOs to take on additional financial risk.

The redesign, called “Pathways to Success,” will generally take effect on July 1, 2019, and offers two participation tracks:

1. A basic track with a glide path for ACOs to progressively move from a shared savings-only model to higher degrees of risk and potential reward
2. An enhanced track for the highest levels of risk and potential reward

While the new flexibilities introduced for ACOs are welcome news, CMS did not incorporate suggestions to allow ACOs to remain in shared savings-only models indefinitely.

COMPENSATION TRENDS

How providers are paid remains one of the biggest levers in healthcare today, influenced by M&A activity, physician shortages, and the growth of recruiting efforts and hospital employment of physicians.

To better understand the compensation landscape, MGMA's 2018 Physician Compensation and Production Report—based on 2017 data from 136,000 providers across the country—yields some anomalies that stand out:

- **Location.** Practicing in a big city doesn't always bring the biggest salary. For example, the median income for a metro-area anesthesiologist was \$444,846, whereas in non-metro areas (comprising populations of 50,000 or fewer) the median anesthesiologist income was \$469,057.⁹ While this trend was true for most specialties, there are anomalies within the anomaly—rural cardiologists, for example, make about 10 percent less than their urban counterparts.¹⁰
- **Slow shift to quality.** For years, healthcare leaders have thought value-based care and quality incentives would become dominant forces influencing physician compensation. While that day may come, about four out of five compensation plans in 2017 did not include quality incentives, while productivity remained the core metric for pay.¹¹ The inclusion of quality incentives in compensation plans depended on practice size: independent and smaller practices were much less likely to provide any kind of quality incentives.¹² An October 2018 MGMA Stat poll with 1,195 responses found that, of organizations participating in value-based payer contracts, two out of three report that value-based contracts make up 20 percent or less of their overall contracts.¹³

“Physician-centricity and patient-centricity today can be enormously leverageable, if you are smart about how you use [technology and care coordination].”

MICHAEL NACHOMOVITZ, MD



• **Productivity and Relative Value Units.**

Physicians are paid about \$42 on average per RVU performed.¹⁴ One might reason that a physician who performs 3,000 RVUs in a year should make about \$126,000.

But consider a new physician working with a guarantee of \$200,000 per year. As that physician begins work, he or she might complete only 1,000 RVUs during the year, netting an average of about \$200 per RVU. That same physician, now completing 10,000 RVUs a year after becoming more productive, might earn closer to \$37 per RVU—below the average.¹⁵


CONCLUSION

In an industry with broad changes in ownership structures and demands to bend the cost curve, compensation—specifically salary figures—can influence a range of behaviors, from the medical schools students choose to a practice leader’s ability to successfully recruit.

At the same time, legislative efforts to push HDOs to provide transparency around the patient’s price for care may still have unknown effects, though the

gradual increase in hospital employment of physicians will mean that the independent-practice space will be largely motivated to engage in similar efforts based on patient consumerism rather than governmental mandates.

The core of the healthcare experience remains the relationship between patient and provider, pushed and pulled by these numerous forces. The focus in the immediate future on nurturing that bond, for physicians and physician-practice leaders, is something Nachomovitz refers to as medical professionalism:

“The doctors are getting together and understanding that the patients are the primary concern. And if they can deliver quality, this is going to get everybody’s attention. If they can deliver quality at a lower cost, that’s going to get even more attention. The leverage of having engaged physicians is enormous. Physician-centricity and patient-centricity today can be enormously leverageable, if you are smart about how you use [technology and care coordination].” 

By Chris Harrop, senior editorial manager, Medical Group Management Association

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Give Your Medical Practice a Check-Up

Tactical and Strategic Approaches to Assessing a Business's Wellbeing

By Chris Harrop, senior editorial manager, Medical Group Management Association

Just as population health requires a patient-centered focus and a wealth

of data to analyze and use to transform the wellbeing of our communities, the wellbeing of a healthcare organization requires similar insights.

Practices produce and capture volumes of practical data. Knowing which data to select and use, however, has proven tricky for some practice leaders. The answer lies in benchmarking, the art of comparing your processes and metrics to industry standards.

Data-savvy practice administrators apprise physician stakeholders of how things are going, by:

- Determining what metrics are critical to the practice's success

- Gathering internal data from an EHR, as well as from practice-management and accounting systems
- Identifying a source for external benchmarking data
- Determining the practice's metrics and comparing them to external benchmarking data¹

Some of the most popular benchmarks that medical practices have tracked include:

- Operating cost per procedure or visit
- Support staff per full-time-equivalent (FTE) physician
- Visits per FTE physician
- Payer mix percentages
- Days in accounts receivable (A/R)
- Visits per day²

Given the importance of financial security to a business's long-term operations, practice leaders should pay special attention to key performance

indicators (KPIs) that explain revenue cycle, cost-efficiency, and the proverbial "bottom line." Medical Group Management Association (MGMA) data suggest that, despite variances based on physician or hospital ownership, the following KPIs are most reflective of the financial health of your practice:³

1. Practice profitability and staffing
 - a. Total medical revenue per FTE physician
 - b. Total operating cost per FTE physician
 - c. Total medical revenue after operating cost
 - d. Total physician compensation and benefit cost per FTE physician
 - e. Total operating cost



2. Revenue cycle
 - a. Total A/R per FTE physician
 - b. A/R over 120 days
 - c. Days of gross charges
 - d. Adjusted fee-for-service collection percentage

The size, specialty, ownership, and governance structure of a practice will dictate how often you want to review these metrics, which should help inform the degree to which your practice invests in the platforms or integrations with an existing EHR to extract the pertinent data for analysis and benchmarking.

Of course, having a handle on the money side is only one component of a multivariate formula that spells success or failure. The recent *MGMA Winning Strategies* from Top Medical Groups report identifies three key differentiators for high-performing practices that lead MGMA benchmarking categories:

- **Engaging, patient-focused cultures:** Better-performing practices are much more likely to conduct staff, provider and patient-satisfaction surveys and share results transparently throughout the organization. Staff are empowered to identify opportunities for improvement and form action plans.
- **Long-term, strategic focus:** Better-performing practices have an established vision and goals that help them prioritize their efforts and resources. Strategies are revisited to adjust tactics as needed. Performance monitoring and analytics enables those reviews at regular intervals.
- **Operational innovation:** Better-performing practices maximize the tools and information currently available, then take a systematic approach to investments in new resources. One of the biggest considerations is technology, as it is a tool to streamline operations

and improve key areas such as communication, patient engagement and compliance—all of which can be monitored for return on investment.⁴

SUCCESSION PLANNING

As physician stakeholders age into retirement or choose to exit the organization, having a succession plan in place is essential to prevent disruption to the business. This is especially true for geographic areas and specialties that are difficult to recruit for amid physician shortages, not to mention the inherent costs of severance packages and onboarding new physicians.

A 2018 survey of MGMA members found that 58 percent of practices lack a succession plan and 71 percent do not feel adequately prepared for an abrupt departure of a key team member.⁵

At the top of an organization, there are two key roles that necessitate a short-term and/or long-term succession plan:

1. A manager or executive board

member: Replacement from within or from among external candidates is required, though promoting from within is preferable, given less time needed for onboarding and learning the organizational culture.

2. A clinical provider: Replacement for a non-shareholder provider or nonphysician provider requires an external search. Practices should build connections with local schools and hospitals to boost networking among new graduates prior to a search. If hiring a clinician, the board should seek out candidates with the potential to become an executive clinical leader.⁶

Other steps that can facilitate a transition include:⁷


1. **Encouraging a positive work culture that might slow a doctor's retirement plans.**

2. Maintaining a database of providers who can be reached out to when an opening occurs.

3. If possible, having a new provider shadow a retiring physician.

4. Expecting all of this to take time.

Even with the right person for the job, it can take a year to fully transition to a new provider, including marketing that provider to your current patients.

As with many administrative aspects of managing a medical practice, the particulars of the processes and policies a given organization follows for benchmarking, long-term strategy, and succession planning should be well documented. Practice leaders should establish clear expectations for how often these topics should be considered, as well as short- and long-term goals to enable physician and administrative leaders to devote the proper resources—time, talent, and otherwise—to achieving the desired outcomes. 

Sources

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² Ibid.

³ Gans, D. "Flooded by Data While Thirsting for Information." MGMA Connection. January 2018. Available from: <https://www.mgma.com/resources/health-information-technology/flooded-by-data-while-thirsting-for-information>.

⁴ MGMA. "New MGMA Data Identifies Most Critical Business Strategies of Top Performing Medical Practices." September 28, 2018. Available from: <https://www.mgma.com/news-insights/press-releases/new-mgma-data-identifies-most-critical-business-strategies-of-top-performing-medical-practices>.

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Good Growth

Washington Gastroenterology Fuses Together Ideals from Multiple Practices for the Greater Good

No one can say the healthcare industry is dull and static these days. Quite the opposite—change is a constant on nearly every level.



While some private-practice physicians find keeping things as close to the status quo as possible works best for them, a growing number are shaking up their organizations by joining forces with hospitals or other private practices. There's strength in size, to be sure, and growth is undoubtedly exciting; but with it comes uncertainty, discomfort, risks, and complications.

With an acquisition by a larger group or hospital system, the transition, while full of challenges, is more straightforward, usually dictated by the buyer.

When Western Washington-based Washington Gastroenterology was formed from four independent practices in January 2018, it didn't have that problem. That's because it had done this before. In fact, one might be pressed to find a more veteran practice when



it comes to blending with others to create a bigger, better organization. Skipping over many of the usual problems attendant upon growth, the organization fused together the practice ideals of each of its practices for the greater good.

PRACTICE MAKES PERFECT

Dr. Ralph Katsman, who has been practicing gastroenterology in Tacoma since 1993, is Washington Gastroenterology's president. Like all of the 41 board-certified gastroenterologists at Washington Gastroenterology, Dr. Katsman, during his medical school at University of

Washington and residency and specialty training at University of Minnesota, was drawn to gastroenterology by the people he encountered in that field.

"The professors and doctors who mentored me, the ones I respected the most, were in gastro," he says. "I was also attracted to the wide variety of practice that gastro entails."

Dr. Katsman has the unique experience of having worked for his whole career at one practice that has successively evolved into new ones over the years. His group has been in a state of consolidation, integration, and growth ever since he came aboard.

When Digestive Health Specialists converged with Olympia's Gastroenterology Associates and Northwest Gastroenterology Associates and Overlake Internal Medicine Associates—Gastroenterology in the Bellevue/Eastside area in 2018, the number of its doctors doubled, making the newly named Washington Gastroenterology the largest gastroenterology practice in the state of Washington, with 20 locations from Edmonds to Olympia.

The four groups had started talks in 2015 about how to collaborate and came to the decision to unite their operations into a single unified practice in order to meet the ambitious goals they all shared: utilizing state-of-the-art equipment, conducting pioneering clinical research, and providing an unparalleled range of clinical and management expertise. "To compete with hospital systems and provide the care we wanted to provide, we knew this was the way to go," Dr. Katsman says. And yet, the organization remains an independent, physician-owned and -governed practice, focused solely on its primary mission: doing what is best for patients and their digestive health.

(Continued on page 30)

"Our main goal is to remain a strong, independent presence in the Pacific Northwest, providing lower-cost, higher-quality care and continuing to expand our geographic reach and availability to patients."

DR. RALPH KATSMAN
PRESIDENT,
WASHINGTON
GASTROENTEROLOGY



The Third Path

Woodcreek Pediatrics by Mary Bridge Children's

A Unique Hybrid Model of Independence and Partnership

In today's healthcare environment, many small independently owned medical clinics are at a crossroads, facing a choice between two vastly different business models. Choose one route, and they'll maintain independence amid mounting risk, shrinking margins, and increasingly complex payer contracts. Choose another, and they'll join a large health network, buffering risk and boosting compensation while losing their founders' institutional knowledge and local roots.

But last year, Woodcreek Healthcare found a third path—one that enabled it to address the needs of its practitioners, owners, administrators, and patients. Founded in 1979 in the rolling hills of the Puget Sound, Woodcreek grew over time to three clinics and two urgent-care locations in and around Puyallup, Washington. As Woodcreek Healthcare incorporated urgent care, behavioral health, asthma care, and allergy care, local demand for its services grew.

In addition, a shift to value-based provider contracts meant that administrators had to sync performance metrics across increasingly diverse payer standards. Providers faced burgeoning patient panels and stagnant compensation, while the practice's owners absorbed ever-growing financial risk.

The solution was a new type of partnership, formed when Woodcreek Healthcare joined Mary Bridge Children's Hospital and Health Network on January 1, 2018. Now called Woodcreek Pediatrics by Mary Bridge Children's, the clinic's nearly 40 providers became employees of Mary Bridge and the MultiCare Health System, nearly doubling the number of general pediatric providers in the network.

The critical employees supporting front-line providers opted to remain independent, forming management-services organization Woodcreek Provider Services LLC. The MSO now employs Woodcreek Pediatrics' nearly 130 clinical and administrative support staff and operates under a contract with MultiCare.

This unique hybrid model pairs independence and partnership, effectively capturing the benefits of both, says Woodcreek Provider Services CEO James Hudson. "For providers, joining a larger organization means they can benefit from economies of scale and secure better contracts," he says. "The day-to-day work of our providers has not changed, but they're being better compensated for what they do."

A SEAMLESS TRANSITION

The transition has been similarly seamless from the administrative side,

Hudson says. Aside from adjusting the clinic's fee structure to match that of Mary Bridge, the administrative work hasn't changed. In fact, patients might not even be aware that their longtime Woodcreek physician is now employed by one of the region's largest health systems.

Hudson notes, though, that even if patients don't notice a change, they still benefit from the partnership. "For one thing, we're now able to accept a larger array of insurance products than before," he says. "Our services are now covered by a robust MultiCare network."

Woodcreek's partnership with Mary Bridge Hospital was a win for the practice's owners, practitioners, support staff, and patients, says Hudson. "Owners face incredible entrepreneurial risk as margins get smaller and smaller. Joining a larger organization is a natural safe harbor for owners to steer into, and that's what we're seeing in the market. As a business manager, I know we're now providing better and more coordinated care with a stronger bottom line." 



James Hudson, CEO,
Woodcreek Provider
Services




(Transforming Contract Challenges, continued from page 7)

the collected amount, and use that data to evaluate contract value and push for higher reimbursement, because your patient accounts receivable will be higher.

Paying attention to billing timelines and the timing for appeals in contract language is key to revenue-cycle management and billing management. Knowing your state rules and regulations on billing timelines is helpful, and providers should negotiate timely filing guidelines to ensure that contract language doesn't default to a national policy that may not work for the provider. It's also important for providers to work with billing to ensure that they can meet the deadlines specified in the contracts.

Effective multi-year agreements spell out every aspect of a contract, from policy implementation to the claims-resolution and appeal process. When conflicts occur, and the provider has made every attempt to resolve the issue, there is also the threat of formal complaint. When providers have been reasonable, often the threat of formal complaint will motivate a payer to resolve the disagreement.

Going into discussions with a payer, it's important for providers to know their own value proposition and be able to articulate how their participation adds value to the payer's network. It's also vital for providers to know their own market value; knowing the "reimbursement floor" can help providers hold their ground during difficult negotiations. 



CHALLENGE

Policy Provision Roadblocks

OPPORTUNITY


Form Robust Relationships That Encourage Collaboration

Approaching potential problems with creativity and collaboration can help providers craft solutions to new challenges. Strong ongoing relationships between providers and payers allow physicians to continue working productively for the patients in their care.

SW: Bundled services can offer a nice solution to potential contract challenges. For example, the ACA has coverage provisions for preventative services like colonoscopy screenings. These services are now covered, but payers can have policies that limit aspects of that coverage. As a solution, providers can build a bundle with the facility that bypasses the policy. The payer gets one bill for everything, instead of separate bills for labs, radiology, anesthesia, and surgery.

Another opportunity is credentialing. We approach credentialing by partnering our credentialing and

contracting efforts. When credentialing goes awry, the process is not timely, it's punitive for patients, and the provider's AR grows. It's important to keep patients' interests in mind during these discussions with payers; timely credentialing is in the payer's and provider's mutual best interests.

Developing and maintaining strong relationships with payers is key. The success of contract management depends on good long-term relationships, which also help with any conflict resolution. If we have a good relationship, everything goes more smoothly. 



Sián Williams, payer contract manager, Oregon Anesthesia Group

2019 PHYSICIANS INSURANCE

Annual Meeting
and Proxy Vote



The annual meeting of the members of Physicians Insurance A Mutual Company will be held on Monday, April 29, 2019, at 1 p.m. Pacific Time at 1301 Second Avenue, Suite 2700, Seattle, Washington. The purposes of this meeting are to elect directors, to amend the bylaws, and to act on any other matter coming before the meeting. Additional information on the vote will be provided on the company's website beginning March 20, 2019.

Visit our website, www.phyins.com/proxy2019, to download your proxy and place your vote by close of business, Thursday, April 25.

“You have to decide if you’re the kind of practice that is capable of change.”

DR. RALPH KATSMAN
PRESIDENT,
WASHINGTON
GASTROENTEROLOGY



(Washington Gastroenterology, continued from page 27)

“Everything we had done prior was on a much smaller scale, but it laid the groundwork for what was to come,” Dr. Katsman says. “We learned that this kind of undertaking is very difficult, and it takes a lot of work,” he adds—which meant that his group knew what they getting into. The most important thing, he’s learned, is that “group members have to be aligned on goals and share the understanding that everything is for the good of the group and the patient base, which means altering practice patterns to achieve efficiencies and increase quality of care. You have to decide if you’re the kind of practice that is capable of change.”

GROWING PAINS

Practices should determine why they want to merge in the first place—and the reasons should be strategic, both financially (in terms of cost savings and higher revenue) and operationally (in terms of efficiency and increased service breadth and reach). The next step is formulating a plan to make those reasons a reality.

Taking care of the business is crucial, and so is taking care of the people—because they’re the lifeblood that will make the new organization thrive.

“Culture is extremely important to bringing people together,” Dr. Katsman says. “Smaller groups are more independent, and it’s harder for them to adapt—but they have to. Likewise, larger groups have to pay attention to the smaller practices joining them and incorporate their ways into the new organization too. You have to create schedules and systems and a work environment that takes everyone into account. We have lots of discussions to arrive at a consensus on everything from deciding on a medical-record system to the role of each leader.”

The practice’s competitors are hospital systems and multi-specialty networks, but, as Dr. Katsman says, “Our advantage is that our outpatient procedures are less costly.” Washington Gastroenterology is also expanding into bariatric work and

FAST FACTS


PHYSICIANS: 41

TOTAL STAFF: 500

SERVICE AREA: Bellevue, Issaquah, Covington, Auburn, Federal Way, Puyallup, Gig Harbor, Tacoma, Olympia

FOUNDED: January 2018

doing more with its management of liver disease—a growing problem with recent increases in hepatitis C and obesity.

“Our main goal is to remain a strong, independent presence in the Pacific Northwest, providing lower-cost, higher-quality care and continuing to expand our geographic reach and availability to patients,” Dr. Katsman says. “There are many small, independent practices with one to three physicians that are interested in our leadership and what we can do to help them.” 

ONLINE CME

CMS Training: Coordination of Benefits

This course explains how the coordination of benefits works when people have Medicare and certain other types of health coverage. Module 5, Coordination of Benefits, explains rules that govern payers' responsibilities when people have Medicare and certain other types of health and/or prescription-drug coverage. This module was developed and approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the federally facilitated Health Insurance Marketplace. This course is designed for trainers and other information-givers who are familiar with the Medicare program. It can be easily adapted for presentations to groups of beneficiaries.

Learning objectives:

- Explain health and drug-coverage coordination.
- Determine who pays first.
- Identify where to get more information.

www.phyins.com/coordination

Advanced Quality Improvement for Leadership

All health centers funded by the Health Resources and Services Administration (HRSA) must have in place a system to improve patient care and outcomes, which is your center's quality improvement (QI) program. Although most health centers have established some QI functions, this course will enable you to take a comprehensive approach to implementing QI systems. You will learn about the essentials of QI infrastructure, systems, and programs, along with how to identify quality-related problems using proactive strategies, such as peer-review and patient-satisfaction surveys, as well as reactive strategies, such as patient-complaint tracking systems. Also included is how to put the FOCUS-PDSA model into action.

www.phyins.com/qualityimprovement

Payer Perspective: Adherence for Clinicians

With healthcare policies shifting from fee-for-service to performance-based payment models that hold providers accountable for poor outcomes, a better understanding of factors that contribute to non-adherence is needed, along with effective strategies for improvement. This course covers the wide array of contributing forces behind non-adherence, along with evidence-based interventions for optimizing outcomes. You will also learn how to apply interventions best suited to individual patients, based on their needs and risks related to adherence.

Learning Objectives:

- Differentiate between intentional and unintentional non-adherence.
- Describe factors that influence therapeutic non-adherence.
- Select appropriate interventions based on factors that influence non-adherence.

www.phyins.com/payerperspective



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GOVERNMENT RELATIONS UPDATE

John F. Kennedy once said, "There are risks and costs to action. But they are far less than the long-range risks of comfortable inaction."



Physicians Insurance understands that 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 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 on legislative and regulatory initiatives that impact healthcare liability, insurance, and patient safety, nationally and in states where we do business.

We provide advocacy to address challenges to the healthcare liability system that may (1) create new causes of action against healthcare professionals and providers, (2) alter the standard of care for healthcare professionals and providers, (3) establish strict liability for healthcare professionals and providers providing or not providing care, and (4) impose onerous or unnecessary duties on healthcare professionals and providers. We support comprehensive effective legislation that enhances the healthcare-liability system, promotes meaningful patient-safety initiatives, improves healthcare quality, and supports communications between healthcare professionals, providers, and patients. We have created a distinct market-differentiating value, as we are the only medical-professional liability carrier based in the Northwest with an in-house lobbyist registered in Washington and Oregon.

FEDERAL EFFORTS: THE NEW CONGRESS

Nationally, we continue to support and work with the MPL Association (formerly the PIAA) and its renewed effort to promote national legislation to improve patient access to healthcare services and provide improved medical care by reducing the excessive burden the liability system places on the healthcare delivery system. Our in-house lobbyist, Anne Bryant, currently serves as the Chair of the MPL Association's Government Relations Committee.

In 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—with a vote of 218-210. The House has passed similar legislation in previous years; the barrier to adoption has been in the Senate. Unlike the previous legislation, H.R. 1215 was limited to claims involving expenditures of federal dollars. In the next Congress, we will continue to promote comprehensive effective legislation that improves the liability system and promotes meaningful patient-safety initiatives similar to California's Medical Injury Compensation Reform Act across all claims. In addition, we will continue to protect the provision that no new standard of care for medical-liability claims is created by the Affordable Care Act.

We will promote passage of the Good Samaritan Health Professionals Act and support Crisis Standard of Care legislation that provides liability protection for healthcare professionals and facilities providing uncompensated services to victims of federally declared disasters, including working with plaintiff trial lawyers to limit protection to states in which a given disaster has occurred. We will continue to promote the framework for legislation that addresses telemedicine liability concerns as telemedicine services expand.

WASHINGTON: A BIPARTISAN APPROACH

In Washington State, we will take a bipartisan approach to defeat any renewed effort to expand liability in wrongful-death and survival claims to include a new class of beneficiaries. We will also work to defeat any renewed effort to expand economic damages by inflating medical expenses in personal-injury medical claims. In addition, we will continue to work to defeat the introduction of exemplary damages, otherwise known as punitive damages, in Washington. We continue to support shared decision-making proposals that do not have the unintended consequences of altering informed-consent requirements. We will support legislation that preserves liability protection for emergency volunteer practitioners. We will also continue to support the pilot program passed in 2018 that provides for reimbursement of telemedicine services as in-person services for certain conditions. We will promote the continuance of confidentiality protections for the Office of the Insurance Commissioner's data reporting related to closed medical-malpractice claims. We will continue to work with the legislature to promote a legislative solution regarding the Washington State Supreme Court decision *Volk v. DeMeerleer*, 386 P.3d 254 (Wash. 2016), which broadens a healthcare provider's duty to protect and

warn in the outpatient context, and any other proposals for the 2019 session that impact our members and their patients.

Physicians Insurance works closely with our allies, including the Washington State Medical Association, the Washington State Hospital Association and the Washington Liability Reform Coalition. We offer to partner with Governor Inslee's Health Care Advisor to implement the Governor's Healthier Washington initiative to transform healthcare delivery by promoting community health, improving quality of care, lowering healthcare costs and empowering patients.

OREGON: A BIPARTISAN APPROACH

In Oregon, we will take a bipartisan approach to defeat any renewed effort to increase the \$500,000 cap on non-economic damages recoverable in wrongful-death actions. We will also continue to promote a reasonable and fair cap on non-economic damages recoverable in personal injury actions. In addition, we will work with our partnerships to continue to defeat legislative proposals that add insurance to the Unlawful Trade Practices Act, and any proposals that expand the types of lawsuits that are brought against insurance companies. We will promote legislation that addresses effective components of California's Medical Injury Compensation Reform Act to enhance and improve the healthcare-liability system and promote communication between healthcare professionals, providers, and patients. We will also work to support phantom-damage legislation that provides language to limit personal-injury damages to amounts billed by healthcare professionals and providers versus those charged by healthcare professionals and providers, and any other proposals for the 2019 session that impact our members and their patients.

(Continued on page 35)



SPORTS-MEDICINE LIABILITY BILL PASSES CONGRESS

MPL Association Negotiates Protections for Insurers

The Sports Medicine Licensure Clarity Act passed Congress as part of the FAA Reauthorization Act of 2018 (H.R. 302). This bill clarifies that sports-medicine physicians, athletic trainers, and other medical professionals have medical-professional liability coverage while traveling across state lines with an athlete or athletic team. The bill ensures that sports-medicine professionals who provide onsite medical treatment will be covered by their MPL insurer, as long as they notify the organization in advance of engaging in sports-medicine care. This stipulation was negotiated into the bill by the MPL Association and gives MPL insurers an opportunity to adjust sports-medicine professionals' premium, add any necessary riders, or decline to cover the professional for the related activity. The bill also stipulates that sports-medicine professionals' medical licenses will be deemed valid in other states when they travel with their teams, but subjects that provision to any other existing state compact, agreement, or licensing exemption. The bill was signed by the president and became law on October 5, 2018.

Physicians Insurance supported the MPL Association as they played a major role in paving the path for the bill's approval, while protecting the interests of its members.

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 healthcare 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.



FAILURE TO IDENTIFY APPENDICITIS ON CT

SPECIALTY: Radiology

ALLEGATION: The plaintiffs claimed that the radiologist failed to identify appendicitis on a CT scan performed on January 2, 2012, resulting in pain, suffering, a large scar, and the need for an open appendectomy via midline laparotomy once acute appendicitis was subsequently diagnosed on April 12, 2012. While the appendix had not ruptured at the time the appendectomy was performed, the plaintiff claimed the open procedure was necessary due to a festering infection, and that a laparoscopic procedure could have been performed with an earlier diagnosis.

The defendant radiologist convincingly testified that her interpretation of the CT complied with the standard of care, stating her belief that the appendix was obscured on the study and that what turned out to be the appendix, she initially believed to be an inflamed loop of bowel.

Defense expert Dr. Bax testified that the sole basis for performance of the open appendectomy was an abnormal location of the appendix, high up in the abdomen near the liver. Any delay in diagnosis or concern about a festering infection had no causal relation to the surgical approach.

Efforts to settle the case prior to trial were unsuccessful.

PLAINTIFF ATTORNEY: Matthew Renda, Kennewick, WA

PLAINTIFF EXPERTS: Timothy Larson, MD, Radiology, Seattle, WA; Jedediah Kaufman, MD, General Surgery, Edmonds, WA

DEFENSE ATTORNEYS: Steve Lamberson and Jeff Galloway, Spokane, WA

DEFENSE EXPERT: Timothy Bax, MD, General Surgery, Spokane, WA

RESULT: Defense Verdict, Grant County

FAILURE TO DIAGNOSE ESOPHAGEAL PERFORATION

SPECIALTY: Orthopedic Surgery

ALLEGATION: The patient was 37 years old when she sustained a neck injury in a motor-vehicle accident. Following unsuccessful attempts at conservative pain management, she underwent a two-level anterior cervical discectomy and fusion of C5-C7, performed by the defendant orthopedic surgeon on May 8, 2014. The procedure was without event, and she had a normal postoperative course and reported immediate relief from her neck and upper-extremity symptoms.

On September 3, 2014, the patient called the defendant's office and reported trouble with swallowing, regurgitation of food, and a sore throat at the incision site. The message was relayed to the defendant surgeon, who asked his medical assistant to instruct the patient to use salt-water gargles, avoid irritating foods, chew carefully, and schedule an appointment with him if her symptoms did not resolve in two weeks.

The patient traveled to Arizona for a softball tournament, and while she was there her symptoms worsened. On October 12, 2014, she went to the ER in Arizona with complaints of neck pain, swelling, and general malaise. A CT confirmed an abscess behind her esophagus from C5-C7. The patient underwent surgery to explore and drain the abscess, remove the hardware in her neck, and repair a small tear in her esophagus.

The patient subsequently developed a Zenker's diverticulum, further delaying her recovery.

By the time of trial, the plaintiff's claims were narrowed to inappropriately managing the September 3, 2014, phone call.

WELCOME TO OUR NEW MEMBERS!

MEDICAL-PROFESSIONAL LIABILITY

Cascade Medical Center/Idaho Hospital District
Cascade, ID

Bingham Memorial Hospital
Blackfoot, ID

Arctic Slope Native Association
Utqiagvik, AK

Doctors and Hospital Health System of Idaho
Blackfoot, ID

EvergreenHealth
Kirkland, WA

Kodiak Area Native Association
Kodiak, AK

Copper River Native Association
Glennallen, AK

International Community Health Services
Seattle, WA

Westside Pediatric Clinic
Portland, OR

Associates for Womens Health
Spokane, WA

Alaska Surgical Group
Anchorage, AK

Northstarr Cardiothoracic Surgery
Anchorage, AK

Radial First Cardiovascular Associates
Idaho Falls, ID

Community Health Centers of Lane County
Springfield, OR

Weiser Memorial Hospital
Weiser, ID

STOP-LOSS Therapeutic Associates
Kent, WA

Physicians Care Network
Seattle, WA


Walla Walla Clinic and Surgery Center
Walla Walla, WA

(Govt. Relations, continued from page 33)

Physicians Insurance works closely with our allies, including the Oregon Medical Association and the Oregon Liability Reform Coalition. We continue to partner with the Oregon Patient Safety Commission to support the Oregon Collaborative on Communication and Resolution Program and the development of a patient-empowerment program.

ALASKA AND IDAHO: NEW GOVERNORS

Physicians Insurance is well positioned to work with the newly elected governors of both Alaska and Idaho. Governor Mike Dunleavy is a former Alaska State Senator, and Governor Brad Little is Idaho's former Lieutenant Governor and Past-Chair of the Idaho Association of Commerce and Industry. Both Alaska and Idaho have strong holds in the Legislature, meaning we do not anticipate any significant areas of healthcare-liability defense, nor do we anticipate any significant areas of healthcare-liability offense. We will continue to monitor legislative activity and work with our partners in both states.

Physicians Insurance serves as a trusted, reliable source for our members and key members of Congress, state legislatures, and state executive branches, with a bipartisan, fair, balanced, and solution-centered approach. 

PLAINTIFF ATTORNEYS: Collen Durkin Peterson and Jessica Holman, Holman Law

PLAINTIFF EXPERTS: Joseph Fetto, MD, Orthopedic Surgery; Brooklyn, NY; Richard Wohms, MD, Orthopedic Surgery, Puyallup, WA; Willard Fee Jr., MD, Otolaryngology, Palo Alto, CA; Safwan Jaradeh, MD, Neurology, Palo Alto, CA; Randall Patten, MD, Radiology, Olympia, WA; Francis Riedo, MD, Infectious Diseases, Kirkland, WA

DEFENSE ATTORNEYS: John Graffe and Michael McDermott, Seattle, WA

DEFENSE EXPERTS: William Smith, MD, Neurosurgery, Las Vegas, NV; Charles Nussbaum, MD, Neurosurgery, Seattle, WA; Dinesh Chhetri, MD, Otolaryngology, Los Angeles, CA; James Anderson, MD, Neuroradiology, Portland, OR; Christopher Graber, MD, Infectious Diseases, Los Angeles, CA; Ali Samii, MD, Neurology, Seattle, WA

RESULT: Defense Verdict, Snohomish County



GOVERNMENT RELATIONS

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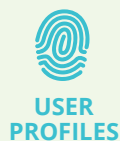
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New incident form that captures vital info from the start