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Leadership council tackles health care costs

Behind-the-scenes organization 'a place to get things done,' new president says

By Cliff Collins
For The Scribe

It operates behind the scenes, has been a key participant in health reform and is comprised of big players who exert a lot of influence in the health care community.

Yet the **Oregon Health Leadership Council** is not particularly visible five years after its founding.

"I've often been told by many people that they know we're out there, but they didn't know much about us," said **Greg Van Pelt**, newly named president of the council. "In some ways that's good—it's a place to get things done."

Van Pelt, who ended a long career with Providence Health & Services last spring after announcing his retirement as chief executive of the Oregon Region, takes over the leadership council at the same time that Denise Honzel retires from its post as founding executive director.

> "I've often been told by many people that **they know we're out there, but they didn't know much about us**. In some ways that's good—it's a place to get things done."
>
> —Greg Van Pelt, Oregon Health Leadership Council president

Van Pelt refers to the council not as an advocacy organization but "a think tank" and "a safe harbor, a venue where people can come together and solve problems." The council's members include senior-level executives of medical groups, health systems and insurers doing business in Oregon.

Striving for efficiencies, delivering high-quality care

Business itself plays an important role in what the council does. In 2008, the Oregon Business Council and other business groups helped launch the council, originally called the Health Leadership Task Force. A collaborative organization, it works to develop practical solutions that reduce the rate of increase in health care costs and premiums so that health care and insurance are more affordable.

Van Pelt said the council brings together health care people who "have to compete" during the workday, but who realize "there are a lot of things we can do better together. That's the goal."

The council strives to identify and act on cost-saving solutions that maximize efficiencies while delivering high-quality care. Since its launch, more than 200 individuals have been working on initiatives in four areas that the council determined to offer the greatest potential for impact:

- Payment and reimbursement reform
- Evidence-based best practices
- Value-based benefits
- Administrative simplification

The leadership of the council itself includes 30 individuals from health care organizations across the state, including eight major medical groups, the Oregon Medical Association, eight health systems, the Oregon Association of Hospitals and Health Systems and 12 health plans. **Bruce Goldberg, MD**, director of the Oregon Health Authority—who has taken a temporary leave of absence to head Cover Oregon—also sits on the council.

The development of coordinated care organizations and patient-centered medical homes to treat Oregon Health Plan patients were concepts the Oregon Health Leadership Council recommended for the state and helped bring about. It served as "a venue where brainstorming took place," Van Pelt said.

The council also aided state officials in developing the current Oregon Health Plan budget and is helping the state formulate the 2015–17 budget, which will see a large reduction in revenue from the one now in place because of the expiration of federal grants given to develop CCOs, he said.

The council's Evidence-Based Best Practices work group consists primarily of physicians. It has created strategies to reduce costs and improve care by encouraging consistent use of proven clinical guidelines in high-cost medical areas. An example of an initiative the work group developed is the Emergency Department Information Exchange within and among hospital EDs.

The program employs software that allows EDs "to notify physicians of unnecessary and duplicative emergency room visits," Van Pelt explained. It is intended to help hospitals get patients treated in the proper setting and reduce prescription opiate abuse, as well as unneeded radiation exposure and expense from repeat imaging.

*See **COUNCIL,** page 14*

Check out this month's Economics focus section on pages 8–9.

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INSIDE THIS ISSUE

Reaching new heights

Three area physicians share their histories with the Mazamas organization. Read a few of their climbing stories and how outdoor experiences help color their approach to medicine.

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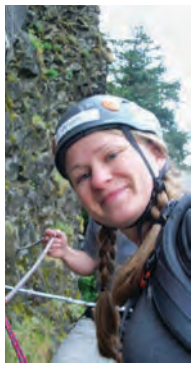

Ann Marie McCartney climbs Rooster Rock in the Columbia River Gorge.
Photo by Shane Harlson

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Virginia Garcia's Newberg clinic 'giant step in the right direction'

By John Rumler
For The Scribe

Location, location, location.

Virginia Garcia Memorial Health Center's (VGMHC) newest clinic, which opened this month in Newberg, is in an ideal place for the 38-year-old, not-for-profit to carry on its mission of providing health care services to communities in Washington and Yamhill counties.

VGMHC specializes in serving migrant and seasonal farmworkers who face numerous barriers to health care. An estimated 8,250 farmworkers are in Yamhill County and another 6,700 are in bordering Washington County.

By the time the clinic's staff of 21 settle into their $1.1 million, 5,400-square-foot environs at 2251 E. Hancock St., it will be time to gear up for their busiest season of the year.

The Newberg Virginia Garcia clinic will provide about 2,400 patients with primary care, mental health services and dental care in the first year, but its impact will be even greater. It will become the headquarters for mobile health care services and outreach to farmworkers scattered throughout an area of migrant camps, nurseries and fruit orchards.

Mobile services and outreach is critical for farmworkers who, because of their transitory lifestyle, economic status, housing and living conditions, and the nature of their work, have unique health needs. Virginia Garcia's Migrant Camp Outreach Program delivers medical and dental care and health education, including information and referral services.

From May through August, several days a week, the VG Mobile Clinic, a large, specially equipped RV, carries health providers and educators to the area's large migrant camps. Last year, these outreach efforts also helped connect migrant children with the Oregon Health Plan, enrolling more than 200 in its Healthy Kids program.

'A valued partner'

The U.S. Department of Health and Human Services provided an $850,000 grant to help launch the Newberg clinic, which is VGMHC's 12th service location and the third in Yamhill County. The balance of the needed funds is coming from a combination of corporate and individual contributions, foundation grants and VGMHC capital funds.

The Newberg digs are creating a wave of excitement, said **Jonathan Fost**, coordinator of special programs for the Newberg School District, which serves about 350 Hispanic kids.

The clinic will be the sole resource for medical needs for many Latino families, Fost explained. "Right now the nearest service center is about 15 miles away in McMinnville. We're all looking forward to working and partnering with Virginia Garcia with high hopes. They already have a presence here with their outreach, but it will be much stronger with their own facility in town."

Providence Newberg Medical Center will work with the Virginia Garcia center to manage the continuum of care for patients, said **Lori Van Zanten**, the hospital's chief executive.

Eva Galvez, MD, meets with a family receiving medical care through the Virginia Garcia Memorial Health Center. The nonprofit's newest clinic opened in Newberg this month and is expected to serve thousands of patients in its first year.

Photo courtesy of Virginia Garcia Memorial Health Center

"This is a giant step in the right direction to increase affordable access to health care in Newberg. The new clinic will enhance the health of our entire county," said Van Zanten, who is also a board member of the Virginia Garcia Memorial Foundation, the agency's fundraising arm.

Yamhill County currently provides mental health services at the clinic site and is ready to integrate its services with the care Virginia Garcia will provide. Yamhill County Care Organization (YCCO) already has more than 5,000 members (Medicaid recipients) assigned to the new Virginia Garcia clinic and anticipates enrolling many more.

Through another partnership with George Fox University, the clinic will offer a practicum training component for advanced doctoral psychology students.

"Virginia Garcia is a valued partner, especially because they bring a medical home model of care that is truly integrated and capable of meeting physical, behavioral and oral health needs," said **Silas Halloran-Steiner**, YCCO board chair and director of the Yamhill County Health and Human Services Department.

The Newberg clinic marks the latest expansion for an organization that, through widespread support, strong executive leadership and steady federal funding, has blossomed from a fledgling, volunteer-run, grassroots clinic named in honor of a 6-year-old who died from an easily preventable malady nearly four decades ago.

On Father's Day in 1975, Virginia Garcia, whose family lived in a migrant camp in Washington County, died of blood poisoning from an infected cut on her foot. Her death occurred because of a lack of medical care combined with cultural and language barriers.

Upset by the girl's death, members of the surrounding community galvanized into action. With support from St. Vincent Hospital in Cornelius, the original Virginia Garcia clinic opened in July of that same year in a three-car garage in Cornelius. The clinic was originally a part of Centro Cultural, a non-profit serving the Hispanic population in Washington County.

Today, the Virginia Garcia Memorial Health Center is a full-service health-care home with a $36 million annual budget, 350 employees, four primary care clinics, three dental clinics, four school-based health centers and the mobile outreach clinic serving about 36,000 patients across the two counties. •

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From operatic stage to rural family medicine

Ahead of match day, OHSU student David Simmons reflects on similarity between music and medicine, opportunities ahead

David Simmons, 43, of Portland, is a former professional opera singer with a wealth of natural talent, but—as noted on Oregon Health & Science University's website—he says he knew from as early as age 8 that he wanted to be a doctor.

"I think the desire to be a doctor came primarily from my mom, an RN, and her nursing school roommate, Darlene, and literally hours spent poring over mom's Taber's encyclopedic medical dictionary," he said in a 2010 piece about him and other incoming med students. "I was side-tracked into music at college and had a reasonably successful career as a singer for a number of years. But I decided to nuke my life as I knew it in the summer of 2007 and enrolled as a 37-year-old, pre-med freshman at Oregon State University. It was terrifying, but now I know I can do this. I am so unbelievably ready to put on that white coat."

Fast-forward to 2014. Simmons, along with fellow OHSU medical students poised for graduation, will learn on "match day" this month where they will serve their residency. He took time to share his thoughts with *The Scribe* ahead of the big day:

Obvious question: How do you get from the operatic stage to med school?

Simmons: Practice, practice, practice. The thing I love about music and medicine is that they're not just jobs: riding your bike, at a party, when you wake up at 2 a.m., you're still a doctor. It frames your entire life. Everything you do becomes part of your art.

And that appeals to you?

Simmons: Absolutely. It's the heart of why I'm planning on going into rural family medicine. When I was a kid, I studied from this collection of Bach edited by Albert Schweitzer. Come to find out, he was a doctor, too! Here was this guy working at the top of both fields. I think it was because for him, there was no separation; there's something about caring for the health of your neighbors and making music together with them that all runs together. So, we can't all be Schweitzer, but there's a unique opportunity in rural medicine to emulate him, albeit on a modest scale: to get involved with the individuals and the community at the deepest level; to understand that health is about people's whole lives.

So, you're about to graduate. What comes next?

Simmons: Ask me again after I open the envelope on match day! There are great family medicine residencies right here in the area at OHSU, Providence and PeaceHealth. There's a well-established rural training track in Klamath Falls, and Providence has a new one in Hood River.

There have been a lot of factors to weigh with my kids, including where the best indie bands and girl's rugby teams are. We have our preferences, but I know that wherever we end up, the family medicine community is supporting us and will ensure that I'm well-trained and that my family's life is well-balanced. I'm not worried.

What about music?

Simmons: Ha! It hasn't disappeared entirely. Recently I texted a soprano to see if she wanted to work on the *Rigoletto* duets together. Throughout school I've been helping Kevin Ahern, a professor at OSU, record his "Metabolic Melodies," which are essentially biochemistry lyrics set to popular tunes. And I'm proud to say that a bunch of us started a glee club at OHSU, the first one in about 50 years.

Four years have gone by fast; it's hard to believe we're already choosing music for graduation. I'm thinking "Gaudeamus Igitur" from "The Student Prince." •

> "The thing I love about music and medicine is that **they're not just jobs:** riding your bike, at a party, when you wake up at 2 a.m., you're still a doctor. **It frames your entire life.** Everything you do becomes part of your art."

msmp.org

Students, what is your biggest aspiration for your residency? If you're already in practice, what is your most vivid memory of your residency? Share your thoughts via the Members Forum section of MSMP's website at www.MSMP.org.

Advancing knowledge, improving health

Kaiser Permanente Center for Health Research's recent evidence review among array of studies conducted over the years

By John Rumler
For The Scribe

Smoking cessation, diabetes in pregnant mothers, weight maintenance, osteoporosis, pain management, the variance of vitamin D potency—this is just a tiny random sampling of the numerous and eclectic studies conducted through the years by the **Kaiser Permanente Center for Health Research** (KPCHR).

Its recent evidence review of colorectal screening home tests shines a new light on the important work of previous researchers and brings a valuable weapon in the arsenal against cancer, the fecal immunochemical test (FIT), to the attention of health care specialists and the public.

Garnering media attention from *USA Today* to *CBS News*, the review's findings are particularly valuable considering that colorectal cancer is the second-leading cause of cancer-related deaths in the United States. In 2010, more than 130,000 people were diagnosed with the condition and 52,045 died. Men and women are equally susceptible.

The Kaiser Permanente Center for Health Research's recent evidence review of **colorectal screening home tests** shines a new light on the important work of previous researchers and brings a **valuable weapon in the arsenal against cancer, the fecal immunochemical test**, to the attention of health care specialists and the public.

Screening, which is recommended beginning at age 50 for most people, can curtail the disease, especially when it is identified in the early stages, but an estimated 22 million people in the nation are not up to date with their colorectal screenings. Colonoscopies and sigmoidoscopies are invasive and expensive, but KPCHR's review brought the FIT to prominence as a simple, affordable and effective cancer-screening device. The review was published Feb. 4 in the *Annals of Internal Medicine*.

The review concludes that the FIT, which should be done annually, requires patients to collect a stool sample at home and mail it to a lab for analysis. It will detect about 79 percent of colorectal cancers on the first screening.

Beth Liles, MD, co-author of the review, divides her time between the KPCHR in North Portland and seeing patients at Kaiser Permanente's Sunset Medical Office in Hillsboro.


BETH LILES, MD

A board-certified internist, Liles during the past eight years has participated in other studies related to colorectal cancer and vaccine trials. She became involved in the FIT review through her collaboration with other researchers, including **Jeffrey Lee, MD**, the study's lead author and a post-doctoral researcher at the Kaiser Permanente Division of Research in Oakland, Calif., and University of California, San Francisco.

"It was a two-year study, or review, of a number of other studies. It started out as Dr. Lee's fellowship research project and grew from there," Liles explained.

Liles helped review 19 studies examining eight different FITs, finding that the tests correctly identify about 94 percent of the patients who do not have cancers of the rectum or colon.

The reviewed studies included between 80 to 27,860 patients, with average ages ranging from 45 to 63. In 12 of the studies, all of the patients took the FIT and received a colonoscopy. In seven studies, patients only had a colonoscopy to follow up on a positive FIT.

According to the National Institutes of Health (NIH), the average cost of a colonoscopy, before insurance, is $1,500 to $3,000, while the less invasive sigmoidoscopy runs between $500 and $750. Liles estimates the cost of the FIT ranges from $20 to $50.

The most satisfying part of the review, Liles said, was summarizing the information and collaborating with other researchers. She hopes that health systems take advantage of the FIT as a low-cost and reliable screening tool against cancer. "It was great that we got those results, now I hope it becomes widely used. If it's available through the health care systems that people have access to it will."

Proactive and preventive

The review, funded by grants from the National Institute of Diabetes and Digestive and Kidney Diseases and the National Cancer Institute, is in many ways a good example of the kind of projects the KPCHR chooses to take on: It is proactive and preventive, and it has the potential to make a difference in many lives.

The mission of the non-profit research institution, which has grown from a handful of researchers working in a small basement office to more than 300 people in three states, is to advance knowledge to improve health.

Now celebrating its 50th anniversary, the Portland CHR, the largest and oldest of the three centers, received a total of $38.8 million in research funding in 2013, while the other centers in Atlanta (founded in 2006) and Honolulu (founded in 1999) received $7 million and $3.7 million, respectively. Most of this funding comes through grants from federal agencies such as the NIH and the Centers for Disease Control and Prevention.

KPCHR's research budget is overshadowed by giants such as Oregon Health & Science University, but its access to secure electronic health records is unique. Kaiser Permanente is an integrated health system with more than 9 million members across the country. Members' lab, pharmacy, hospital and outpatient records are stored in a secure electronic system, which KPCHR researchers use to conduct research.

The first few years, the Portland center focused on health services research, examining the delivery and cost of health care using the Kaiser Permanente program in Oregon as its laboratory.

CHR became more prolific when Kaiser Permanente pioneered its own secure electronic health records system in the mid-1990s, allowing access across all health care services. Researchers also work closely with community health centers and programs that care for the poor and uninsured.

"We've partnered with many federally qualified health centers to study how their chronic care is managed, to see how rates of breast and cervical cancer screenings can be improved, and to determine how a lack of insurance affects the quality of care their patients receive," said assistant investigator **Rachel Gold, PhD**.

The partnerships were made possible, in part, because Kaiser Permanente assisted the clinics in setting up their own electronic records systems and worked with them to build their capacity to conduct research with electronic data.

CHR's capacity to access huge amounts of data and to link different categories has led to breakthrough research—in one case, regarding diabetes during pregnancies.

In 2007, researchers linked mothers' and children's health records, discovering that untreated diabetic women bore children who were twice as likely to be overweight or obese at ages 5–7 compared to the children of women with normal glucose levels.

Further research found that treating the mothers with the most severe cases of gestational diabetes greatly reduced the likelihood of their children becoming obese.

"Having high glucose in pregnancy changes the metabolism of the future child. If we can intervene and normalize the glucose level during pregnancy, we can modify that extra risk of childhood obesity," said senior researcher **Teresa Hillier, MD**.

CHR has also taken on some long-term studies. The Study of Osteoporotic Fractures began in 1986 and followed some of the patients for 30 years, yielding nearly 400 scientific papers. One of the major findings was that elderly women who suffered a hip fracture had an increased chance of dying within one year of the mishap. •

Did you know?

Besides contributing important research, the KPCHR also influences national public health policy.

In 2012, researchers from CHR joined with colleagues from HealthPartners and Group Health to form Kaiser Permanente Research Affiliates, one of 11 Evidence-based Practice Centers (EPCs) designated by the federal Agency for Healthcare Research and Quality.

One of the main functions of the EPCs is to provide systematic evidence reviews for the U.S. Preventive Services Task Force, an independent body of national experts that makes recommendations for preliminary care screening and treatment.

Partner Profile

Staffing service helps physicians find the right person

Editors' note: *This article is part of a series profiling MSMP partner organizations. To read the most recent Partner Profile, highlighting OnPoint Community Credit Union, visit MSMP.org, click on the News and Publications tab and view the January 2014 Scribe.*

By Cliff Collins
For The Scribe

About 40 percent of the requests to fill positions that **Medical Society Staffing Inc.** receives are for medical assistants, and as many as 50 percent of the positions placed are in that category.

Medical assistants are specially trained for the outpatient setting. They can perform tasks in both the front office and back office, enabling them to help with both administrative and clinical functions.

The need among doctors' offices for medical assistants continues to be strong each year: They belong to one of the top-10 fastest-growing occupations nationally, pointed out **Paula Purdy, CMA (AAMA)**, general manager of **Medical Society Services Inc.** and of the staffing service, a division of **the Medical Society of Metropolitan Portland.**

As is also true for using Medical Society Staffing to recruit permanent, temporary or temp-to-hire employees, MSMP members can receive special benefits for sending medical assistants to the classes.

For regular services provided by Medical Society Staffing, it offers a 10 percent discount to medical groups in which all physicians of that group are MSMP members. In addition, if at least one physician in a group is an MSMP member, the doctor or group can send a medical assistant to the review class at no charge.

Medical Society Staffing handles permanent, temporary and temp-to-hire positions for jobs ranging from management, reception, billing and bookkeeping to direct-care personnel such as registered nurses, nurse practitioners and physician assistants.

"Our **objective is to match the person with the client.** When a client tells us, 'We hired someone you sent us years ago, and she is still with us,' that's a success to us."

— Paula Purdy, CMA (AAMA), general manager,
Medical Society Staffing Inc. and Medical Society Services Inc.

"What has changed is actually finding medical assistants," she explained. "Finding properly credentialed medical assistants is a huge challenge." One reason physicians' offices increasingly want credentialed medical assistants is a direct result of a requirement now imposed by the Centers for Medicare & Medicaid Services. It stipulates that, in order to meet "meaningful use" in employing electronic medical records, clinic personnel who access or enter orders for medications, lab and imaging must be either licensed or credentialed, Purdy said.

As a result, and to help prepare more medical assistants for job placement and retention, last April, Purdy inaugurated a continuing series of medical assistant review classes to help medical assistants prepare for certification tests.

Services it provides include:

- Pre-screen each candidate with a personal interview
- Check references
- Verify a license and credentials
- Conduct background checks on all candidates offered a position
- Arrange drug screens on temporary and temp-to-hire staff

Working as an extension of, or replacement for, the human services department of a medical practice, Medical Society Staffing has been providing staffing services to its physician members and the medical community for 50 years.

Purdy has been with Medical Society Staffing for exactly 30 of those years. She became manager after about two years working as a recruiter, and she herself

*See **PARTNER PROFILE,** page 13*

Practices can profit with new CMS data capture, coding rules

By Pam Klugman
For The Scribe

Changes are coming that will drastically impact how physicians in Portland and around the country are paid as well as how the care they provide to their patients gets captured and reported. This is no trivial matter. Physician groups, along with the Medicare Advantage plans with which they work, stand to collectively lose billions of dollars in revenue if they don't learn how to adapt to the new environment.

By now physician groups should be well aware that the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets on Oct. 1, 2014. These new codes are not simply increased and renumbered code sets, but include fundamental differences such as changes in terminology and a greater level of diagnosis detail to appropriately reflect advances in medical knowledge. The degree and complexity of these changes underscore the need for physician groups to have the right tools, knowledge and foresight in place to make this conversion as easy as possible.

With the cost savings and extra benefits they offer, Medicare Advantage plans are seeing an uptick in enrollment. Concurrently, **the Centers for Medicare & Medicaid Services (CMS)** is shifting how it sets the reimbursement rate to these plans, and that has significant implications affecting the cash flow for physician groups as well.

Currently, the rate setting for Medicare Advantage plans is based on the cost of covered Medicare services using data collected from fee-for-service (FFS) providers. CMS is changing that methodology and will begin calibrating payment on the FFS *equivalent pricing* using "encounter data" submitted by Medicare Advantage plans. While medical record documentation will continue to be the source for diagnosis validation, the reimbursement for provider groups that work with these plans will be based on how closely the data they send to the health plans for Medicare Advantage members resembles an actual FFS claim for payment with all the accompanying nuances required for calculation of FFS reimbursement.

That single change will require a more comprehensive approach to data capture and submission than has historically been the norm. Traditional FFS medical billers will continue to focus on procedure coding for original Medicare as this drives their payments. But for Medicare Advantage plan members, capturing both procedure and diagnostic codes within the full encounter data format—including precise coding that reflects the conditions with which each patient has been diagnosed—will be critical.

Pam Klugman

With the clock toward implementation already ticking, now is the time for Portland's physician groups to ensure that they have the technological infrastructure in place to capture and submit complete claims data to payers. Most practices are already submitting claims data electronically, but they need to be sure that their practice management software can accommodate the much higher data management demands of larger procedure and diagnosis code sets.

It is equally important to equip billing operations with the latest codebooks each year to ensure that medical billers are using the most up-to-date codes. Physician groups must ensure that all services provided are documented and coded appropriately, along with fully noting and submitting diagnoses and linked conditions in the patient encounter record.

It's also recommended that physician groups conduct quarterly chart audits to ensure patient data capture is not only complete, but fulfills the differing requirements mandated by the type of Medicare coverage for each patient. Identifying problems and correcting them early can save practices thousands of dollars in rejected claims. And because rejected claims are an unfortunate part of most practices, physicians would be advised to have a system in place that provides regular reports on these items. Doing so may unearth problematic patterns in the data or the codes being submitted. By correcting the codes and resubmitting them quickly, practices can capture dollars that may otherwise be left on the table.

The changes taking place with respect to data capture, coding and billing are some of the most significant transformations ever in the Medicare Advantage industry. Physician groups that are well versed about these changes and prepare by building new billing competencies that better align with their provider partners will not only find themselves ahead of the game, but will also ensure that their practices remain profitable in a rapidly changing world. •

Pam Klugman has more than two decades of health care experience, specifically in the area of Medicare in both the health plan and provider arenas. She is vice president and chief operating officer of Clear Vision Information Systems (www.cvinfosys.com).

The **changes taking place** with respect to data capture, coding and billing are **some of the most significant transformations ever** in the Medicare Advantage industry.

Better business: Tips for improving practice efficiency and, as a result, the care you provide

By Jon Bell
For The Scribe

Not many physicians will tell you that they got into the medical field because they loved the idea of running a business. The payroll to meet, the staff to manage, the bills to pay; it sounds glamorous and all, but most doctors went into medicine so they could actually practice medicine, not so they could run a business.

Yet there's no getting around the fact that doctors who hang up their own shingles have to play many more roles than they may have originally bargained for in their pursuit of medicine. The result can be inefficient offices, with doctors juggling business duties with treating patients, and both turning out weaker because of it.

"I think the underlying notion is that doctors want to provide medical care and the business gets in the way," said **Tannus Quatre**, president and CEO of Vantage Clinical Solutions, a Bend business solutions company for medical practices. "They end up wearing a bunch of hats and they're not able to focus on everything. Business in general is tough, but you throw that into the health care mix, where doctors need to be at their best and serving patients, and it becomes even more challenging."

But it doesn't always have to be that way, and there are some steps that doctors can take to be more efficient, run their businesses better and spend more time doing what they do best—treating patients.

For **Julie McGovern**, CEO of Practice Wise, a medical practice management consulting firm in Wilsonville, one of the biggest challenges facing physicians and their clinics right now is the implementation of electronic medical records.

"Practices are really flailing right now and doctors are struggling because they're learning how to use EMRs," she said. "It's making them less efficient."

It's not necessarily the software itself that makes physicians less efficient, however, though some of the cheaper options available may contribute to the problem by not offering enough support or training. Instead, McGovern said, some physicians do not fully embrace the technology they've invested in.

"It's about learning to be a doctor with these new tools," she said. "They need to demand greater support and really invest the time into making it work for them, not against them."

When it comes to EMRs, McGovern said it's important to go with a package that comes with on-site training and implementation, not just web-based offerings. Ensuring that all staff are properly trained on the software is key as well. It may cost money to send staff to training conferences, but McGovern said it's money well spent.

"Staff are the ones who are protecting your business so they definitely should get continuing education," she said.

Training staff on the use of an EMR can help free up physicians' time for patient care. Similarly, McGovern said some doctors could really benefit from either hiring a scribe or using someone on their staff as a scribe.

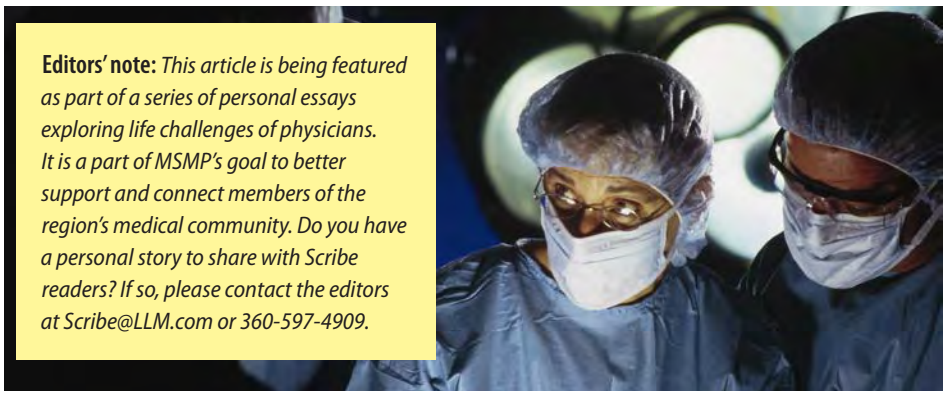
Farming out some of the business end of a practice can also help improve efficiency. Quatre said his firm handles systems such as medical billing, EMRs, payroll processing and marketing for clinics so that physicians don't have to.

"It lets them focus on health care," he said.

When it comes to EMRs, Quatre said it's also important for doctors to see the big-picture, long-term benefits behind them and not just the seemingly time-consuming step of data entry.

*See **ECONOMICS,** page 13*

A lesson in humility and forgiveness



Editors' note: *This article is being featured as part of a series of personal essays exploring life challenges of physicians. It is a part of MSMP's goal to better support and connect members of the region's medical community. Do you have a personal story to share with Scribe readers? If so, please contact the editors at Scribe@LLM.com or 360-597-4909.*

By Richard T. Bosshardt, MD, FACS

In 17 years of private practice, I have been named in three malpractice suits. You'll just have to take my word for it when I say that not one was truly malpractice. Two involved adverse outcomes, and although I felt both were defensible, I chose to settle rather than go to court. I was dropped from the third suit because it was clear, even to a very aggressive plaintiff's attorney, that I was not culpable. This story, however, is about the time I wasn't sued.

The patient was a middle-aged woman on whom I had performed carpal tunnel surgery years earlier. Now, the problem was her right ring finger, which was tender over the proximal interphalangeal (PIP) joint, and she felt something "catching" or "snapping" when she flexed it. Her examination was normal except for the impression that something was getting hung up as she flexed the finger. I felt that, for reasons that were unclear, part of her extensor mechanism over the joint might be slipping laterally as she flexed the finger. The X-rays were normal. I recommended surgical exploration and repair.

I had not encountered this problem before, so prior to surgery, I reviewed my finger anatomy, especially that of the extensor mechanism. On the morning of surgery, I carefully checked the finger in the preoperative holding area to verify that the problem had not changed. In the operating room, I put on my 3.5x surgical loupes, as was my practice for all hand cases, and went out to scrub, as I had done hundreds of times before. Reentering the room, I approached the table, where the arm had been prepared and draped by the circulating nurse. Sitting down and peering through the loupes, I grasped the finger and carefully marked out a gently curving incision over the PIP joint. After exsanguinating the arm and inflating the pneumatic tourniquet, I incised and reflected the skin, and began to explore the extensor mechanism, which looked surprisingly normal.

At this point, Mike, the circulating nurse, approached the table and looked over my shoulder. "I thought we were doing the ring finger…," he noted, the sentence left hanging. I felt a cold chill. As the implication of his comment became clear, I suddenly felt, quite literally, nauseated. I looked around the telescopic lenses of my loupes and verified that I was indeed operating on the wrong finger—the long finger, as it turned out. It was one of those situations from which there is no graceful recovery. Neither was there a hole in that OR big enough for me to crawl into. With a sigh that could probably be heard far down the hall, I carefully closed the incision and, after regaining my composure, proceeded to explore the correct finger. I found a small bony spur that was snagging the edge of the extensor tendon and trimmed it away. Her problem was solved, but mine was just beginning.

After settling the patient in the recovery room, I had to go out and face her husband. Fortunately, their pastor was with him. Doubtless, his presence served as a buffer and softened the husband's reaction at my unwelcome news. I apologized, explained what had happened, and reassured him that, beyond the small scar, there should be no ill effects to the long finger. Although upset, he reacted graciously, probably more so than I might have, had I been in his shoes. When I explained the situation to the patient later, she was so kind and understanding that she just made me feel even worse, though I wouldn't have thought this possible.

Reflecting on events, it became clear what had happened. The involved finger did not show any external abnormalities. Since it was not marked in any way, the tunnel vision induced by the loupes allowed me to grasp the wrong finger. My chagrin at this gross error was all the more painful as I really had no excuse for it. I was not in a hurry, had not been distracted in any way, and had even taken extra precautions to prepare for the case, including my immediate preoperative reexamination. Before this case, I would not have imagined that this scenario was possible. I was shocked at how easily this happened.

Although the patient and her husband took the news well, the incident sent shock waves through the hospital. Meetings were held with hospital administrators, operating room staff and the chief of surgery. As a result, the hospital's protocol for identifying the site of surgery was completely revamped, especially as it pertained to extremity surgery.

The state board of medicine initiated a full-blown investigation of the event to determine what action needed to be taken. I wrote out a summary of the events, as accurately as possible, along with my assessment of how this happened. Because of potential licensure issues, I retained an attorney to represent me before the board and was informed that the best I could hope for was a "Letter of Concern." As he explained it, this would be tantamount to the board saying "go, and sin no more." So long as I had no further incidents, after a couple of years, the letter would be removed from my file at the board of medicine. Much to my relief, this was, in fact, what happened.

So, in all this, what about the patient and her husband? As I had expected and fervently hoped, she did well and had no further problems with either finger. We discussed my "faux pas" in my office at length, and the husband stated that he had been very angry at first, but after

*See **PHYSICIAN WELLNESS,** page 12*

Doctors get out—and up—with the Mazamas

Area practitioners find climbing experiences color approach to medicine

By Jon Bell
For The Scribe

On July 19, 1894, close to 200 people climbed to the top of Mount Hood: men in bowler hats, women in floor-length dresses, one climber in a Civil War-style cap with a bugle, another waving a full-size American flag. They were all on the mountain for one main reason: to form an outdoors organization for climbers and nature lovers. They did just that, officially creating the Mazamas.

Nearly 120 years later, the Mazamas are still climbing. They lead more than 1,000 hikes and climbs every year, their extensive museum and archives document the history of Northwest climbing and their membership now tops 3,000 people. Among them are three physicians who recently shared their own histories with the Mazamas, a few climbing stories and how their outdoor experiences help color their approach to medicine.

Ann Marie McCartney

Ann Marie McCartney, MD, grew up in Colorado with a father who's climbed almost all of the state's 50-plus 14,000-foot peaks. So she's used to mountains and early alpine starts.

Ann Marie McCartney, MD, rappels at Central Oregon's Smith Rock State Park. McCartney learned mountaineering fundamentals and cultivated best friends through the Mazamas, and now is pursuing a mountain medicine diploma.

Photo courtesy of Kathleen Hahn

But there aren't many mountains near the University of Nebraska Medical Center, where McCartney earned her medical degree and completed her residency in internal medicine. Needing a little more dramatic topography, McCartney came to Portland in 2011; needing to meet some mountain-minded people here, she found the Mazamas online.

"I went on an off-trail hike to an old lava crater with some people, and I've just made a bunch of friends since then," said McCartney, an internal medicine doctor at The Portland Clinic. "My best friends in Portland are also members. It's really a fabulous organization with a lot of like-minded people."

The 33-year-old signed up for the Mazamas' Basic Climbing Education Program in 2012 to learn the fundamentals of mountaineering. She's currently in the group's intermediate program, and she also serves as one of the lead organizers of the Mazamas' annual used gear sale. Among her summits so far are Mount Adams, Mount Saint Helens and a few of the peaks in Washington's Tatoosh Range. McCartney has her sights set on Mount Hood this year and Mount Rainier next year.

She's also pursuing a diploma in mountain medicine and she has completed her wilderness first responder certification. One of her dreams would be serving as an expedition doctor on, say, a trip to Antarctica. Until then, McCartney plans to continue getting outside with the Mazamas. She said she uses her climbing experiences to show her patients that, even though they may be busy, it's possible to get out and be more active.

David Zeps, MD, shown here during a personal climb of Ecuador's Cotopaxi volcano, encourages patients to not give up on exercise, even if the first few minutes are difficult. It's a challenge he, too, confronts in outdoor adventures, among them as a hike and climb leader for the Mazamas. Photo courtesy of David Zeps

"It can be very inspirational for people," she said. "I tell them that I'm so busy with my practice, but I can still do this. It gets them excited, too."

Brad Farra

Brad Farra's involvement with the Mazamas crosses over into his chiropractic sports practice in a pretty direct way.

"Inevitably I do end up seeing some of the Mazamas who can't figure out their injuries on their own," said Farra, a certified chiropractic sports physician who's been practicing in Portland since 2008.

But Farra, who grew up in the Portland area, does more with the Mazamas than just treat some of their injuries. A former helicopter rescue swimmer and emergency medical technician with the U.S. Navy, Farra got involved with the organization in 2008 as a way to meet people to climb with and to brush up on his own skills. He took the group's advanced rock climbing and snow and ice courses and has been teaching different Mazama courses as well.

*See **OFF HOURS,** page 14*

Brad Farra, DC, recently climbed the challenging Devil's Thumb in Alaska. Farra, who joined the Mazamas to meet fellow climbers and to brush up on his skills, teaches courses for the organization and also helps members with injury prevention.

Photo courtesy of Brad Farra

Use these questions to assess your practice's lab test results tracking, reporting system

The goal of every practice is for the correct test to be performed on the correct patient at the correct time with the results being returned to the physician, who then communicates them to the patient with a plan for follow-up care, all done in a timely manner.

In the handing off or transitioning of clinical information, it is critical to avoid delays in diagnosis and necessary treatment. Claims and lawsuits have arisen from patients harmed by latent or hidden failures in this process.

To assess the tracking and reporting system in your office practice, can you answer "yes" to the following questions?

- Is there a system in place to reconcile ordered laboratory tests and imaging studies with the results received so that if results are not received within a defined time frame, there will be follow up? (The system should not be dependent on a return appointment or holding the medical record.)
- Is there a system in place for tracking referrals to consultants and specialists to ensure follow up if results are not received in a timely manner?
- Do referrals indicate the reason for the consultation and outline who will be responsible for overall care, testing, treatment, and follow up?
- Does the staff make appointments for consultations?
- Is there evidence that a provider has reviewed all test results (i.e., initials, electronic signature, etc.)?
- Has the staff been trained not to file or scan test results and reports without evidence of provider review?
- Are all test results, even those that are "normal," provided to patients?
- When there are abnormal findings, is the follow-up plan that has been established with the patient updated or, when necessary, is the patient's refusal to cooperate with the plan documented?

Remember to document the medical record with patient noncompliance observations, such as the patient's refusal to get a test, x-ray or consult. Note in the chart all callbacks made to the patient to attempt to get his or her compliance. •

This article is courtesy of The Doctors Company, the nation's largest insurer of physician and surgeon medical liability. For more information, contact Sarah Wolfenbarger or Christopher Clark at 800-243-3503, or visit www.thedoctors.com/patientsafety.

Series offers Portland-area doctors chance to share 'untold' ER stories

Are you an emergency room doctor? Have you experienced cases involving ethical or moral issues, new or unusual procedures, or mysterious or bizarre circumstances?

The television show "Untold Stories of the ER" wants to hear from you.

The documentary series, back for its ninth season on Discovery Fit & Health and TLC, is reaching out to health care professionals with the Medical Society of Metropolitan Portland to share their ER stories.

Here's how it works: Those behind the series say they talk with doctors who share their unusual or memorable, and sometimes humorous, cases. A script is written, and episodes are cast and shot in Vancouver, B.C. The show brings the doctors to Vancouver, where they appear in the segment.

There is no cost to the doctors or hospitals involved. "Untold Stories of the ER" takes care of all expenses for the doctors, who receive an honorarium if they are brought to Canada.

The series' producers are open to hearing about a wide range of ER events—"from the life threatening to the lighthearted, from the mysterious to the bizarre," according to a promotional flyer. Past episodes have borne that out. One installment featured a prisoner faking an ailment to escape jail by climbing through an emergency department's ceiling panels; newlyweds who discovered on their wedding night that the bride suffered from a blood disorder; and a patient who drove his vehicle through a chain-link fence, resulting in a fence pipe wedged in his mouth and through back of his neck.

The attending doctor who worked on the latter case, a trauma and critical care surgeon, is quoted in the segment as saying not only should the patient not be awake in the ER (at one point the man was sitting up, and even sent a text message while the pipe was still lodged in his head), but he shouldn't be alive. If you missed seeing the episode, all turned out well in each case.

Ann Hassett, senior story producer and physician liaison for "Untold Stories of the ER," said among the stories the series steers clear of are those in which a patient dies or a child's life is on the line. The series, she added, is careful to ensure it depicts medical procedures correctly; participating physicians can review the scripts and make corrections. Hassett also said some details, including patient ages and genders, are changed to comply with HIPAA.

Show producers say the "best stories recount surprising medical or personal challenges, deal with ethical or moral issues, involve new or unusual procedures, inspire us, or simply entertain us with insight and humor." •

UNTOLD STORIES OF THE ER

To be considered for the TV series "Untold Stories of the ER," email a short description of your true-life emergency room story to **ahassett@UntoldER.com**.

Be sure to include a phone number and return email address so that you can be contacted by those behind the series. If your story is chosen, you'll be asked to appear in an on-camera interview and to spend a day in the series' ER studio.

To learn more about "Untold Stories of the ER," visit: **www.discoveryfitandhealth.com/tv-shows/untold-stories-of-the-er**

PHYSICIAN WELLNESS

from page 10

reflecting a bit and talking it over with his wife, he realized that mistakes happen. The fact that I had owned up to it immediately and without excuses went a long way toward allowing him to accept this as an unfortunate, but sometimes unavoidable, aspect of medicine. The patient herself never expressed any displeasure or consternation and did not seem to lose any confidence in me. The possibility of litigation never even came up. It was a very humbling experience and a demonstration of patients' amazing capacity for forgiveness when their physicians prove all too human. •

Richard T. Bosshardt, MD, FACS, is a board certified plastic surgeon in Florida. This article, which first appeared in The Doctor's Advocate, *a publication of The Doctors Company, won a writing contest.*

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Do you have a personal story to share about a patient's capacity to forgive, or about the dynamics of patient-physician relationships in general? Share it, or respond to this essay online, via the Members Forum section of MSMP's website at www.MSMP.org.

PARTNER PROFILE *from page 7*

is a certified medical assistant, which she said helps her be more knowledgeable about what they do and the valuable role they play in medical practices.

Purdy has been active with the American Association of Medical Assistants at the national, state and local levels for many years, including serving as president three different times of the Oregon Society of Medical Assistants, and serving two terms as a trustee of the American Association of Medical Assistants.

On the national level, she currently is speaker of the house and is running for vice president in September. If she wins the latter, she would have the opportunity to be installed as president at the 2015 AAMA Annual Conference, which happens to be scheduled in Portland at the DoubleTree by Hilton Hotel at Lloyd Center.

Purdy's long tenure and the fact that her colleague, recruiter Bob Kress, has been working with her for more than a dozen years gives clients confidence that they can rely on the people Medical Society Staffing screens and refers to them.

About 80 percent of Medical Society Staffing's business is from repeat customers and regular clients, with the remaining coming from referrals and other sources, she said. "It boils down to the right fit. We match the client's need with the kind of personnel that fit that office's environment."

Purdy said some longtime clients prefer temp-to-hire to start out, allowing the medical office a trial period to see if the individual is a good fit for the work and setting.

She has established a rapport with a large number of clients. For many of these, she will call an office if she finds a person who matches the needs an office has had in the past or has on a regular basis. Even if that office may not have an immediate need for a new employee, managers usually appreciate being kept apprised when a qualified person is available, Purdy said.

"Our objective is truly to match the person with the client. When a client tells us, 'We hired someone you sent us years ago, and she is still with us,' that's a success to us." •

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ECONOMICS *from page 9*

"When you look at all of the downstream efficiencies that come along with that—like how fast you get paid, how efficiently you can pull data to help make good business decisions—that's the perspective to have," he said.

Some other ways physicians can be more efficient in their practices and spend more time practicing medicine than running a business:

- **Communicate**—Make sure proper communication systems and processes are in place. That covers everything from returning patients' messages to answering emails and scheduling.
- **Look outside**—Bringing in an outside consultant can offer new perspective on what's working on the business end of a practice and what's not.
- **See patients in a new way**—For better or worse, a medical practice is a business. Look at patients not only as individuals, but as customers, too. Add value to your services and earn the loyalty of patients and families who can help a practice flourish. •

What specific strategies has your practice implemented to improve efficiencies and patient care? Share them via the Members Forum section of MSMP's website at www.MSMP.org.

COUNCIL *from page 1*

An Advanced Care Planning work group will begin meeting regularly to support health plan payment strategy for end-of-life care. Initially, the work group will explore the use of an evidence-based advanced care planning tool and a common payment methodology for certain patients receiving care by oncologists. Van Pelt said health care personnel who assist with end-of-life care contribute "very valuable service and should get reimbursed for providing that care."

Also under the category of payment and reimbursement reform was the High-Value Patient Centered Care Model initiative aimed at patients with complex and chronic conditions. The demonstration program ended Dec. 31 and is being evaluated for cost savings and quality improvement.

Remaining lean

Van Pelt said variations of groups such as the Oregon Health Leadership Council exist in some other states. For instance, in Washington state, the Washington Health Forum "operates a little like ours," and that group came up with the concept of the ED information exchange, he said. Several health plans and systems that are members of the Oregon council operate both here and in Washington, so council initiatives sometimes overlap.

The council's board of directors is co-chaired by two physicians, **George Brown, MD**, of Legacy Health and **William Johnson, MD**, of Moda Health. Other doctors serving on the board include **Craig S. Fausel, MD**, of The Oregon Clinic, **Joe Robertson, MD**, of Oregon Health & Science University and **Ralph Yates, DO**, of the Portland Coordinated Care Association. Regular council members and work group participants include many medical directors, and "they, as much as anybody, drive what's important," Van Pelt said.

In addition to his new role heading the counsel, Van Pelt was appointed by Gov. John Kitzhaber late last year to assist Goldberg in helping right the ship of the troubled Cover Oregon. Van Pelt said he acted as a second "set of eyes" to help set up processing of paper applications in lieu of the malfunctioning exchange website and to "build a command center."

Another retired Providence chief executive who works with the Oregon Health Leadership Council is **John Lee**. The council remains lean, "tries to use resources within our member organizations" and employs no staff, Van Pelt said. The two former CEOs and new Executive Director **Sharon M. Fox** serve as "nonemployee consultants to the council," Van Pelt said. The council does not occupy an office and holds meetings downtown in the offices of the Oregon Business Council. •

OFF HOURS *from page 11*

"It's nice because I am able to take what I do professionally and apply it to the Mazamas, whether it's helping with injury prevention or training for a climb," said Farra, who's also a certified strength and conditioning specialist.

Though he stays involved with the Mazamas by helping out with its education programs, Farra said most of the climbs he does these days are not through the Mazamas. He's climbed Mount Hood about 15 different times up 12 different routes, and last year he bagged the challenging Devil's Thumb and Moose's Tooth in Alaska and Johannesburg Mountain in Washington's North Cascades.

David Zeps

When David Zeps, MD, is trying to motivate patients to exercise more, he tells them this: The first few minutes can seem difficult and unsustainable, but that initial inertia is something you just have to get around.

It's a thought that Zeps confronts himself every time he sets out on a hike or a climb.

"I'm in pretty good condition," he said, "but the first few minutes when I just start out, especially up a hill, there's a thought in my mind of how am I going to be able to keep this up? You have to ignore that initial resistance and keep going."

A semi-retired internist who does home care and nursing home care for Kaiser Permanente, Zeps, 68, had always enjoyed the outdoors, whether he was hiking or hunting. When he and a friend got the idea to climb Mount Hood, a mutual friend suggested that training through the Mazamas would be the way to go. Zeps joined the group and took the basic climbing course in 1991.

"Once I took it and got involved with people who knew mountaineering, I was hooked," he said.

As he gained experience, Zeps started teaching for the Mazamas and eventually became a hike and climb leader. He usually leads about four climbs and six hikes each year for the group. Over the years, Zeps also broadened the geography of his climbing adventures, scaling Nepal's 20,300-foot Island Peak, the 18,871-foot Nevado Pisco in Peru and Aconcagua, a 22,837-foot mountain in Argentina. Just last year, Zeps summited Denali. Among his favorite local climbs are one-day trips to do Mount Washington or Three Fingered Jack.

"I love getting out and I love getting to the top of mountains," he said. "It's kind of infectious." •

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