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Medicine

The Changing Face of
Primary Care
in Wyoming

- Patient Centered Medical Homes
- Pharmacy Dispensing Machines
- Direct Primary Care

Wesley Hiser, MD Named WMS Physician of the Year
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The Healing Space in Cody
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FALL 2015

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ABOUT THE COVER

James Babson, MD visits with a patient at his practice in Cheyenne. Babson and Associates are a Level III Patient Centered Medical Home.

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The WWAMI Program In Laramie Is Undergoing Changes

BY ROBERT MONGER, MD



I recently had the pleasure of attending the WWAMI White Coat Ceremony in Laramie for the brand new first year Wyoming medical students and it was an incredibly fun and inspiring event. The 20 students in this year's class come from 11 different towns from all over our state, and they are smart, funny and enthusiastic. All 20 students offered admission to this year's class accepted, and for the first time in Wyoming WWAMI history no students were taken from the alternate list. We're very lucky indeed to have such great students entering our profession.

The WWAMI medical education program is changing rapidly these days, particularly with respect to its robust new curriculum, but it is facing a critical space issue that needs to be resolved for the program to maintain its accreditation and commitment to excellence. We'll need your help with the Legislature to make this happen.

Back in the day when I was a medical student we

spent almost all of our first two years of medical school sitting in classrooms listening to lectures and we had very little clinical exposure until our third year. But the approach to medical school teaching has changed a lot since then, and this year's first year students will be the first class participating in a new "integrated" curriculum that is not lecture based but instead emphasizes active learning, and that teaches blocks of information in a way that integrates basic science and clinical information at the same time.

In this new curriculum students learn most of the factual material outside of the classroom on their own time using textbooks, videos and podcasts and spend very little time sitting in a room listening to live lectures. But they'll be scheduled to

be in a classroom four days per week, from 1 PM to 5 PM, with almost all of that time spent participating in group discussions and hands on projects. The curriculum also incorporates clinical exposure from day one of medical school, and each student is paired with a primary care physician with whom they'll see patients on a regular basis.

The new curriculum is designed to provide continuity of clinical training throughout the first and second years of medical school, and this is where the space issue becomes important.

All WWAMI states except Wyoming train their first and second year students in their home states before the students go to Seattle for their third year clinical rotations, but it isn't possible to keep the second year students in Laramie right now because of a lack of space.

The Wyoming WWAMI classroom was designed in 1997 for a total of 10 students, and it doesn't meet accreditation stan-

dards for the 20 students who are currently using the space. The classroom isn't designed for the active learning that it will need to accommodate with the new curriculum, and if both the first and second year students stay in Laramie before going to Seattle then there will be 40 students using an area that was originally designed for 10.

In addition to improved classroom space the program also needs a bigger gross anatomy lab (the current lab doesn't allow for dissections, for example), more administrative office space, and a dedicated computer room as all medical school exams will now be computerized.

There are several options under consideration for new WWAMI facilities including new or remodeled space on the



The incoming class to the WWAMI program are photographed during their white coat ceremony in Laramie this August. The WWAMI program is in the process of going through changes in hopes of keeping future physicians on their local campus for the first two years of medical school.

UW campus or possibly partnering with Ivinson Hospital to relocate the WWAMI program to the hospital campus, and UW is working with an architectural consultant to help evaluate different options.

But new facilities are expensive. The University of Wyoming Board of Trustees is asking the Wyoming State Legislature for \$5.3 million in the 2016 budget for this project, and it may well be that the final price tag will be significantly more than that. It is anticipated that the Legislature will discuss WWAMI space funding during the upcoming 2016 budget session.

The timeline for the new curriculum is that the second year students will remain in Laramie starting in the fall of 2018, and in order for the new WWAMI facilities to be ready by then it's critically important that the Legislature approve the UW funding request during the 2016 budget session, and this is where you come in. The WMS will be actively lobbying on this issue, but your legislators need to hear from you about how important the WWAMI


The WWAMI program is facing a critical space issue that needs to be resolved for the program to maintain its accreditation and commitment to excellence.

program is to our state and I ask you to contact them directly about the issue. If you're not sure who to talk to or need more information please contact Sheila Bush at the WMS office.

The WWAMI program continues to successfully produce Wyoming doctors, and of the 16 Wyoming WWAMI students who finished their residency training in June 2015, nine have

returned to Wyoming and are now practicing in our communities. Four others are pursuing fellowship training which means that only three out of those sixteen have elected to not return to Wyoming. As of August 2015, there are 79 WWAMI graduates practicing in Wyoming.

It's great to have such smart and enthusiastic Wyoming students go through the WWAMI program and if

you ever have the chance to attend a White Coat Ceremony I would definitely encourage you to do so. Now we need the Wyoming Legislature to appropriate funds to modernize the WWAMI infrastructure in order to maintain this outstanding program. 



The intersection of health care and law is a puzzling place. We can help put those pieces together.

Health care is a constantly and quickly changing field, and health care law is no exception. Over 30 years, we have developed significant experience advising physicians on the impact of the myriad laws affecting their practices, and we spend a great deal of time and energy staying on top of current developments in health care law to better serve Wyoming's physicians.

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Wyoming Medical Society Looks at CME Accreditation

BY SHEILA BUSH



There are a few core competencies of medical societies that remain the same regardless of staff size, membership count, and location. We all were initially formed with the sole purpose of representing physicians and their patients in a variety of legislative and regulatory environments. Doctors wanted a voice, they wanted to come together and speak as one recognizing that when compromise could be achieved internally, the collective voice of doctors would have greater impact in any setting whether that be at the local hospital or the state Senate.

The Wyoming Medical Society (WMS) has over 110 years of being the voice of physicians in Wyoming. The strength of the WMS advocacy voice is due in part to the number of members within our organization. In order to maintain a strong membership, we strive to provide benefits to our members above and beyond advocacy. Continuing Medical Education (CME) remains an area of need for physicians across the state, with Wyoming physicians needing 60 hours of CME every three years, and an area in which WMS can play a key role.

Medical Societies have historically partnered with the Accreditation Council for Continuing Medical Education (ACCME) to ensure quality in-state CME programming is available. WMS is committed to reengaging that partnership with ACCME.

WMS was a recognized CME provider until 2008 when it became too cost prohibitive to provide the service. At that time the Colorado Medical Society (CMS) took over accrediting CME providers in the state. Wyoming had one in-state facility authorized to accredit CME programming until late 2014.

Currently, Wyoming does not have an in-state CME accreditor. The WMS Board of Trustees is intent on remedying this problem and reentering the CME accreditation space out of a sense of obligation to our members, and stewardship to the state's greater medical community to ensure the availability of quality CME programming.


WMS is encouraged by its conversations with the ACCME and is working diligently toward a new partnership design wherein multiple small state medical societies could join together to align

goals and combine resources to more affordably provide CME accreditation services.

This consortium idea was one that WMS initiated and proposed among the states and was pleased to see the warm reception of the idea both among our sister states and the ACCME.

Also, due to my lengthy conversations with the ACCME to date, they have tentatively asked me to head up a national focus group composed of my state CEO colleagues to serve as a liaison group between the state CEOs and the ACCME. Right now the ACCME is suggesting the accreditation process could be ready by April of 2016.

If the solution comes to fruition the WMS would be able to accredit hospitals for efforts such as grand rounds, and local county societies who were interested in collecting CME's for their meetings.

While advocacy remains a pillar of WMS, we continue our commitment to meeting the needs of our physicians in other aspects of their profession. CME is just one of those aspects, but one to which we are fiercely dedicated. 



If an effort to bring accreditation through the ACCME to the Wyoming Medical Society is successful, the WMS may be able to accredit facilities in Wyoming by the middle of 2016.

Sheila Bush is the Executive Director of the Wyoming Medical Society. She is available at 307-635-2424 or at sheila@wyomed.org.

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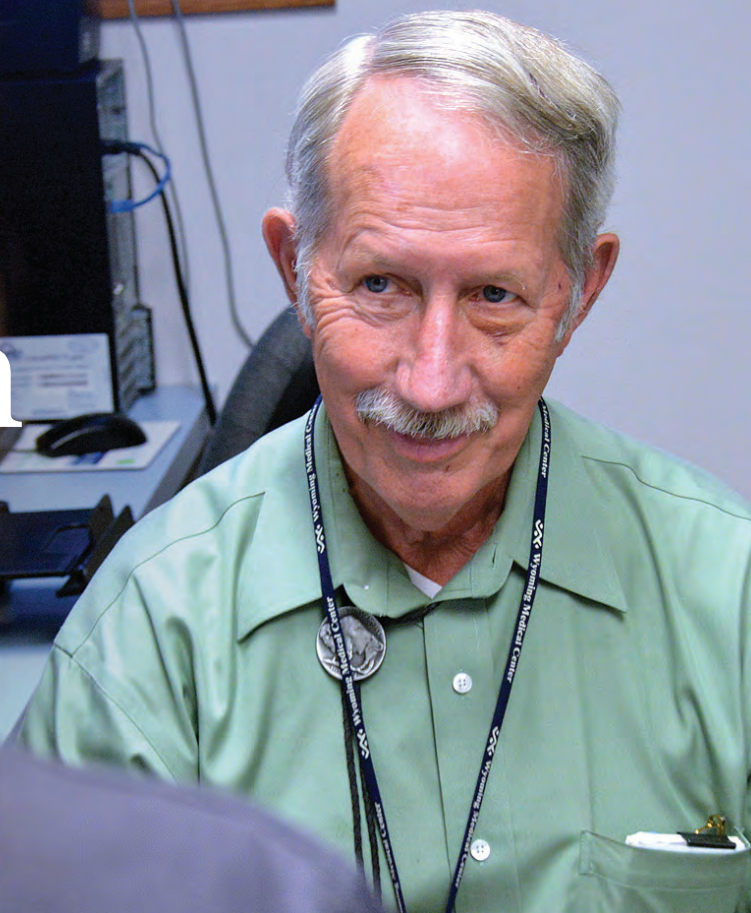
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LARAMIE, WYOMING

From Farmboy to Physician

Hiser Named 2015 WMS
Physician of The Year

BY TOM LACOCK
Wyoming Medical Society



“I’m still basically a farm boy.”

WES HISER, MD SAYS AS HE LEANS BACK IN HIS OFFICE CHAIR,
FEET EXTENDED AND LEGS CROSSED.

Here sits the Godfather of the specialty outreach clinic in Wyoming in a dress shirt and brown Ariat boots — with no embroidery to speak of - that suggest the owner places a premium on steak over sizzle.

Hiser still runs nearly 200 registered cattle on pastures around Casper and Fort Laramie. Toni Paget is the outreach clinic medical assistant in Hiser’s Douglas clinic. She says Hiser’s ranching background offers him a certain credibility in Converse County where his patients know he works as hard as they do.

“Dr. Hiser is also a rancher himself, and therefore he has a connection to his patients in a whole different way,” Paget says. “He understands them and they trust him. These folks like honesty without the candy coating.”

You would expect nothing less of the kid who grew up on the farm in Piqua, Ohio, raising hogs before attending Ohio State University, where he took a track toward becoming a veterinarian. He says before enrolling in veterinary school he needed three letters of recommendation from vets he had worked with. When he asked the three if they would do it all over again had

they the chance, two of the three said no. Hiser said they based their answers on the fact they felt they were always on-call. One suggested he become a physician instead.

That advice has yielded him a career spent doing as much for cardiopulmonary medicine in Wyoming as anyone, thanks to his willingness to travel the state and develop a network of outreach clinics. For his service to the state, Hiser has been named the 2015 Wyoming Medical Society Physician of The Year.

An unexpected career

The high school seniors of Newton Local High School in Pleasant Hill, Ohio, might have gotten it right when they voted Hiser “Most Likely to Succeed” in 1959. After medical school he joined the US Army and worked with the 5th, 7th and 10th Airborne Special Forces in Vietnam, where he completed 34 parachute jumps, half of them coming at night. While he admits he landed in trees about three times, he insists a jumper can see better during a night jump than one would think.

Hiser won a Bronze Star and the Combat Medic’s Badge for his service. Before leaving the military he decided to take



Wyoming Medical Society Physician of The Year for 2015, Wes Hiser, MD has built Wyoming Cardiopulmonary Services into a well-respected facility in Casper.

his career in a different direction — up. He applied to be an astronaut through the Army’s aerospace medicine program and Navy Flight Training Program. When the surgeon general’s office refused his application because it was mistakenly concerned that his enlistment would finish before he could complete the astronaut program, he did the flight training anyway and went to Kentucky for residency.

Hiser said his time in residency at the University of Kentucky in Lexington showed him the value of outreach clinics as he watched the school do outreach into Appalachian Mountain communities.

Building an Outreach Network

Hiser came to Casper in 1976 after considering practices in Missoula and Idaho Falls. He says at the time he

wasn’t sure Casper would be large enough to sustain a specialty business, so he made some moves to begin a network of outreach clinics. In 1977, he enticed his sister, Joan Brown, to come to Wyoming and act as his practice manager. In 1980, he used his experience in Kentucky to develop a model that would draw patients back to his office in Casper, with the first clinic set up in Newcastle. He says he hoped to set up a sophisticated clinic, and in order to do so he needed a higher patient population.

“It was a competitive edge,” Hiser says of his clinics. “Over the years there was out-migration of patients to Rapid City, Billings, Salt Lake, and Denver. In order to have a population to support a full fledged cardiac medicine program in Casper, Wyoming, the clinics would have to be a big part of it.”

“In the early 1980s he pioneered the practice of specialty outreach clinics in Wyoming. Most of his original outreach clinics are operational today and have thrived in his path.”

LANNY REIMER, MD
Newcastle Physician



Casper physician Hiser looks over records in his office on First Street in Casper.

He now has clinics in Buffalo, Gillette, Douglas, Wheatland, Lusk, Riverton, Lander, Rawlins, Thermopolis and Worland. He says he previously had clinics in Sundance, Newcastle and Sheridan as well. He now has seven partners, as well as three physician assistants or nurse practitioners. He estimates 60 percent of his patient load comes from the outreach clinics.

“In the early 1980s he pioneered the practice of specialty outreach clinics in Wyoming. Most of his original outreach clinics are operational today and have thrived in his path,” Newcastle physician Lanny Reimer says. “Wes is the family doctors’ specialist and generalist. Every patient’s workup is complete, and he addresses their cardiopulmonary problems as well as he identifies and considers their general medical problems like

no other specialist.”

Reimer nominated Hiser for the Physician of the Year award, pointing out Hiser taught physicians in Newcastle how to do intravenous thrombolysis to treat acute myocardial infarction before the procedure was available in surrounding major hospitals.

Nicholas Stamato, MD also nominated Hiser for the Physician of The Year award. Stamato writes, “His role in the care of patients reaches nearly every corner of Wyoming. Hiser was the driving force in the growth of Wyoming Cardiopulmonary, P.C. and of the cardiac program at the Wyoming Medical Center.”

Hiser says he received notification of his winning the award from longtime friend and colleague Marion Smith, MD of Torrington. In addition

“I feel my career has been very rewarding. We can go in and help people who have had heart attacks and other issues and improve their lives and their function. That has been very rewarding.”

WES HISER, MD
2015 WMS Physician of The Year



Wes Hiser, MD came to Wyoming after growing up a farm kid in Ohio and nearly became a veterinarian. Hiser was named the 2015 Wyoming Physician of The Year by the Wyoming Medical Society.

to being a member of the WMS Board of Directors, Smith was also a student of Hiser's at one point.

The résumé remains impressive and includes fellowships at the University of Colorado and The University of Colorado Medical Center. He is board certified by the American Board of Internal Medicine. Hiser was adjunct faculty at the Lincoln Memorial University's DeBusk College of Osteopathic Medicine, as well as a clinical associate professor of internal medicine at the University of Utah. He has been named to the board of Wyoming Medical Center as well as a part of the Governor's Task Force for Emergency Services.

He says he still likes to fix things (his daughter once surmised his work was akin to a plumber for the heart) and although the all-nighter on top of an all-day rotation is getting a little harder, he still handles it all right. At the end of the day, he is proud of his place in Wyoming medicine and has no interest in slowing down.

"I think we developed a very good program from the time we got out here when medicine was not very sophisticated," he says. "I feel my career has been very rewarding. We can go in and help people who have had heart attacks and other issues and improve their lives and their function. That has been very rewarding."

When he isn't on the road to a clinic or in the office Hiser spends much of his time at the ranch or with his cattle near Fort Laramie. He has six children and a stepson, the youngest of which starts at Kelly Walsh High School in Casper this year — the only not to attend Natrona County High. He also has a nephew who comes out in the summers to help with the ranch. Hiser calls him a "good hand," though it is clear he isn't about to leave all the fun to the young guy.

"I think of myself as a cardiologist/rancher." 



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The Changing Face of Primary Care in Wyoming

Patient Centered Medical Homes Coming to the Forefront of Primary Care

BY TOM LACOCK
Wyoming Medical Society



James Bush, MD, is the Medicaid Medical Director for the State of Wyoming, which has begun its own PCMH program for Wyoming physicians.

While the concept isn't new, the high profile afforded to Patient Centered Medical Homes (PCMH) by the Affordable Care Act is. PCMHs are being embraced by practices that say they have done this work for years, as well as public payers. However, they hope to be paid for their efforts through third party recognition.

The concept has its detractors as physicians and practices say the process could be ironed out, and private payers still seem undecided on an exact formula to reimburse practices willing to make the leap to become a PCMH. However, the theory that maintaining a medical home helps keep costs down for patients and payers alike seems universally agreed upon.

"To the extent that the PCMH is able to coordinate the care for our members, it should improve the quality of care, accessibility of care for our members and may improve the costs associated with providing care to our members," says WINhealth CEO Stephen Goldstone.

What is a PCMH?

The National Committee for Quality Assurance (NCQA) is a non-profit dedicated to improving health care. It is also one of the leading organizations in the certification of PCMH's. It defines the PCMH as a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." It claims medical homes lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

The Agency for Healthcare Research and Quality (AHRQ), a division of the US Health and Human Services Department, defines a medical home not simply as a place but as a model

of the organization of primary care that delivers the core functions of primary health care. The medical home encompasses five functions and attributes:

- comprehensive care (accountable for meeting the majority of a patient's physical and mental health needs, including chronic care and wellness);
- patient centered (relationship-based care with an orientation on the whole person);
- coordinated care (medical home coordinates care across all specialists, and hospitals), accessible services (open scheduling, enhanced in-person hours) and;
- quality and safety (evidence-based medicine and clinical decision support tools).

The concept suggests using a PCMH will result in less duplication of services and an emphasis on getting patients to the appropriate setting for their care. On its website, NCQA has a list of studies that supports the theory. NCQA has a list of studies on their webpage which support the theory. One 2012 study said PCMH-treated adults and children had 12 percent and 23 percent lower odds of hospitalization, respectively, and required 11 percent and 17 percent fewer emergency department services, respectively, than non-PCMH patients.

"PCMH is not a new model," says Phyllis Sherard, PhD., of the Wyoming Institute for Population Health (Institute). "It was created in the 60's by the AAP as a best practice for pediatric care. The model is still used in pediatrics, but it has been slow to spread."

The PCMH model organizes workflows so everyone in a clinic works to the top level of their license, meaning nurses aren't



“To the extent that the PCMH is able to coordinate the care for our members, it should improve the quality of care, accessibility of care for our members and may improve the costs associated with providing care to our members.”

STEPHEN GOLDSTONE
WINhealth CEO

taking phone calls and physicians see patients. Terry Johnson, the practice manager for Babson and Associates in Cheyenne, said this requires more accountability by those in the clinic, but also makes workflow go smoother. He says Babson and Associates achieved Level III PCMH status in July of 2013 after starting the process in 2011 with facilitation supported by Cheyenne Regional and the Southeast Wyoming Preferred Provider Network. He said the PCMH model meant changes to the day-to-day duties of everyone in the office, which have been for the better. The clinic also promptly advertised their NCQA recognition and can claim the well-deserved “bragging rights” in their marketing materials.

“The restructuring of work flows and load has greatly improved the speed that care is delivered in our clinic,” he says. “The clinic is real-time with appointments; referrals and prescription refills. When the patients leave the clinic, office notes are signed off, referrals are completed, supporting notes are already sent and labs/x-rays are received and reviewed with the patients. We finish today’s work today and allow our providers and staff to have better quality of life when they go home.”

How to achieve PCMH status

According to Greg O’Barr, Director of Business Development for the Institute for Population Health, the \$14.2 million Healthcare Innovation Award the Institute received was dedicated to expanding medical neighborhoods across Wyoming. Part of that effort involved helping practices to become PCMH’s. Since 2012 it has helped 27 Wyoming clinics (representing 50 percent of primary care providers) attain a level of PCMH status, working through the nearly 168 areas where

documentation is needed for NCQA recognition. O’Barr said the Institute offered PMCH transformation coaches, as well as gap assessments and modules to work with practices. Certainly, O’Barr says, clinics can go online to walk through the process on their own, but he believes working through the Institute of Population Health can shave 15-20 months off the PCMH application period. Highly motivated clinics can achieve PCMH recognition in as little as 18 months, but 24 months is more realistic. While the Innovation Award ended June 30, 2015, the Institute is in the process of developing a pricing structure to enable them to continue to provide transformation assistance to the remaining 50 percent of primary care providers.

Maintaining any help available will be important to the future of PCMH in Wyoming as the process is lengthy. Johnson says among the practice community, the PCMH is known as the “paper centered medical home” because of the onerous process for accreditation. He says clinics seeking the classification can expect to provide evidence that they have implemented every requirement of a PCMH in order to secure recognition by the NCQA. He adds that any clinic attempting to attain PCMH status should prepare to have their every process dissected by NCQA.

Tonya Bartholomew, clinic manager for the Platte Valley Medical Clinic in Saratoga, says it took her 12-18 months to complete the NCQA application, which included uploading around 150 documents to support the application. She credited the community medical foundation in Saratoga for providing funds to hire a patient care coordinator at the clinic to perform care management, which she called the meat of the PCMH model. Even with help from the Institute of Population Health,



The Changing Face of Primary Care in Wyoming

there were challenges such as a lack of a clinic coach to extract documentation from the clinic’s EMR. Wyoming’s failure to develop and launch a statewide Health Information Exchange actually cost the clinic points towards its PCMH certification.

Goldstone says WINhealth has also gone through NCQA certification process, and while he considers NCQA certification a good validation measure, he agrees it is arduous and would like to see the process change its focus.

“These processes tend to be process-oriented - do you have a process in place for doing this or that?” he says. “For all of our benefit we need to become more outcome-oriented. Are we improving the patient population health we serve? Are we making healthcare affordable? We can’t keep adding costs on top of costs unless there is some benefit on the other end.”

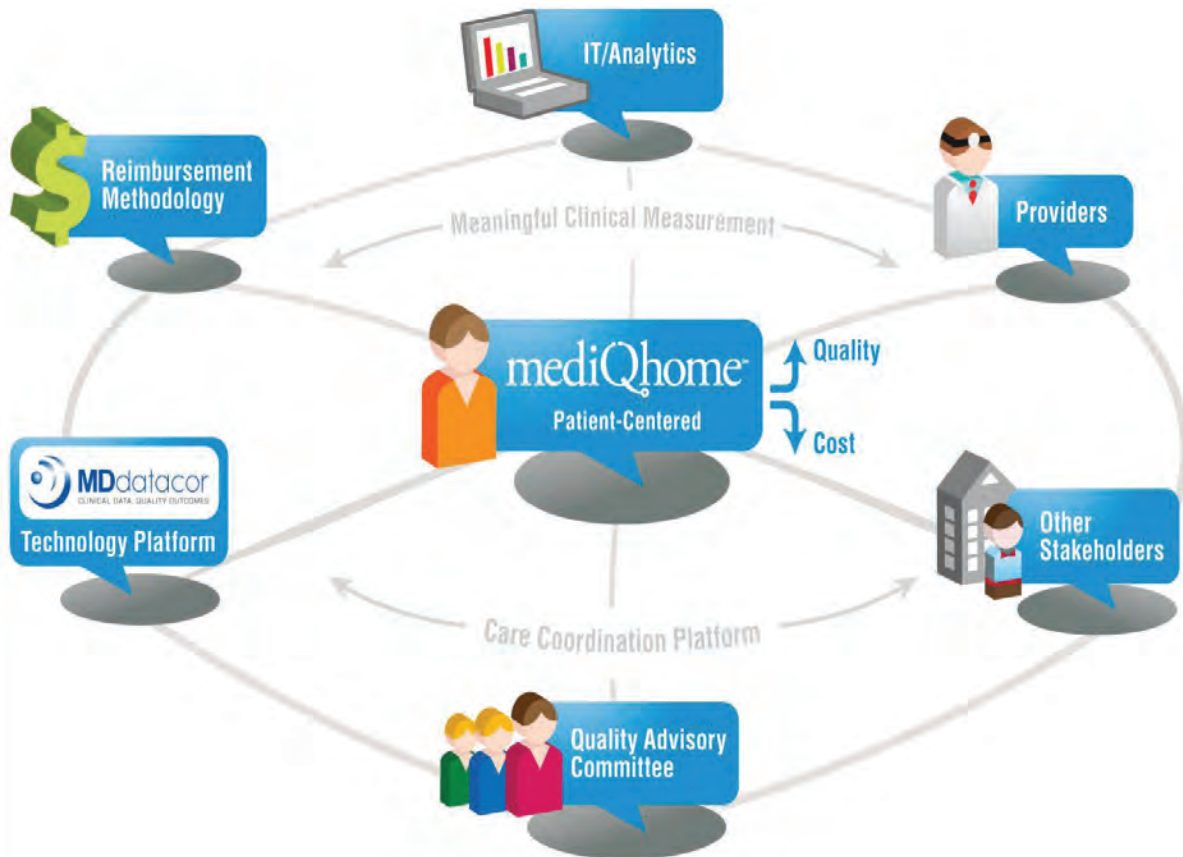
The Public Payer’s Perspective

James Bush, MD, Medicaid Medical Director for the State of Wyoming, helped develop a PCMH program for the state’s Medicaid program. He says for a physician or practice in Wyo-

ming to enroll in the Medicaid PCMH program, they must sign a survey put out by the NCQA, pull continuity of care documents on at least 50 percent of the Medicaid patients they see in a month, and at least once a quarter submit clinical measures into a state level registry. Bush says the measures are the same being used for meaningful use, in hopes of not duplicating efforts where possible.

The payoff for practices participating in the state’s Medicaid program is a \$3 payment per Medicaid patient per month whether the client has been seen that month or not. Bush says that number will likely increase as the program matures, as he expects the high-performing practices to receive \$6 per patient per month in year two of the program, pointing out it is important to reward physician practices for improved care. Bush said the program rolled out in January 2015 and has four practices onboard with 29 others now eligible and going through some level of NCQA accreditation.

Bush says the metrics Medicaid is receiving are helping them to suggest prevention screenings to physicians. Based on the



Blue Cross Blue Shield has rolled out its MediQHome Program in Wyoming and offered this graphic to explain its process.



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The Changing Face of Primary Care in Wyoming

numbers Medicaid has received through PopHealth, 8,709 of 9,993 adults in Medicaid have received their tobacco use screening and intervention in the first quarter.

“I think the biggest thing we will be able to see is they will be able to track quality over time,” Bush says. “We were tasked with coming up with a system for value-based purchasing and rewarding quality medicine versus quantity medicine. You are being paid more for better care. That is very, very exciting and rewarding.”

The private payer perspective

Bartholomew said when her clinic was first approached about being a PCMH by the now defunct Wyoming Integrated Care Network in 2012, the pitch was simple - it is the right way to take care of patients and there would be an attempt to get payers to the table to discuss increased reimbursement to clinics who became PCMH's. The Institute agreed to take on that role, which Bartholomew said was still a work in progress.

Currently, WINHealth offers a per-member-per-month payment for patient management. WINhealth CEO Stephen Goldstone said he remembers discussing a system for compensation in 2013 with the Platte Valley Medical Clinic over dinner in Saratoga, roughing out a compensation plan on the back of an envelope. He said his company receives data from clinics such as Platte Valley in hopes of impacting changes in population health. However, he said WINhealth isn't seeing much in the way of cost savings yet.

“At the end of the day, what will these do to improve the health of the population they serve?” Goldstone asks. “Just to add a patient management for a fee-for-service we already pay is adding to our costs, and we aren't seeing the offsetting reduction.”

Dana Pepper manages population health and wellness at WINhealth and says the company wants to see data (through

the PCMHs) on where clients seek primary health care, the better to make sure it is the appropriate avenue and, by extension, the least costly to WINhealth. She adds that practices, patients and insurance companies can all make positive changes with the appropriate data.

Blue Cross Blue Shield also pays on a per-member/per-quarter basis to physicians and clinics that are either NCQA-certified as a PCMH or those that take part in Blue Cross' version of a PCMH, the MedicQHome program. According to Wendy Curran, the vice president of care delivery and communication, MedicQHome offers physicians the use of its MDInsight computer software, which reports patient data to both Blue Cross (for Blue Cross clients) and the clinic enrolled in the MedicQHome (for all patients).

Curran says MDInsight helps physicians understand which of their patients would benefit from things like screenings and other preventative measures. Curran said the MDInsight tool also acts as a population management tool for NCQA certification and earns providers points toward that end. Curran also said many of their larger

groups and self-employed clients are looking for ways to keep their employees healthier and have gravitated to the data the MedicQHome program provides.

“We think it is a good thing,” Curran says of PCMHs. “It incentivizes providers, and helps to coordinate care. It starts to move us away from fee-for-service payment system and towards something that rewards the providers who reward outcomes and quality measures. We believe the end result is potentially cost savings for us and our members.”

While Blue Cross Blue Shield pays PCMHs whether they are part of the MedicQHome or an accredited PCMH, she said her organization's clinical advisory group has discussed an interest in incentivizing further the clinics which have become accredited through NCQA and that is something that may happen in

“People aren't falling through the cracks. There are communications systems and people are held accountable for their responsibilities. The processes are in place and it is understood who needs to do what. We are better advocates to our patients. They appreciate the level of care we are offering them.”

TONYA BARTHOLOMEW
Clinic Manager Platte Valley Medical Clinic, Saratoga



the near future.

Kris Urbanek of Blue Cross Blue Shield’s Provider Services said once they receive enough statistics, his firm might use the data to increase patient education in a specific medical issue, or offer additional resources to tackle the issue past care management. He said the hope for Blue Cross is to set the bar for compensation of clinics high enough to offer an incentive to participate and yet not too low that it won’t modify behavior within the clinics.


What’s next

Sherard says there are advantages beyond just patient care to a PCMH. She points out that patients are becoming more discerning consumers of health care as their insurance plans ask them to pay higher deductibles. The PCMHs focus on wellness and prevention should appeal to those trying to keep themselves healthy and out of the doctor’s office. She also thought younger physicians might find working in a PCMH more attractive due to the physician-led multidisciplinary team approach to care, which offers them more time for work-life balance, and has the added advantage of helping to mitigate the physician recruitment and retention challenges Wyoming continues to face.

“Younger providers are reluctant to be on call 24-7,” Sherard says. “They want a balance in their family and work life and take as many call as they want to. They are looking for a practice that has a care team that can help carry some of the low-risk patient load, allowing physicians to see the highest-risk patients.”

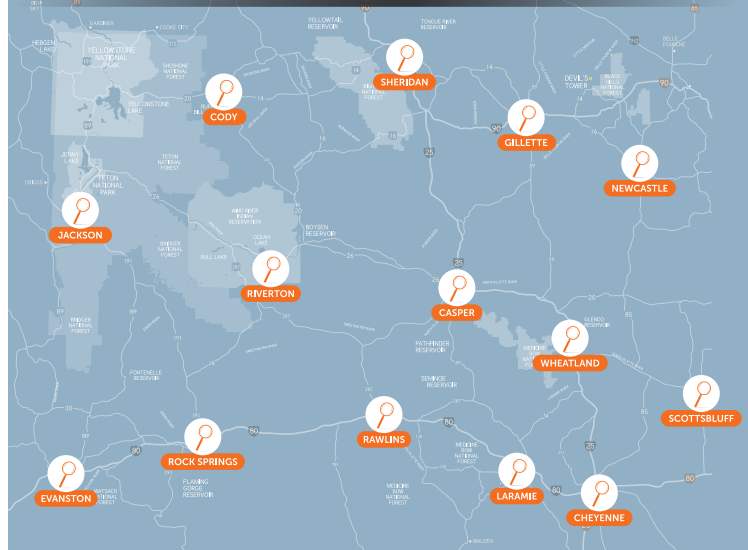
While there are issues with the process, it is hard to find someone who doesn’t agree with the basic tenets of PCMH – give the patient one central place to receive their health care and have that place communicate with any other providers to coordinate care for that patient going forward.

“It is the right thing to do for the physicians, the clinics, and the patients,” Bartholomew says. “People aren’t falling through the cracks. There are communications systems and people are held accountable for their responsibilities. The processes are in place and it is understood who needs to do what. We are better advocates to our patients. They appreciate the level of care we are offering them.”

“The clinic was built on the some of the main core components of PCMH: superior access to care, providing individualized care, promoting wellness and chronic disease management with the assistance of interdisciplinary teams,” Johnson says. 

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The Changing Face of Primary Care in Wyoming

Direct Primary Care Begins to Take Hold in Wyoming

BY TOM LACOCK
Wyoming Medical Society

Kristina Behringer, MD shows off her new Direct Primary Care clinic in Cheyenne, Grasslands Medicine. Direct Primary Care is catching on as a new philosophy where patients pay physicians direct instead of billing insurance through a subscription or membership model. In exchange, physicians do not cap the number of times a patient sees them over the course of a month.

In an industry so dominated by insurance companies, a form of primary care without insurance administration is beginning to gain popularity as two more physicians have recently opened Direct Primary Care (DPC) practices in Wyoming.

DPC is a model of healthcare that has patients pay a physician directly and receive services with both parties agreeing not to bill insurance. Contracts allow patients to see physicians as often as they want or need to, and physicians receive the service by subscription in some cases and ala carte in others.

What sort of physician is attracted to DPC?

Hint Health is a Membership Management and Billing Platform for Direct Care, Direct Primary Care and Concierge Medicine Providers based in the Bay Area. Michael Lubin is the vice president of sales and marketing for Hint and says most DPC

physicians fit a similar profile. He says Hint's primary clients have hit a wall practicing in the insurance-based fee-for-service world. He adds Hint's clients try to improve their quality of life and get away from feeling like they are working for insurance companies instead of the patient.

That might describe the dean of DPC in Wyoming, Grace Gosar, MD. The Buffalo physician practiced in Marbleton, Powell and Buffalo in traditional family practice settings before she broke away two years ago to start her own DPC practice. She says she felt she spent most of her day faxing and making requests to a third-party payer for permission on behalf of her clients. It was a wall she couldn't overcome — and a system she decided she wouldn't be a part of.

"One day I decided this is not right, I am not going to do it anymore and I am lending my energies to something I disagree with," Gosar says.

Kristina Behringer, MD hung out her DPC shingle this May in Cheyenne, leaving the Cheyenne Regional Medical Center. She says her practice, Grasslands Medicine, came about through a level of frustration over time being dictated by quotas of patients seen or the requirements of health insurance companies. She says there is less stress and points out she is “just a doctor” now instead of worrying about billing codes and how many minutes she can devote to a patient.

“I am very happy because the stress is gone,” she says. “It is a different type of stress because I am running a business, but as far as the medicine I am practicing, it is much more gratifying professionally. What we do is about relationships with people. This allows us to do that.”

“If this were about money, I could have stayed at what I was doing,” said Mike Tracy, MD who recently opened a DPC practice. “I am turning 50 in a couple weeks. If you look at demographics



Mike Tracy, MD (left) and Bob Chandler, MD go over their day prior to seeing patients last month in Powell. Tracy and Chandler recently opened 307Health in Powell.

of primary care physicians, there are a lot of people in the age range of 50-65 thinking about doing something different.”

Research by Direct Primary Care Journal shows 60 percent of DPC physicians report the size of their patient panels were less than 300. Eighty percent of those in the DPC business are family physicians and more than 80 percent of DPC physicians operate in a solo practice. Among the other 20 percent is 307Health in Powell, where Tracy and Bob Chandler, MD opened their new facility at the end of July.

Tracy is coming off 13 years working at Powell Valley Healthcare and said he and Chandler expect to offer their new patients their cell phone as the main form of contact with their physician.

“If you are a patient in my new practice, instead of having an office phone number that will yield you several hurdles clinically, every patient just has my cell phone as the primary means of communication,” Tracy said. “This way the patient and I can decide together if they need to come in for a visit or if they don’t need to come in for a visit.”



Powell’s Mike Tracy, MD opened 307Health, along with Bob Chandler, MD in July. Tracy said he likes the transparency of pricing that comes with the Direct Primary Care model, as well as the opportunity to forge strong relationships, which is made possible by DPC.



The Changing Face of Primary Care in Wyoming

Payment model

There appear to be two common models in DPC - subscription based and ala carte. Direct Primary Care Journal's survey of DPC practitioners suggested that 68 percent of fees inside most DPC practices cost between \$25 and \$85 per month. Behringer and 307Health will each use a model that allows patients to see their physician an unlimited number of times in exchange for a monthly fee. Gosar said she used to charge \$60 for 20 minutes and \$120 for more than 20 minutes. She adds that she issued an invoice the client could submit to insurance. She says some did, particularly for preventative and wellness services mandated by the ACA. However, submission of claims wasn't always an easy venture.

"If a client filed with insurance or Medicare, they engaged the same tedious system, and many had some small understanding of how the third parties behave and why a person can go mad constantly dealing with them," says Gosar.

Some DPCs require one-year contracts. Direct Primary Care Journal's survey of DPC providers suggests 53 percent of DPC offices require cash/debit/credit card payments only. Tracy says his shop will have a monthly membership model as they believe it will allow for better relationship building. Tracy says part of the reason for his interest in leaving traditional primary care is a lack of pricing transparency. He also hopes to convince payers to recognize virtual visits whether it be via phone or online.

"I think medicine lacks transparency in terms of its pricing structure," Tracy said. "Restaurants post their menus and customers make decisions based on their prices and I think medicine has

fought that in some ways because medicine feels like we need to take care of people no matter the cost."

For Behringer, the decision to go with a monthly cost has to do with her interest in working with patients who would like to be seen for chronic issue such as diabetes or weight management and the pricing model that includes unlimited visits per month allows for a deeper conversation.

"We are now discussing lifestyle and how to follow a plan and takes time and it takes dialog and I never had that before."

What sort of patient is attracted to DPC

According to Direct Primary Care Journal, there are some similar characteristics of DPC patients. The industry tends to attract its clients through low monthly fees - generally millennials and generation Xers.

Gosar said she believes the market for DPC is still being defined, but from her experience in Buffalo, she said social networks and younger users of her service tended to gravitate to the ability to make same-day appointments online and pay for services rather than force them to purchase insurance, or in some cases, notify their parent's insurance. Gosar said it took her a little over a year to accumulate nearly 600 patients.

"In a college town like Laramie, my client would be someone under 30 whose home base for care may be wherever they come from," Gosar says. "They would use this for online scheduling, ease of access and predictability of cost. I would save that person a ton of hassle and money, and they would get in to see me, likely within 24 hours."

Perhaps few research the concept of DPC as intensely as Philip Eskew, MD. He has put together DPC Frontier, a



“But right now with Medicaid, clients are accessing the highest-price care (ER) with the least continuity and preventative management attached to it.”

GRACE GOSAR, MD
Buffalo, Wyoming

website he hopes will be a resource for those looking into DPC. Eskew has recently finished his final year of family medicine residency at the Heart of Lancaster, a practice in Pennsylvania. Before medical school, Eskew was an attorney and has used his education to advise state and federal lawmakers on DPC, as well as sitting on the steering committee of the Direct Primary Care Coalition.

He says DPC appeals to the price-conscious and pointed out the toughest patients to attract to the DPC model are well-insured with no copays and no deductible. He adds that with the Cadillac Tax implementation coming up, he sees this as a shrinking group.

“DPC physicians negotiate cash prices for MRIs, CTs, specialty visits, etc.” Eskew says. “But if it is more cost effective for the patient to use his insurance policy for these referrals, then that is what will be done. Typically the DPC fees do not count toward the patient’s deductible since no insurance claims are filed, but usually the DPC fees are so low this does not make much difference.”

Gosar believes DPC may be one alternative to the state’s efforts to grapple with uncompensated care and Medicaid expansion. Gosar said setting up five DPC clinics around the state and offering a public-private partnership with physicians to see what would otherwise be a Medicaid patient at a negotiated price would save the state money and add to the state’s payroll while also allowing lawmakers the ability to put forth a solution that is Wyoming-specific.

“They could spend a lot less than the \$10 million than they spent for hospital uncompensated care last year,” Gosar said. “Logistically, it isn’t even hard. But right now with Medicaid, clients are accessing the highest-price care (ER) with the least continuity and preventative management attached to it.”

What’s Next for DPC physicians in Wyoming?

As the state grapples with a new form of primary care in DPC, there are several questions from a legislative standpoint (see Healy column) that will be worked out with the help of the WMS.

On a national level the Direct Primary Care Coalition has two key components to its legislative agenda. The first is to ensure a pathway for Medicare and Medicaid to pay doctors using the DPC model in the same way another payer working with an employer or a private payer would. Currently, Medicare does not have a way to pay the fee. The other component of the DPC agenda is making it easier to use HSA with DPC.


Tracy and Chandler have gone from physicians to interior

decorators as they open their new facility in Powell. Gosar has recently shuttered her practice as she is receiving treatments for cancer.

“One weakness in this model is that the solo provider has to remain well,” Gosar said. “I got sick and that’s kind of ironic.”

Meanwhile, Eskew has completed his residency and will open his own DPC clinic in Cheyenne later this summer. As he gets his clientele built up he is working with correctional medicine in Torrington.

Behringer’s traffic through the office is picking up, but for a new provider the stress of purchasing everything from tongue depressors to medical malpractice insurance — as well as acting as your own medical assistant — is new.

“There is something sort of easy about pulling up, walking in and your patient is roomed for you,” she said. “You just have to do your thing and walk in and walk out. But there again, I don’t think I could ever go back to that because I don’t have the pressures anymore. I do have pressure in running the business, though.” 

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The Changing Face of Primary Care in Wyoming

Pharmacy Takes on a New Feel

BY TOM LACOCK

Wyoming Medical Society

Those being treated after normal business hours in the emergency department at West Park Hospital in Cody no longer must wait until morning to get prescriptions filled. The facility has installed an InstyMed prescription vending machine just outside of its ED. The machine was placed there in an attempt to allow ED patients access to a number of medications when a pharmacy wasn't available.

Hospital leadership says the machine stocks pain medications, as well as antibiotics and albuterol inhalers. They suggest it gets used fewer than 10 times per month presently.

"It is considered a service," says Doug Wenke, West Park's Director of Pharmacy. "We don't do very much volume out of it. The few items that are in there are the ones we designated as most likely to use. There is at least a 72 hour supply of most medicines to get patients to a point where they can get to a retail pharmacy."

Bob Bang, InstyMed's Vice President of Client Operations, says the machine in Cody is the only one of his company's 200 dispensers in the state and he expects West Park to eventually open its dispenser to include over-the-counter medicines such as Tylenol. He adds that prescription compliance is a strength of his firm's machines, placing the national average of patients who fill a prescription around 70 percent. He claims those who receive a prescription through an InstyMed machine is closer to 90 percent.

Mary Walker, the Executive Director of the Wyoming State Board of Pharmacy, said her group has no statutory authority over the InstyMeds Machines. She says she is aware of four machines that have been in Wyoming, including one in the emergency department at Torrington, the machine in Cody, and machines that have been removed from Meeteetse and Baggs.

While they were not required to, Walker said the Board of Pharmacy did meet with West Park and the Torrington Community Hospital regarding their machines. She says the board had questions regarding how records were kept, how medications would be labeled and who would check for outdated medication. She adds there have been no reports of safety concerns of the machines to the board.

The machine's presence in Cody also keeps the hospital from dispensing prescription medications to patients as they are discharged from West Park. The machines are loaded like a newspaper box with pre-packaged medication in bottles. Menke says each day West Park receives a report on what needs to be refilled and




InstyMed sends a new package of medication to be inserted into the machine with bar-coded medication.

Providers who prescribe medication that can be retrieved from the vending machine can do so through an online interface in the ED and transmit a prescription to the machine, along with patient insurance information. The physician also hands a voucher to the patient which features a code on it with the medicine. The patient enters the code into the machine for verification that it is the correct patient. If the transaction requires a copay, patients can use a credit card reader on the machine and can do a pharmacist consult through the system, should they decide it is necessary. The machine prints labels and attaches it to the medication bottle before dispensing.

Wenke says West Park actually leased two machines and had placed one machine at an outreach clinic in Meeteetse, which was staffed by Banner Health. Wenke says the machine was stocked with medication that was commonly prescribed by the on-site physician. He added that usage of the machine was little and it didn't warrant keeping the machine there.

Anne Burns is the Vice President for Professional Affairs for the American Pharmacists Association and says her organization is watching the increase of dispensers and vending machines closely.

"In general, we support automation when it doesn't disrupt the relationship the pharmacist has with the patient for things like questions about the medications," she said. "We do have policy that any automation that is used in dispensing process or in general should be under control of the pharmacist and we have questions to make sure the pharmacist is available to the patient." 



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The Changing Face of Primary Care in Wyoming

The Shortest Distance Between Physicians and Patients

The Legal Perspective of Direct Primary Care

BY NICK HEALEY

Dray, Dyekman, Reed & Healey, P.C.

Direct: going the shortest distance from one place to another; going straight without turning or stopping. Many Wyoming physicians strive to practice as “directly,” as possible – providing patient care in the most efficient, “shortest,” way possible, without being “turned,” or “stopped,” by third party payer pressures (eg. commercial health insurers, governmental payors, HMO’s, third party administrators of self-insured employer plans).

Increasingly Wyoming primary care physicians are evaluating whether DPC practices (sometimes called “concierge,” or “retainer,” practice), can help them reduce these perceived third-party payer pressures.

DPC models offer flexibility

DPC practices can resemble a “traditional” physician practice—the patient pays the physician directly for services provided. Retainer model DPC practices can coexist with traditional commercial insurance, with practices charging a retainer fee for inclusion in the practice, but also billing insurers for services outside of the scope of the retainer agreement. Most DPC practices encourage patients to obtain “wrap-around,” insurance coverage covering services not covered by the DPC practice (such as specialty services) and/or catastrophic events (e.g. hospital stays). It is important to note that membership in a DPC practice, on its own, may not be considered “health insurance,” for purposes of meeting the federal Affordable Care Act’s insurance mandates. However, the ACA does permit a DPC practice plan, coupled with a complementary insurance plan covering non-primary care services, to meet the mandate’s requirements under some circumstances, and may be offered on exchanges on the same footing as traditional health insurance plans.

Co-existing with Medicare may prove difficult for a retainer model DPC practice. In 2004, the US Department of Health and Human Services, Office of Inspector General (OIG), is-

sued a special alert warning Medicare-participating physicians about charging patients extra for items and services the OIG considered covered by the Medicare payment for other services. The OIG cited enforcement action it had taken against a retainer-model practice that charged a \$600 annual fee for coordination of care with other providers, a comprehensive assessment and plan for optimum health, and “extra time” spent on patient care. The OIG alleged the physician had violated his Medicare assignment agreement by charging the Medicare beneficiaries extra for Medicare-covered services. However, the OIG did not specify which of these extra services were covered by Medicare, or identify any other Medicare-reimbursable services for which payment already covered some or all of these services. This leaves physicians with no guidance as to what Medicare truly covers, and what violates the physician’s Medicare assignment agreement. For physicians seeking to include Medicare patients in a retainer-model DPC practice, opting out of Medicare may be the only option.

DPC as “health insurance” under Wyoming law.

One of the primary challenges retainer model DPC practices face in Wyoming is potentially being considered “health insurance,” under the Wyoming Insurance Code, subjecting the practice to regulation as an “insurer,” by the Wyoming Insurance Commissioner. While the Wyoming Insurance Commissioner has not formally stated that he considers retainer model DPC practices “insurance,” states such as Washington and New Jersey have aggressively discouraged direct primary care or “retainer,” medical practices by considering them “insurance.” Washington, for example, has required DPC practice to certify that they are financially prepared to deal with the “risks,” of the practice. Similarly, West Virginia’s Insurance Commissioner determined that a physician providing care for a flat fee was operating as an unlicensed insurer.

A retainer model DPC practice may fit the Wyoming Insurance Code's general definition of "insurance," which is "a contract in which one undertakes to...pay or allow a specified amount or determinable benefit in connection with ascertainable risk contingencies." A retainer model DPC practice, may fit into this definition - a determinable benefit (the medical services package) in connection with ascertainable risk contingencies (whether the services are actually used and in what amount) on both sides. More specifically, a retainer model DPC practice fits the Code's definition of a "prepaid health services plan", a subset of "insurance" under which:

Any corporation which establishes, maintains or operates prepaid hospital medical-surgical or other service plans or combination thereof, in which hospital, medical-surgical or other health service may provide to its members or subscribers by hospitals or physicians with which the corporation has contracted for that purpose, is transacting insurance and subject to regulations and taxation as an insurer under this code.

In a retainer model, the practice could be considered "establishing, maintaining and operating" a "plan" by which it provides "health services" to its "members or subscribers", with the practice's physicians contracted with the practice to provide services. As of the date of this article, draft legislation is being considered by the Wyoming Legislature's interim Joint Labor, Health and Social Services Committee to accept health care providers providing routine health care services" under a "retainer agreement" from the definition of "prepaid health service plan" If that draft legislation is enacted, it could help Wyoming retainer model DPC practices avoid regulation as "insurers".

Retainer model DPC practices can be structured to avoid regulation as "insurance"

Wyoming physicians can structure retainer model DPC practices to avoid regulation as "insurance," by following guidelines provided by other states' insurance regulators. Maryland's Insurance Administration (MIA) has provided guidance to direct primary care providers to avoid those practices being considered unlicensed "insurance", suggesting that DPC practices

implement (some or all of) the following measures:

- Annual Evaluation Model. The annual fee of the retainer practice does not exceed the market value of the services included in the annual physical exam. Should the annual fee be in excess of the market value of the services included in the annual physical exam, the fee may approach a capitation payment, triggering a finding that the retainer practice is engage in the business of insurance.
- Limited scope of services. Limiting the services

provided in the year for an annual fee to an annual physical exam, a follow-up office visit and a limiting number of other office visits;

- Defining the services to be provided in a written agreement, so that the scope of services to be provided is not unlimited;


- Allowing the consumer or the physician

to terminate the retainer agreement for any reason and provide for the pro rate reimbursement of the retainer fee if the written agreement is terminated;

- Placing a cap on the number of patients a practice can sign up based on the physician's ability to provide all the services specified in the written agreement to each patient on the panel.

The key to these guidelines is that the provider's liability for providing services is not unlimited; the provider does not, therefore, bear the entire risk of "loss" and it is not necessary or the provider to meet the reserve and licensure requirements for insurers. In combination with the "company-operated exception", these measures could cover the whole range of direct-primary care services a Wyoming DPC practice provides.

Conclusion

Several states have created specific exceptions for DPC practices to the definition of "insurance," allowing the services to be provided without regulation as insurance, and Wyoming may follow. For now, Wyoming physicians wishing to set up retainer-model DPC practices should follow other states' guidelines to avoid being regulated as "insurance." 

One of the primary challenges retainer model DPC practices face in Wyoming is potentially being considered "health insurance..."

Determining The Eligibility

Disability Determination Services Reaches out to Physicians

BY TOM LACOCK
Wyoming Medical Society



Robert Kanard, MD looks over a file with Tara Ackerman, a caseworker with Wyoming Disability Determination Services (DDS). Kanard is a retired physician from Cheyenne who lends his expertise to DDS to help the organization to make determinations on who should receive disability payments from the Social Security Administration.

Given the sheer number of cases put in front of them in a year, you have to wonder when the staff at Disability Determination Services (DDS) finds time to sleep.

The organization is in charge of determining the eligibility of Wyoming residents who apply for social security benefits because of a physical disability. The organization averages 3,500-4,000 initial claims a year, in addition to another 500-700 case reviews to determine whether someone on disability should have those benefits continue. DDS makes these assessments with a staff of 17.

“The consultants here really care about the mission,” says James Hruby, a Medical Relations Officer with DDS. “When it comes down to it, our employees, our consultants — everyone here cares about the clients. We can’t always make a favorable decision, but they deserve a quality decision.”

DDS makes its decisions through a system that puts a premium on the opinions of physicians making examinations and offering their opinions on those exams. For that reason DDS seeks a greater relationship with the state’s physicians in hopes of finding more physicians interested in doing physical exams for DDS.

Hruby says DDS will set up an appointment with a qualified physician for anyone who has applied for social security because of a disability. Then, a physician is asked to submit a report based on any existing template the physician already uses for an office visit. All x-rays, stress tests and other information DDS can receive from the physician then goes into the DDS’ ruling on disability eligibility.

Jeff Graham has been in the field of vocational education for 21 years and is the deputy administrator for DDS. He said his organization seeks the opinion of physicians on the patient’s functionality, such as how a client bends, stoops or lifts, as well as other range of motion capabilities.

Graham says the determination of social security benefits isn’t made by a physician, but by a medical examiner who generally comes to DDS from the fields of nursing, social science or law, and


is required to take part in a 13-week course on medical terminology, systems and social security administration procedures. The determinations take into account any medical information from a physician, as well as the opinions of physicians employed by DDS, such as Robert Kanard, MD.

“We ask for a report based on how the person presented at the evaluation,” Graham says. “We are looking for objective medical information — how that person was able to come in to the appointment, were they assisted? We just want you to document this information like you would a new patient report.”

Graham says the most common areas of the body they see claims on are arms, shoulders, back, legs and knees. He and Hruby both stressed the need for complete medical records from physicians as quickly as possible in hopes of making the determination process run as smoothly as possible. Hruby said if medical records aren’t sufficient for a determination to be made, exams are then ordered.

“We can’t make decisions without the medical community,” he says. “No matter what you think about disability, we need to work together as a team.”

With nearly 3,000 initial complaints coming across the desk of DDS annually, the agency is seeking more qualified physicians to do patient exams. Hruby says DDS can offer a fairly quick turnaround on payment and the agency pays customary rates for exams. He says DDS recently attended the Wyoming Medical Society’s Annual Meeting in hopes of recruiting new physicians to perform exams and his office is constantly recruiting new physicians. Graham says physicians can take as many or as few DDS exams as they would like, and it is a great program to take advantage of for physicians looking to start a new practice.

“We can send claimants to the physician for these types of work and the physician is compensated fairly quickly,” Graham says. “If someone really enjoys learning, this is a great way to learn about the various impairments out there. We work with so many claimants who have impairments ranging from A to Z.” 

For more information on performing exams for Disability Determination Services, contact James Hruby at 307-777-6927

Making the Case to Physicians

BY TOM LACOCK
Wyoming Medical Society

Robert Kanard, MD said doing physical exams for Wyoming's Disability Determination Services (DDS) was a part of his Cheyenne-based practice for the past 15-20 years. His sales pitch to other physicians considering taking on DDS physicals is an easy one.

"These are simple exams, very straight-forward," Kanard says. "It is no more than doing a complete physical exam on a new patient. There is no increase in liability. I never had a claimant contact me, or a lawyer contact me regarding any work I did due to DDS. I don't want to say it is easy money, but I don't know how else to say it."

Since leaving his own practice, the former internist and rheumatologist has consulted with DDS for the past 17 years, helping the staff at DDS with their medical knowledge as they make determinations on whether applicants qualify for social security disability. He makes it a point to tell visitors he is impressed with the level of medical knowledge the staff has, as well as with their willingness to ask questions when making medical determinations.

For more information contact:

James Hruby
Medical Relations Officer
Wyoming Disability Determination Services
307-777-6927
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Staffer James Hruby says DDS is always on the lookout for more physicians to perform physical exams for the DDS. He says getting to a physician to make his pitch is difficult, though when he does, he sometimes hears concerns about patients' credibility, or being asked to perform more work than a routine exam. Hruby says the exam is simple, quick and offers usual and customary rates paid within 30 days. He says physicians are not asked to make determinations or provide treatment, only asked to offer their expertise in the medical field.

"We really rely on the medical field to tell us what is going on with individuals conditions," Hruby says.

"You do a complete physical exam, dictate it like you would any other physical exam and then fax it to DDS," Kanard says. "Sometimes DDS will ask you to comment on something specific like their gait, or trigger points for fibromyalgia."

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A Healing Space Comes to Cody

BY TOM LACOCK
Wyoming Medical Society



Allen Gee, MD, PhD has designed the Healing Space in Cody, an 8,500-square-foot facility that features exam rooms and physical therapy areas, along with concepts such as a tea bar, a three-story water feature and connection with nature as illustrated by floor-to-ceiling windows with views of the mountains to put patients at ease.

Two steps into The Healing Space in Cody, you realize this isn't a typical doctor's office. Two minutes into a conversation with its designer, owner and lead practitioner, Allen Gee, MD, PhD, FAAN, you realize that was very much on purpose.

Gee, a neurologist, opened the doors to Healing Space in September 2014, growing from a clinic of 1,500 square feet to 8,500 square feet. The clinic itself uses concepts such as a tea bar, a three-story water feature and connection with nature — illustrated by floor-to-ceiling windows with views of the mountains — to put patients at ease.

The medical infrastructure also allows for Gee and his staff to practice and examine what he refers to as a patient's entire landscape. That means sleep labs, a nutritional teaching kitchen, physical therapy, psychiatric/ psychological services,

massage therapy, craniosacral and yoga offerings. With the full range of services available, he said he hopes The Healing Space will become a destination for those looking for a new way to deal with their dysregulation, and he talks of offering his patients an "experience" that will keep them coming back for continued wellness.

"In my vision of integrated neurohealth, I have found if we get our patients sleeping well, if we get them moving regularly, if we get them eating better, and regulating the nervous system, their neurologic issues and other health issues are more easily treated," Gee says.

The focus of the Healing Space is more on health and wellness and perhaps less on a traditional physician/patient disease treatment. Scott Wilson, PA-C, says the office uses research from the book, "Healing Spaces," which discusses ways



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architecture, colors and other techniques are used to promote healing. Wilson and Gee both talk about their hope of sending someone to the “doctor’s office” — without ever seeing a doctor.

Wilson says he has been with Gee for the past four years and has practiced for 12. He says their practice tends to see patients with “nervous dysregulation,” and says many have medically unexplained diagnoses, such as fatigue, dizziness, tremors or other non-provable diagnoses.

Many patients have come from other offices due to failed pain contracts or other issues. Wilson said chronic pain patients have sometimes been in confrontational situations at physician’s offices. He said appointments with that segment of the practice have been more productive and he isn’t sure why.

“I am finding those appointments are going much better,” Wilson says. “I don’t know if that is me because I am calm in the space with the calming views and the Healing Space is allowing me to practice medicine with less stress, or if it is changing the patients, or a combination of both. Many times the patients and I will stand together and look out the windows and talk. It is more of a conversation than a traditional exam.”

“Many times the patients and I will stand together and look out the windows and talk. It is more of a conversation than a traditional exam.”

ALLEN GEE, MD, PHD, FAAN
The Healing Space, Cody, Wyoming

Gee says his PhD is in psychoneuroimmunology, the study of the interaction between psychological processes and the nervous and immune systems of the human body. He said severe forms of neurodysregulation are labelled as anxiety, PTSD or panic disorder. He said he believes that by taking care of the whole patient his group can resolve medically unexplained symptoms more effectively, treat hypertension, diabetes and hypercholesterolemia and reduce the reliance on medication. He adds that he is also reaching out to a younger clientele to take advantage of the neuro wellness services such as nutrition and yoga in hopes of lowering their future disease burden.

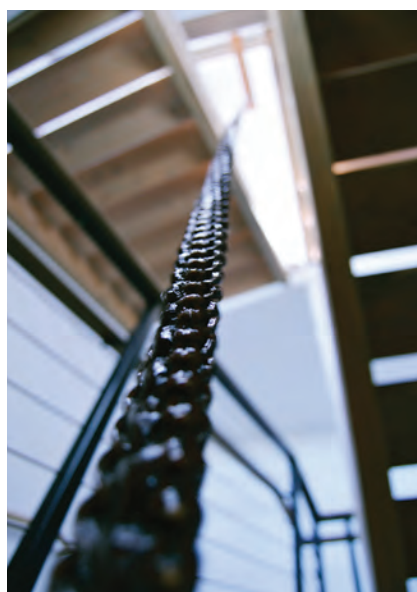
“It is an ongoing significant financial risk and a reputation risk, but it comes down to my beliefs about how we can best help patients,” he says. “By taking the concept of caring for the whole patient and accommodating the practitioners, we are going to be able to substantially increase the care offered to patients.”



Scott Wilson, PA-C talks about the features of The Healing Space and the impact it has had on him as a provider during an interview in July.



The waiting room at the Healing Space in Cody includes a tea bar, water features, and floor-to-ceiling windows.



Among the features of the Healing Space in Cody is a sleep lab which allows Allen Gee and his team to do sleep studies on-site.

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Laramie Physicians Are in The Cowboys Corner

BY TOM LACOCK
Wyoming Medical Society

While they may not wear helmets and jerseys, the team physician is a valuable part of any squad at the high school or collegiate level. One organization helps staff fields and courts around the state.

Mark McKenna, MD is a Casper native who, along with Ryan Aukerman, MD, helps Premier Bone and Joint in Laramie to staff all NCAA sports for the University of Wyoming, and some of the club sports, too. McKenna says Premier staffs all football games and the majority of home basketball games. The university works out an agreement with the opposing teams during the basketball season to offer coverage for UW student-athletes for road games.

McKenna estimates between 10-15 percent of his patient load comes from UW student-athletes. In addition to on-field exams and surgeries, Premier also holds clinics inside the UW training rooms.

“The biggest difference in treating an athlete at Wyoming is the level of strain they can put on their bodies,” McKenna says. “They can put more torque on their bodies, so they tend to have a more significant level of injuries.”

According to Kendle Dockham, the marketing director for Premier, the organization is allowed an in-kind donation for its services, which includes the ability to market the facility as the official team doctors of University of Wyoming Athletics. McKenna says team doctors do not get paid by the University. He says insurance of either the athlete or the university is charged for Premier services. The partnership has been in place since 1978.

“That way I am not employed by the university, and in that way I do not feel



Casper native Mark McKenna, MD is one of the lead physicians serving as team doctor for the sports programs at the University of Wyoming. McKenna estimates between 10-15 percent of his patient load comes from UW student-athletes.

beholden to them in any way, shape or form,” McKenna says.

For McKenna, the opportunity to get back on the field as a physician comes from his own history of playing football for Rocky Mountain College in Montana. Because of that background, he said he feels he can relate to players and coaches interested in getting back on the field as soon as possible. Though coaches by nature push to get their players back on the field quickly, he says the UW coaches respect the team physician’s opinions. The university also has a protocol for communicating with student-athletes that keeps a member of the training staff with injured athletes during physician visits,


and allows for coaches to be a part of the meetings as well.

McKenna will soon be joined on the sidelines by Matthew Boyer, MD who joined the university in July as the athletic department’s primary team doctor. Boyer, a Laramie native, comes from the University of Sioux Falls. UW athletic director Tom Burman said Boyer will work in the Rochelle Athletic Center (RAC) in the training room to work set office hours during the day, and will be on the field or court when appropriate. Burman said Boyer will also have final decision on whether a student-athlete wearing the brown and gold will be allowed to play.

“We felt like we needed to enhance



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the service we provide to athletes on a day-to-day basis,” Burman says. “I wanted to have someone in house who was a general doctor who had a fellowship in sports medicine, and he had done his fellowship at Virginia Tech University.”

Burman says the funding to bring Boyer onboard came from Cowboy Joe Club donations and pointed out the UW athletic department has requested \$10 million for the two-year biennium to the state legislature this year to address a number of areas, including cost of attendance, concussion protocol and other areas. Sustainable funding for Boyer’s position is a part of that request. Eventually, Burman said Boyer will move to a new office after the completion of the High Altitude Training Center, currently in the fundraising phase.

Burman says to his knowledge no other Mountain West school has a physician paid for by the university on-staff. He said schools generally partner with a medical school or large medical facility nearby. He said he believes once the High Altitude Center is built, the facilities and the personnel will offer a recruiting edge.

“It is something we will use as a sales tool,” Burman says. “Especially when we get the new facility up and going and fully staffed, we will have — if not a world-class — a first-class, state-of-the-art sports medicine, hydrotherapy and training center that no one else in the Mountain West is going to have, and few will have regionally.”

Jeremy Shyatt is an assistant coach with the UW men’s basketball program and says the team uses an athletic trainer as a liaison between the coaches and the team physicians. Last year, when Alan Herndon and Larry Nance Jr. emerged from bouts of mononucleosis, Shyatt said the team brought a physician on the road to help with IVs and other treatments to speed up the recovery time of their athletes.

Acting as a team doctor is nothing new to Premier as it uses a small fleet of planes to staff sports injury clinics around the state for high school student-athletes. Dan Levene, MD is an orthopedic physician who serves as team physician for Laramie High School.

“It is a lot of fun to work with the athletes because they love the game, they enjoy it with their parents and it isn’t a profession they will be working on when they are older.”

DAN LEVENE, MD
Laramie, Wyoming

Some Advice...

Advice for physicians considering becoming a team doctor at the college or high school level from Mark McKenna and Dan Levene:

- Know what you are responsible for. Understand what you are expected to cover and treat both at the games and afterward, especially the scope of practice.
- Make sure coaches have access to the physicians and understand when and how the lines of communication are to be used.
- Understand that parents can sometimes push for a student-athlete’s return more than a coach, and advocate for the athlete at all times.
- Understand it is more of a time commitment than you think.
- Be aware of the resources available, including EMT, equipment for head, neck, or spinal injuries, what athletic training resources are available.
- Have fun. It is a very rewarding endeavor.

“Twenty years ago I started covering high school football games during residency training at UC-Davis,” he says. “I loved sports and I enjoyed the extra money, which supported my residency salary.”

Levene travels either every week or every other week to sports medicine clinics to see high school athletes in Rock Springs, Casper or Torrington. Dockham said Premier has satellite clinics in Cheyenne, Torrington, Wheatland, Douglas, Gillette, Casper, Rawlins, Riverton, Rock Springs and Green River. Casper and Rock Springs have full radiology services, as well as permanent offices.

“We have four planes that fly the docs to 10 other towns around Wyoming,” says Dockham. “Most days 2-3 planes are flying in different directions each morning to take the docs and their staff to the clinics.”

Closer to home, Premier has also helped outfit a training room at Laramie High School in an effort to offer student-athletes, trainers and physicians on-site coverage.

“It is a lot of fun to work with the athletes because they love the game, they enjoy it with their parents and it isn’t a profession they will be working on when they are older,” Levene says.

“In a lot of situations, especially in some of the rural areas there aren’t a lot of great medical resources to really look out for the kids over the long term, and we try to help our athletes to have a real long healthy, active lifestyle.”



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How to Build a Better Medical Mouse Trap

BY TOM LACOCK
Wyoming Medical Society



“I ask “Why” a lot, and I think that is what has gotten me where I am today with medical device development.”

JOE MCGINLEY, MD, PhD
Owner, McGinley Orthopedic Innovations

The effort to build a better mousetrap extends to every industry, and medicine is no different. Joe McGinley, MD, PhD understands the game better than most. The Casper musculoskeletal radiologist and his company McGinley Orthopedic Innovations developed the IntelliSense Drill Technology, an orthopedic surgical drill that incorporates technological advances into the standard orthopedic drill, including continuous hole depth measurement and auto-stop capabilities.

McGinley also has an approved and soon-to-be-issued patent for a medical procedure he performs on chronic exertional compartment syndrome (“shin splints” to the layman, says McGinley) in world-class athletes. He developed a procedure to treat the issue using botulinum toxin in areas where muscles tighten on blood vessels.

McGinley took a different route to medicine than most phy-

sicians, earning his bachelor’s and master’s degrees from Temple University in engineering, then teaching while getting his M.D. and Ph.D. He said his engineering background came in handy while developing his procedures and devices.

“Engineering is great for a basis of general problem-solving skills, and then you learn the science behind the issues,” he says. “I became interested in biomechanics, and the body is just a very complex mechanical machine with complex organ systems that function as pumps and everything else.”

The IntelliSense Drill has been cleared for use in the operating room by the FDA this year, and on July 29 was used successfully by surgeons from Shriners Hospitals for Children in Philadelphia.

The process from idea to operating room took McGinley around three years from the time he started the company until the drill’s first use, a quick turnaround for a product. McGin-

ley says he made such rapid progress by surrounding himself with the right people. A willingness to call in experts such as a patent attorney and a business planning consultant paid dividends. This year, he decided it was time to hire full-time staff, including three engineers, an internal financial expert and communications and quality systems associates.

“In the long term, hiring just consultants is not feasible,” McGinley says. “If they go under or change direction, you are at their mercy. As we are entering the market, we saw it was the time to control the process.”

McGinley says he appreciated the help he found along the way from economic development groups such as the Wyoming Business Council, Manufacturing-Works and the Casper Area Economic Development Alliance. McGinley Orthopedic Innovations is located in the Wyoming Technology Business Center in Casper, a University of Wyoming-run business incubator.

McGinley Orthopedic Innovations recently purchased a manufacturing firm in Glenrock and is in the process of expanding thanks to a grant through the Wyoming Business Council’s Business Ready Community Grant and Loan Program. This summer, the State Loan and Investment Board (made up of the Governor, Secretary of State, the State Treasurer, the State Auditor, and the Superintendent of Public Instruction) approved full funding of a \$1.35 million Business Ready Communities


Grant. The grant will be administered to the town of Glenrock to purchase a building, install fixed assets and perform necessary improvements for a medical device manufacturing facility used by McGinley Orthopedic Innovations.

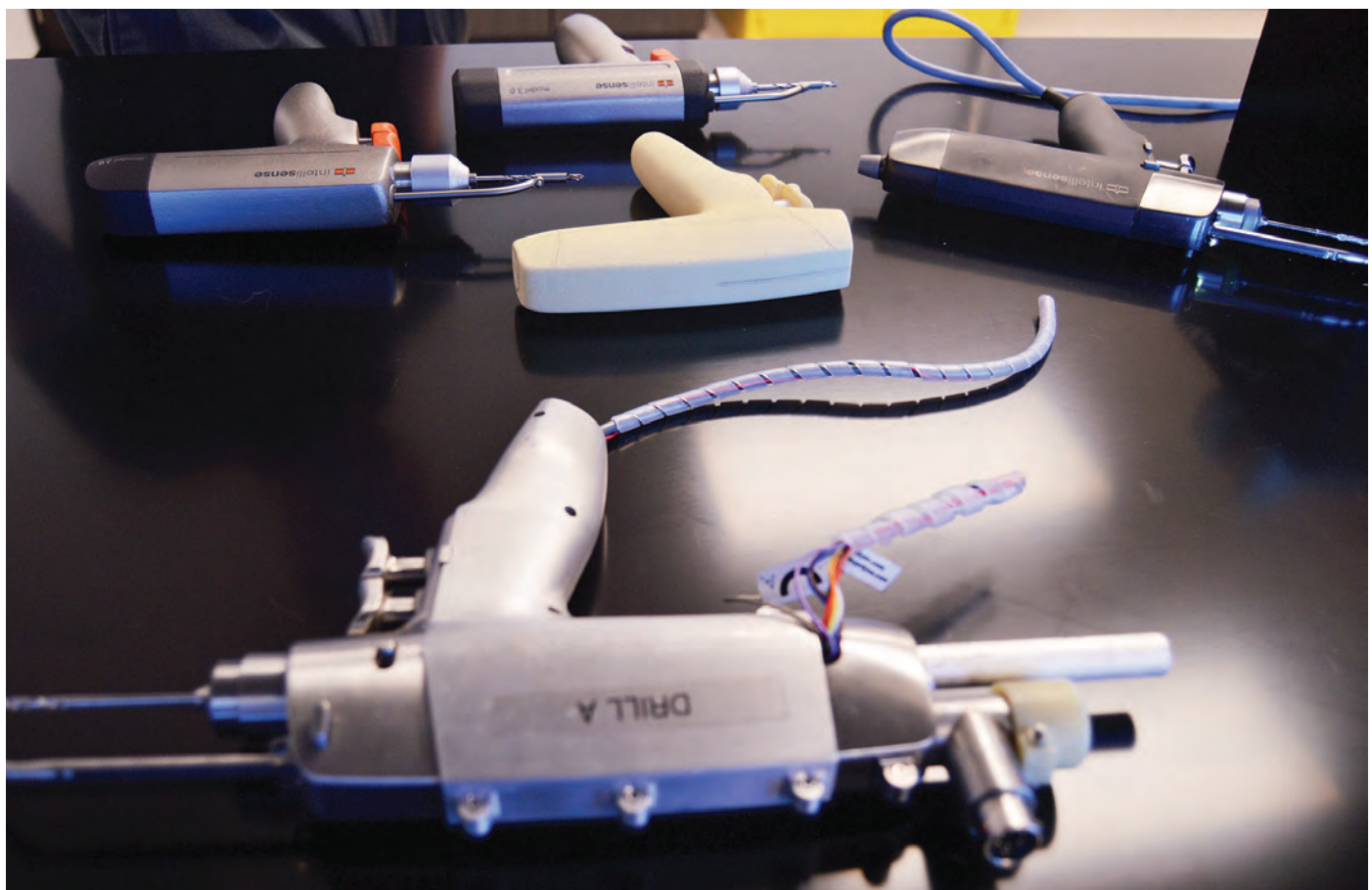
McGinley says the production facility purchase came as an unexpected perk of working with DS Manufacturing in Glenrock, which was actually looking for a buyer as McGinley began to explore options for bringing some manufacturing work in-house.

Now, McGinley has a nearly 10,000-square-foot facility, where work for the extractive services industry is also performed. As a side, it also offers a nice playground for the roomful of engineers working with McGinley.

“It was like buying a toy store for kids,” McGinley says.

McGinley admits he might become a victim of his own success, as more productivity with McGinley Orthopedic Innovations might mean less time seeing patients. But he says he wants to maintain his time with patients.

“For me, I love practicing medicine and seeing patients, but what frustrates me is how medicine is performed in general,” he says. “I see some of the limitations in terms of tools we are using in medicine, and people tend to accept the status quo as fact. I ask ‘Why’ a lot, and I think that is what has gotten me where I am today with medical device development.” 



A number of prototypes were built during the process of development for the IntelliSense drill. Pictured are a few of the models which were used as the drill was developed.



The IMLC Closer to a Reality

BY KEVIN BOHNENBLUST
Wyoming Board of Medicine



Under the watch of the WWAMI class the Wyoming State Senate works bills during the 2015 session in Cheyenne. This year the Legislature paved the way for Wyoming to join the Interstate Medical Licensure Compact.

As noted in the last issue, Wyoming was the first state to adopt the Interstate Medical Licensure Compact (IMLC) when Governor Matt Mead signed the enabling legislation on Feb. 27, 2015. Since then, the IMLC has rapidly gained acceptance across the country. Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, and West Virginia have also passed Compact legislation, and it is pending or under discussion in several other states. With adoption by the seventh state, the IMLC came into being, and planning began for the first meeting of the Interstate Medical Licensure Compact Commission.

The Commission is composed of two representatives from each member state. Governor Mead has appointed Board of Medicine public member Jody McGill of Jackson and myself as Wyoming's IMLC Commissioners. We will participate in a meeting later this year where the Commission will begin establishing the organizational framework for the Compact and its operations.

When the Compact becomes operational, physicians licensed in Compact Member States may go through the IMLC to become licensed in other Member States. The process will be:

1. A physician licensed in Wyoming, for example, contacts the Wyoming Board of Medicine, and submits an application for licensure in other Compact states.
2. The Wyoming Board verifies the physician meets the Compact requirements of:
 - a. A full and unrestricted medical license in Wyoming;
 - b. Successful completion of an accredited graduate medical education;
 - c. Lifetime or current certification by a nationally-recognized (ABMS or AOABOS) specialty board;
 - d. No history of convictions (or alternatives to conviction) for a felony, high misdemeanor, or crime of moral turpitude;
 - e. No history of discipline by a medical board, except for actions related to non-payment of licensing fees;
 - f. No history of revocation or suspension of a controlled substance license or permit; and,
 - g. Not under investigation by law enforcement or a medical board.
3. If the physician qualifies, the Wyoming Board notifies the Compact Commission of his eligibility and the other Com-

pact member states where he wishes to become licensed. Wyoming is considered the physician's "State of Principal License" in the Compact

4. The Compact notifies the physician of the licensing fee for each Member State selected, and the processing fee charged for the Compact's services.
5. Upon receipt of the fees, the Compact notifies the selected Member States of the physician's application, and forwards to each state its respective licensing fee and the physician's data.
6. The selected Member States then issue their licenses to the physician.
7. As various Compact state licenses come up for renewal, the Compact notifies the physician of the need to renew, and again collects the licensing fees, plus a processing fee, and passes the fees on to the appropriate states. It is important to note that renewal of a license issued through the Compact does not require participation in maintenance of certificate programs with specialty boards.
8. If the physician chooses to add more Compact state licenses, he will follow the same process as before.


The key to success of this model is a robust data sharing system with the Compact Commission at the hub and interfacing with each member state medical board. Getting it right the first time will be critical, and will likely take the most time in bringing the Compact into operation.

The data system will also be critical to protecting the public by keeping bad actors from using the Compact to run away from discipline. When the medical board in a physician's State of Principal License revokes, suspends, or accepts relinquishment of a license, that information will be immediately shared with other Member States. The physician's licenses in those states will immediately, and without further action required, be placed on identical status, and will only be restored by action of the respective Member State boards.

If a Member State revokes, suspends, or accepts relinquishment of a license issued through the Compact, licenses held by that physician in other Member States are immediately suspended for 90 days or until those medical boards act, giving them time to investigate and take action if appropriate.

In situations where a Member State or the State of Principal License takes less severe action against a license issued through the Compact, other Member States may deem the underlying facts to have been proven and impose the same or lesser sanctions, or take separate action under their medical or osteopathic practice act.

Given the qualification standards for physicians to use the Compact, and the fact that less than one percent of physicians are ever subject to licensing board discipline, it is believed these procedures will rarely be needed.

The Wyoming Board of Medicine looks forward to the Compact becoming operational as the next step in streamlining physician licensure in Wyoming. 



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"..The Doctors Company, is always available to answer 'best practices' questions and allow me insight into what other practices might be doing..."

JOHN MANSELL, MD
Gillette, Wyoming

WMS members also have access to industry-leading patient safety tools and programs, including CME programs, resources to help with the ICD-10 transition, on-site surveys, and informed consent resources, available at www.thedoctors.com/patientsafety. Upcoming CME seminars include "One Click Away: Risks of EHR," which will be held in Cheyenne on October 27 and in Casper October 28. The Doctor's Advocate, The Doctors Company's quarterly publication for members, contains timely information on patient safety topics, legislative updates, and the latest industry and company news.

"Kathy Springer, our patient safety risk manager at The Doctors Company, is always available to answer 'best practices' questions and allow me insight into what other practices might be doing, and what lessons that might offer

to help me improve my practice," Dr. Mansell says.

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Wyoming Institute
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Medical Neighborhoods Have Transformed Care Delivery in Wyoming

**A Uniquely Wyoming Solution to the
Challenge of Health Care Transformation**

BY PHYLLIS SHERARD, PhD
The Wyoming Institute of Population Health



The Wyoming Institute of Population Health is committed to building bridges between communities and health systems. The Institute was created to develop strategic platforms that proactively address the evolving needs of patients, providers and communities across Wyoming.

In 2012 the Wyoming Institute of Population Health received a \$14.2 million Health Care Innovation Award from the Centers for Medicare and Medicaid Innovation (CMMI). Using this resource, along with \$250,000 in funding from the Wyoming Department of Health's Medicaid Division, the Institute, the Wyoming Medical Society, the Wyoming Primary Care Association, the University of Wyoming School of Pharmacy and the Wyoming Hospital Association planned to address three drivers of rising health care costs: failures of care delivery; failures of chronic care management and transitions across sites of care; and, over-treatment, often associated with failures of care coordination or communication.

The three drivers would be addressed by creating medical neighborhoods that included four key sustainable strategies. By the Award's conclusion in the summer of 2015, 14 hospitals and 21 medical practices were working together to achieve a three-part goal for Wyoming citizens: Better health, better care, at a lower cost.

Better Health

Patient-centered Primary Care Medical Homes (PCMHs), focused on comprehensive primary care services, formed the core of Wyoming's medical neighborhoods. The PCMH facilitates care coordination, forms inter-professional care teams, develops individualized care plans for complex patients and maintains connections with community-based services for referral and follow-up. Pharmacists also play a key role in managing medications and patient education.

Result: All clinics that submitted for The National Committee for Quality Assurance (NCQA) consideration under the Award attained recognition and demonstrated improved patient outcomes. The PCMHs demonstrated that they had become learning organizations and that clinical quality reporting and performance evaluation had become core functions. Data on quality, performance and costs are now available and used for learning and continuous quality improvement

Better Care

Wyoming Rural Care Transition, a protocol created by the Institute, trained registered nurses (RNs) to provide education and facilitate continuity of medical care as complex patients with one or more of 10 qualifying conditions transitioned between hospitals and post-acute sites of care.

Result: RNs from 14 hospitals served more than 4,500 high-risk patients. Data from the Wyoming/Montana Quality Improvement Organization on readmission rates for patients with the 10 qualifying diagnoses showed that the non-participating hospital readmission rate was 16.9 percent, compared to 10.89 percent for patients receiving services from participating hospital care transition RNs. Other data show significant increases in the patients' ability to better manage their care (including taking medications correctly and participating in care planning) and a 97% patient satisfaction rate.

Better Access

Physician Desktop Solutions were deployed across Wyoming, expanding the state's telemedicine system. This system has improved access to specialists and coordination between sites of care for high-risk patients. It has also facilitated effective medical decision making.

Result: Thirty-two communities from 23 Wyoming counties

and one Nebraska county were provided with video capability. Additionally, 366 new connections (including mobile devices) were made. Tele-psychiatry was the most-used clinical application (85 percent); other applications included weight management, rheumatology, endocrinology, oncology, and wound care.

The Wyoming Donated Medication Program expanded statewide, increasing access to medication resources—helping providers develop and support comprehensive care plans for low-income patients.

Result: Enhanced access to prescriptions improved patient medication compliance from 52 percent in March 2014 to an average of 88 percent in 2015. (National literature frequently cites 85 percent compliance as a goal.)

Lower Cost

CMMI and its contractor HealthInsights, Inc., have certified that the medical neighborhood strategies saved \$38,592,356.10, based on an overall decrease in hospital admissions, readmissions and avoidable emergency department utilization.

Critical Success Factor: Collaboration

Wyoming can take great pride in the fact that the medical neighborhood strategies continue and are self-sustaining:

- The Institute has certified PCMH coaches ready to assist primary care practices who want to achieve NCQA recognition.
- Wyoming's payers/purchasers, along with Medi-

care, have played key roles in providing incentives for care coordination and sustainability.

- The Wyoming Department of Health is supporting ongoing maintenance of the pharmacy software, prescription filling and supplies associated with the expansion of the Donated Medication program;
- Wyoming hospitals are adapting the Rural Care Transitions demonstration model to fit their unique needs;
- PCMHs are coordinating the care of their patients and are better prepared to report improved clinical outcomes associated with chronic disease management and preventive screenings;
- Specialty providers are using Physician Desktop Solutions to bridge geographic distances, and clinical site-to-site consultation is increasing across Wyoming;
- Hospitals are sharing accountability for the care of complex, high-risk patients and are collaborating on the development of care transition plans.

Wyoming hospitals and providers must foster the development of medical neighborhoods as they seek to form collaborative relationships that support healthy communities and healthy behaviors. Related to this, hospitals must also be meaningfully involved in developing community health needs assessments and supporting the development of results-based community health improvement plans.

Phyllis Sherard, Ph.D., Chief Strategy is the Officer/Vice President of Population Health at Cheyenne Regional Medical Center and the Wyoming Institute of Population Health.

Wyoming MAKE-A-WISH® Seeks Referrals

BY TESS KERSENBROCK
Community Relations Coordinator

Six-year-old Parklen of Casper suffers from ALPS, which required a bone marrow donation. He had his wish to go to Hawaii granted by Wyoming Make-A-Wish last January. His mother said the trip wasn't as much about enjoying a tropical paradise as watching Parklen's dreams come true.

"I weep when I recount the visions of my son running alongside his brother on the beach," she said. "The beauty in his laughter as he watched the fire dancers at the luau and the squeal of delight from the fish he saw through the glass-bottom boat."

Current data says that for every child whose wish is granted, another child in Wyoming is eligible but has not been referred. This data means each year as many as 30 children battling

life-threatening medical conditions are not referred for a wish. This 50-percent net incidence rate can be directly impacted by referrals from physicians statewide. Make-A-Wish Wyoming's qualifying conditions do not require a child to be terminally ill. Children between the ages of 2.5 and 18 who have been diagnosed with a progressive, degenerative or malignant and life-threatening medical condition at the time of the referral are eligible for a wish. After a child is referred, Make-A-Wish will work with the treating physician to determine the child's eligibility for a wish. For additional questions related to medical qualifications, or to refer a child you believe is eligible, contact Make-A-Wish Wyoming Wish Coordinator Dana Wirtz at 307-234-9474 or visit wyoming.wish.org.



ICD-10 Provides a Standardized and Streamlined Approach to Coding

BY CAITLIN ROONEY
WINhealth

ICD-10 implementation kicks off on October 1, 2015. The transition will affect every part of a provider’s practice, from software upgrades, to patient registration and referrals, to clinical documentation, and billing. It is a long awaited change in the U.S., one that swept over the rest of the world years ago.

ICD-10 codes will replace current ICD-9 codes. These codes reflect current medical practice and technology and are a step in the right direction to more coordinated patient care. ICD-10 codes are far more specific, allowing providers to capture much more information about their patients. The level of detail that ICD-10 provides means researchers and public health officials can better track disease, illness, and health outcomes across the country. It also means that when a patient sees a new provider, they will be able to see a more detailed health history and can provide the patient with more coordinated care. Procedure codes for outpatient services will remain the same in the transition to ICD-10.

To prepare for the transition, the Centers for Medicare &

Medicaid Services (CMS) suggests a five step approach:

Step 1: Make a plan – Obtain access to ICD-10 codes and gain an understanding of the transition

Step 2: Train your staff – Clinical and administrative staff will need to get up to speed

Step 3: Update your processes – Get your forms ready

Step 4: Talk to your vendors and health plans – Confirm systems are ready, including partners like health plans, billing services, and clearinghouses

Step 5: Test your systems and processes – Verify you can generate claims

Health plans will no longer accept ICD-9 codes with a date of service on or after October 1, 2015. These claims will be rejected, resulting in a delay of payment until the claim is properly coded with ICD-10. Claims may also be denied as untimely if an updated claim with correct coding isn’t received by the health plan’s timely filing rule.

For more information, tools, resources, and tips visit cms.gov/icd10

Caitlin Rooney is the Director of Marketing, Communications, and Community Relations for WINhealth. She can be contacted at crooney@winhealthplans.com

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Mountain-Pacific Quality Health Means Quality Care

BY MARION SMITH, MD
Wyoming Medical Director, Mountain-Pacific

Health care providers across Wyoming are dedicated to delivering the highest quality care possible and Mountain-Pacific Quality Health is here to help them do just that. As the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Wyoming, Montana, Hawaii and Alaska, Mountain-Pacific has been working with Wyoming health care providers since 1984.

As the QIN-QIO, Mountain-Pacific brings communities together to locally achieve national health quality goals. Supporting providers and practitioners with evidence-based clinical interventions and objective expertise, Mountain-Pacific works with both Medicare beneficiaries and providers to ensure the delivery of safe, efficient and cost-effective care.

What is a Quality Innovation Network-Quality Improvement Organization (QIN-QIO)?

Funded by the Centers for Medicare & Medicaid Services, the QIO program is one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries and is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy for providing better care and better health at lower cost.

Federally funded, locally operated.

Mountain-Pacific is focused on helping improve the health of Medicare beneficiaries and health care systems in local communities with their staff of clinicians, analysts, physicians and quality improvement experts located right here in Wyoming and Montana. With an office in Casper, Mountain-Pacific staff travel statewide to work with all levels of health care providers and those working in communities to provide services to older adults.

Mountain-Pacific works to bring value to health care facilities, staff, clients and patients by being a free resource of current information, best practices, patient education, clinical tools and quality improvement. Dedicated to quality improvement and patient safety, all Mountain-Pacific services are free and confidential. With a proven track record of success, our

staff and board members are known and respected locally for their experience and commitment to Wyoming patients.

Get to know our projects and our staff.

State Director

Pat Fritz, RN, BC, LNHA, Wyoming Director and Nursing Home Project Manager

Medical Director

Marion Smith, MD, CDE, is a family physician who has been with Banner Health Systems for 30 years. In addition to working for Community Hospital in Torrington, she is the Wyoming medical director for Mountain-Pacific.

Improving Cardiac Health and Reducing Cardiac Disparities & Coordinating Prevention through Health Information Technology

Nickola Bratton, BS, Cardiac Health and Coordinating Prevention through Health Technologies project manager

Reducing Disparities in Diabetes Care

Glen Revere, MS, RDN, CDE, Diabetes Self-Management Educator

Kevin Franke, BSN, Care Coordination and Everyone with Diabetes Counts project manager

Promoting Effective Care Coordination & Communication

Kevin Franke, BSN, Care Coordination and Everyone with Diabetes Counts project manager

Reducing Healthcare-Associated Conditions in Nursing Homes

Pat Fritz, BSN, RN, BC, NHA, Wyoming Director and Nursing Home project manager

Reducing Healthcare-Associated Infections

Ellen Williams, RN, BA, Healthcare-Associated Infections project manager

Improving Care Through Quality Reporting

Sharon Phelps, RN, BSN, CHTS-CP, Quality Reporting project manager

Improving Immunization Rates and Reducing Immunization Disparities

Brian Hoflund, MPH, CHES, CSCS, Immunization project manager

Marion Smith, MD, CDE, is a family physician who has been with Banner Health Systems for 30 years. In addition to working for Community Hospital in Torrington, she is the Wyoming medical director for Mountain-Pacific.

Summit Medical Center Granted Permanent License by State

Summit Medical Center was recently granted a permanent license by the state of Wyoming, following a survey conducted July 20-21 by the State Department of Health. The hospital proved to be a rare example of excellence, with zero deficiencies reported, indicating that daily operations, governing policies, patient care and documentation met or exceeded standard quality.

In Wyoming, new facilities operate under a provisional license until they can be surveyed by the state while serving patients. During the survey, state health representatives observe all aspects of patient care, including infection control, care plan creation and procedural documentation, as well as facility policies and procedures, operating room cleanliness and how work is processed.

“Because our staff is committed to living ‘survey-ready’ everyday, they welcomed the opportunity to demonstrate the quality care they provide,” said Vanessa Sorensen, Chief Nursing Officer.

CEO Dennis Jack added, “In my 30 years of hospital administration, this is the first time I have been part of a hospital that had zero deficiencies in the state survey. This is a huge testa-

ment to the quality of care here at Summit Medical Center.”

With four operating rooms, two procedural rooms and 16 inpatient rooms, Summit Medical Center—a physician-owned hospital—offers a wide range of services and specialties to patients of all ages, including dietary, imaging, laboratory and pharmacy services.



Summit Medical Center in Casper has been licensed by the State.



Banner Health®

Banner Breaks Ground on New Washakie Medical Center

Washakie Medical Center (WMC) broke ground on its new \$23.4 million facility in Worland on June 16.

Jay Stallings, who arrived as chief executive officer at Washakie Medical Center just over a year ago, said there are many people to thank who worked diligently to see the project through to this point.

“This is a true collaboration,” Stallings said. “Banner Health is pleased to be working with the citizens in the Big Horn Basin to continue to provide excellent patient care close to home.”

The event, with more than 80 in attendance, started off with comments from Stallings, Aaron Anderson, chairman of Washakie County Commission; Dan Scheuerman, president of the Washakie Hospital Board; Jim Ferando, president of Banner Health’s Western Region and Duane Whitlock, community president of ANB Bank in Worland

The construction will be done in phases to create new space

so departments can move into those new areas and vacate existing areas to allow for renovations. The construction includes:

A new patient wing with 12 patient rooms and 16 beds, plus two labor and delivery rooms dedicated to obstetrics. Rooms will be larger with some accommodating double occupancy based on demand to provide a total of 18 licensed beds.

- A new surgical suite with two large, state-of-the-art operating rooms and one endoscopy suite;
- New pre-operative and post-operative recovery areas;
- Renovations to accommodate a new Emergency department;
- Expanded, new laboratory and pharmacy;
- New respiratory therapy, chemotherapy and endoscopy areas;
- Renovated front entry with impacts to the admitting, business office, waiting room and gift shop.

Washakie Medical Center is a county-owned hospital in Worland, Wyo., built in 1962. The hospital is operated by Banner Health, which operates 28 hospitals in seven states.

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