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### BREAKING NEWS



## CMS relents, will reduce 2017 MIPS reporting burden

You can expect CMS to soften the impact of its Merit-Based Incentive Payment System (MIPS) for 2017. There will be four options given to providers for complying with MIPS on Jan. 1, 2017, which is when performance-measuring begins for 2019, the first MIPS payment year.

Each option offers varying levels of difficulty, so providers can choose how much effort to invest based on their readiness. The agency made the [announcement via a blog post](#) authored by CMS Acting Administrator Andy Slavitt.

Details are sketchy, but these options are expected to be fleshed out in the final rule for the Medicare Access and CHIP Reauthorization Act (MACRA). The MIPS program consolidates all of Medicare's existing major pay-for-performance incentive programs into a single entity, and MIPS is a core component of the MACRA law.

Here are the four options outlined by Slavitt:

**1. First option: Report some, not all, MIPS data for 2017.** This option should have the least impact on practices, and will result in no MIPS payment adjustment in 2019 (e.g. avoid any negative adjustment, but get no positive adjustment either). As long as you report some data for some period of time in 2017, you won't be dinged in 2019.

**2. Second option: Report all MIPS data, but only for part of 2017.** This option raises the stakes slightly by requiring full MIPS participation for part of the year. Slavitt did not provide a specific timeframe for "part of the year." Choosing this option will result in a "small positive payment adjustment" for 2019, though how much was not specified.

**3. Third option: Report all MIPS data for all of 2017.** This option is basically what all providers would be required to do under the MACRA proposed rule. This will result in a "modest positive payment adjustment" for 2019, though again no value was provided for "moderate."

(continued on pg. 3)

#### BREAKING NEWS

**CMS relents, will reduce 2017 MIPS reporting burden** 1

#### PRACTICE MANAGEMENT

**Concierge medicine: Personalized, cost-effective care** 3

#### MEDICARE RULES

**Specialists hope to avoid MIPS via APM participation** 4

#### PRACTICE MANAGEMENT

**Revenue cycle: Proven tools to boost efficiency** 6

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**4. Fourth option: Participate in an Advanced Alternative Payment Model (APM).** Assuming your practice participates fully in an APM, such as an Accountable Care Organization, the Medicare Shared Savings Program (tracks 2 or 3), or any other pay-for-performance model in 2017, you'll get a 5% positive payment update in 2019. The catch is that only APMs recognized as "advanced" by CMS will be eligible. A full list of advanced APMs and the criteria for an APM to be recognized as advanced is [available on the agency's website](#).

The problem is that there are no numbers or values for any of the terms that Slavitt uses in his blog post, says Brad Coffey, government affairs manager for the Association of Orthopaedic Executives (AAOE) in Indianapolis. "All we have are what's in the blog post. I think we'll see actual numbers in the final rule." The lack of specificity means you won't know exactly how much data you need to report, or for how many days, or how much of a positive adjustment you'll get for each option yet.

Without that information, practices won't know if it's worth their effort to participate partially with MIPS in 2017, Coffey says. "The only thing this really solves for is giving us more time to prepare. Ultimately, if the structure for MIPS in the coming

years is still going to be similar to what's in the proposed rule, we'll still be concerned."

Look for the four-option provision to appear with specific details in the MACRA final rule, expected in early November.

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## PRACTICE MANAGEMENT



DOUG GRAHAM



KAREN PETRILLO

**Concierge medicine: Personalized, cost-effective care**

**Note:** This is the first half of a two-part series on concierge medicine by experts at DoctorsManagement who have helped many practices incorporate this model into their businesses.

Concierge medicine, also known as boutique or private medicine has grown beyond just a trend. Paid entirely by patients rather than health insurance companies, "concierge" physicians offer more personalized health care to reduced patient bases.

Although once thought to be an insignificant niche in health care delivery, more and more consumers are seeking out this health care model. Ten years ago, there were only a few hundred of these practices in the country, according to an article entitled "Concierge Medicine ... Another Option for Frustrated Doctors" (*Tennessee Medicine*, November 2006, Vol. 99, No. 11). Today, the number of concierge and direct pay physicians is [estimated at more than 12,000](#).

As stifling health care regulations continue to overwhelm physicians, many feel as though they've done everything humanly possible to continue delivering quality healthcare under today's healthcare model. To compensate, physicians and their staff must either spend less time with each patient or devote more of their day to patient visits—by coming in earlier, staying later, or shortening their lunch breaks. Despite the extra effort, practice revenues are stagnant, at best. As

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reimbursements shrink and the quality assurance demands from government and private insurers increase, physicians and staff—who are already over-extended—are feeling the pressure. Smaller practices with limited resources to meet the requirements of health care reform are turning to the concierge medicine model as a way out of the modern medicine labyrinth.

## The return of personalized care

As the trends converge and the landscape of health care morphs, savvy physicians are developing models to meet the needs of their patients, deliver health care as they see fit for the patient, and create a more palatable lifestyle for themselves. Physicians who set out to design a concierge practice have creative license to design a practice that best suits their professional and personal goals and take into account the needs of their patient base and market demographics.

The imbalance between supply and demand also helps make the case for concierge medicine. [A 2016 study](#) conducted for the AAMC by IHS Inc., predicts that the United States will face a shortage of between 61,700-94,700 physicians by the year 2025. Combine physician shortages with the aging population in the U.S. and the writing on the wall becomes quite clear; timely access to quality health care will soon be more elusive than ever.

As this reality filters to the consumer through the media and personal experience, patients interested in the peace of mind that comes with flexible scheduling, immediate access to their physician, and more personalized attention may drive an increased demand for concierge physicians. Baby boomers (those born during the demographic birth boom between 1946 and 1964) are projected to have enough disposable income to take advantage of this more tailored delivery of health care. Boomers will be the wealthiest group of elderly in history, *USA Today* reports. Although they make up only 20 percent of the population, baby boomers will control 40 percent of the nation's disposable income.

## How concierge medicine works

In the classic concierge medical practice, a physician accepts a monthly or annual fee in exchange for granting the patient special access. Services may include priority appointments (same day, in some cases), 24/7 access via email and cell phone, house calls, ample time with the physician during visits, and escort to hospital emergency room visits. Depending on the services they deliver, concierge physicians charge up to \$10,000 a year, with most charging \$1,500 to \$2,000, according to *The New York Times*.

Some high-end concierge practices are all inclusive, while others charge a modest annual fee with additional fees required for services and tests as they are rendered. It is common for a concierge physician to set a price schedule that offers several tiered options. For example, one option might include ample visits per year, along with various tests and maybe even a couple of visits for out-of-town guests (should the need arise). A different option, with a lower annual fee, might offer two visits per year, one round of standard blood work with additional visits, and tests available at pricing spelled out in the patient contract. The variations are endless, and it is up to the physician to decide the structure based on the needs of the patient base and vision for the concierge practice. A very clear and concise contractual relationship is vital.

In the classic model, the physician does not accept any form of health insurance. In addition to the physician having the freedom to deliver the level of care he or she sees fit, the primary advantage of a classic concierge practice is reduced administrative costs by cutting out third-party payers. Patients participating in a concierge arrangement generally have a high deductible medical insurance plan to cover catastrophic events or other medical services that the concierge practice cannot provide.

**Next issue:** We will conclude this two-part series in the next issue of *The Business of Medicine*. We will discuss a hybrid model where a practice offers both concierge care and regular care with insurance carriers, and outline detailed steps for determining whether concierge care makes sense for you, and how to implement it.

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## MEDICARE RULES

### Specialists hope to avoid MIPS via APM participation

CMS has announced that it will make the Merit-Based Incentive Payment System (MIPS) easier for practices to handle in its first reporting year, 2017, but the overall structure of MIPS doesn't seem likely to change. That means each subsequent year will require more reporting and better outcomes, as practices

nationwide essentially compete against one another to ensure positive payment updates – because MIPS is budget-neutral, there will be winners and losers.

But CMS does offer a way out of MIPS via the Alternative Payment Model (APM) – and some specialty practices in particular are hoping to ride out the storm using this option. First, let's remember that CMS is actually dividing APMs into two categories: Advanced, and not advanced. The agency has also used the term "eligible" and "ineligible" to mean the same things, respectively.

**Advanced or eligible APMs** are the ones that offer an exit from MIPS. Participating fully in an advanced APM means your providers won't be measured under MIPS, and will instead get a regular positive payment update of 5% to their Medicare fee schedule rates each year, with more future bonuses in future program years.

The list of ACOs currently recognized as advanced is fairly small, but it does include all CMS Innovation Center models, which means Accountable Care Organizations (ACOs) are potentially eligible for advanced status.

### ACO practice hopes for APM recognition

The Sierra Regional Spine Institute is an orthopaedic group focusing on spine procedures in Reno, Nev. It has seven physicians and has been participating in an ACO for one full year, says Penny Forbes, practice administrator.

The group had little choice but to join their local ACO, run by their regional level 1 trauma center, Renown Regional Medical Center. Over the years, the Renown system acquired roughly 50% of the primary care practices in the northern Nevada area, which comprised the bulk of referring physicians who sent patients the Spine Institute, Forbes says. Suddenly her practice was on the outside looking in; the acquired primary care physicians had to refer to specialists within the ACO, because Renown didn't want to be accountable for the cost of care provided by non-ACO physicians.

Eventually, Forbes' practice signed a contract to participate in the ACO so they could get the referrals back. Now they are part of an APM that hasn't yet received "advanced" status from CMS, but is hoping to get it.

The Renown ACO hasn't yet produced any cost savings, but still has time to do so under CMS rules. Unfortunately, specialists like the surgeons at the Spine Institute aren't

eligible for the potential gainsharing, Forbes explains. The argument is that because the brunt of the data-gathering for the ACO data and quality measures is borne by primary care, specialists don't do as much work. "They argue that spine care is highly episodic," she says.

Thus the possibility of becoming an advanced APM is the upside benefit that her practice is looking for. "It would be nice just to be excluded from the potential MIPS penalties," Forbes says. "Right now my doctors are worried that, because this is all budget-neutral, even if we met all the MIPS requirements, we could still be at the bottom quarter of participating providers and be penalized."

### CMS decides which APMs are 'advanced'

Advanced or eligible APMs earn that status from CMS, which currently only has the following requirements for granting this status:

- APM requires participants to use **certified EHR** technology. Specifically, an advanced APM must require at least 50% of their providers to use certified EHR. This value goes up to 75% after the first MIPS program year.
- APM bases payment on quality **measures comparable to those in the MIPS** quality performance category. Fortunately, the advanced APM doesn't have to report any minimum number of measures or domains. CMS is also open to accepting quality measures that it determines to be evidence-based, even if they haven't appeared under existing quality reporting programs such as the Physician Quality Reporting System (PQRS) or been created by groups like the National Quality Forum (NQF).
- The APM either a.) requires its members to bear **more than nominal financial risk** for monetary losses, or b.) is a Medical Home Model expanded under CMMI (Centers for Medicare and Medicaid Innovation) authority. "Nominal" risk is being defined currently as a total risk of at least 4% of expected expenditures to provide care, and marginal risk of at least 30%, with a minimum loss ratio of no more than 4%. If any ACO has a participating provider cost more than projected (e.g. no savings), it must recoup those costs by charging the provider, reducing payment rates, or withholding payments.

These criteria are not final, and CMS is still in the process of recognizing existing APMs as advanced, but already many APMs are lobbying CMS for recognition. For example, practices participating in the Bundled Payments for Care

Improvement (BPCI) model have asked CMS to certify their APM as being advanced. Many orthopaedic groups could thus avoid MIPS as more advanced APMs are certified by CMS, including ACOs that aren't centered around any one specialty, such as in Forbes' situation.

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## PRACTICE MANAGEMENT



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### Revenue cycle: Proven tools to boost efficiency

**Note:** This is the last of a four-part series on improving your practice

processes and workflow to boost revenue. The third article ran in the August issue of *The Business of Medicine*.

We use 24 tools, chosen based on our experience, in our process improvement work with healthcare facilities. Obviously, we don't use all of them on every project. In fact, the tools can be mixed and matched *pro re nata*. The five that we tend to use in almost every engagement however are:

1. Flow charting (or process mapping),
2. value stream mapping,
3. causal analysis (often referred to as an Ishakawa analysis),
4. Voice of the Customer (sometimes referred to as the Kano model), and
5. Critical to Quality (CTQ) trees.

In process mapping, we create a flow chart of all of the steps within a given process. For example, for a typical patient visit, we would map out from appointment to check-out, and we would include all of the steps in between, such as check-in, wait time, provider encounter, coding, etc. Remember, the purpose of the flow chart is to be able to visualize the process steps, and its creation requires the involvement of the process owners.

When we move to value stream mapping, we begin to apply data and other information to the process map. For example, for each step in the process map, we want to know things such

as, how much staff does the step require? How long does it take? How long from the last step to this step? What are the step details? What are the biggest mistakes that are made, and how often are they made? We also want to develop a list of things that could go wrong at each step, along with their risks. This is a great way to create contingency plans ahead of time, allowing errors to be caught before they create any collateral damage.

We then use these data to get to the root cause or causes for each issue identified. Remember, we want to be etiological in our approach; we want to cure the problem, not just treat the symptom. We use the latter two tools, Voice of the Customer and CTQ trees, to identify process improvement projects based on customer needs.

The Kano model creates a matrix of issues that identifies the differences between what the customer expects, wants, and needs and how variation in each of these creates both business opportunities as well as risk. For example, the basic need for a patient is proper diagnosis and treatment. It's tough to improve much on this process, but if you don't meet this basic level, you're in the wrong business and likely won't last long.

A patient's expectations, referred to as "performance attributes" may elevate variables like being seen within a reasonable period of time, or being treated with courtesy and respect. Improvement in this area improves satisfaction scores and can drive more business to the practice, especially in a more competitive market.

When we deal with "excitement attributes," we see activities such as a call from the office on the day of a visit to check on the patient and see how he or she is doing. Patients appreciate this and are likely to share this with their friends.

### Know how to use your tools

Also, consider the manner in which these tools will be implemented into the process model. Tools are great, but if you don't know how to use them, they can be as dangerous as they are helpful (like a scalpel in a 2-year-old's hands). For this exercise, we consider an assortment of what we refer to as deployment platforms, which are structured processes that are used to deploy, manage, and validate process improvement projects. Before we look at their differences, however, let's discuss the five basic steps they all have in common:

1. Defining the issue,
2. creating the benchmarks,
3. finding the root cause(s),

4. identifying and testing possible solutions, and
5. validating the results.

It sounds simple enough until you realize that many organizations get stuck on the first step and can't define the issue. Often their problem is not a failure to recognize issues, but rather having so many concurrent issues that they are overwhelmed and can't choose one to prioritize.

This effectively is the initial triage stage of the process. Creating the benchmarks, often becomes the starting block for any process improvement project, and analytics define the difference between anecdote and antidote. Maybe here more than anywhere else, the phrase "If you can't measure it, you can't manage it" comes into play. Finding the root cause, as discussed previously, is critical to effective problem-solving; and identifying and testing possible solutions comes from the ability to prioritize the root causes.

The first four steps are easy to follow logically, but the final step, "validating the results," might be the most critical step in the entire process and yet it's often the most neglected.

Here's an aphorism we coined: Whenever you change something (anything), you always end up with something different. What's important, however, is to recognize whether the "something different" is better or worse (or the same as) what you started with. In other words, you might have completely revamped one or more of the critical processes within your practice and felt really good about making those dramatic changes, but if you haven't validated whether any

of those changes actually improved your organization in any quantifiable way, what's the point?

## Deployment platforms include DMAIC, PDSA

Of all the different deployment platforms, two tend to get most of the attention, and for good reason. The first is DMAIC, which stands for define, measure, analyze, improve, and control. As you can see, these steps match quite nicely with the five steps outlined previously. The other main deployment platform is referred to as PDSA (or PDCA), which stands for plan, do, study (or check), and act. Although it's similar to DMAIC in its conceptual approach, it's much leaner and, as it sounds, much more applicable to Lean projects.

PDSA is about small, nondestructive tests. For example, if you want to improve wait time, then DMAIC would demand a long-term, statistically valid, well-designed experiment that would take 3 months and much staff time to complete. Using PDSA, on the other hand, you could complete your project within a week with limited resources and at just about no cost.

We don't want to give the impression that DMAIC is never a good idea; it's just that PDSA is a less cumbersome and most often, equally effective platform to use for medical practices.

## When practice improvement fails

In all, one question bears answering: Does process improvement always work? The answer is an unequivocal "no." When a process improvement project fails, it may

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be because the project wasn't a candidate for process improvement. Most often, however, the failure is due to more tangible, human issues. And although projects fail for many reasons, three reasons seem to be the most common, in our experience:

- **Lack of support and/or buy-in from top management.** Support normally comes in the form of passive approval from the owners of the practice, usually the physicians. In the current economic environment, everyone is on-edge, and risk-aversion rules the roost when it comes to investing into new opportunities. Without active support from the top, you can pretty much count on a failed effort.

- **Lack of a specific target or goal.** More specifically, if you don't know where you want to be, it's highly unlikely that you'll know when you arrive. Not having a specific goal will make it nearly impossible to stay on track, just about guaranteeing failure.

- **Unanticipated effects.** The third reason that projects fail is more phenomenological, and it rests in the understanding of chaos. Not always, but much of the time, when you apply a change to one area, it creates changes in other areas, often unexpected change. It's important to recognize that, in most cases, change is more global than we might imagine. Looking at the system as a whole is one

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Pediatric group, TX	Provider enrollment research
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Family and pediatric group, TN	Employee handbook
Solo practice, PA	DM University renewal
Pediatric group, TN	Employee handbook
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Pediatric group, NC	CLIA technical consulting
Pediatric group, MS	CLIA technical consulting
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way to assess the potential for collateral effects.

Is process improvement the silver bullet, the antidote for all that ails us? Again, the answer is “no.” If a process is not subject to some form of quantification, then it’s not a candidate for what we have discussed here. In a medical practice, quality of care is of utmost importance, and although LSS can be applied to the understanding of outcomes, quality is a characteristic inherent within the practice and the practitioners. And as a characteristic, like class, either you have it or you don’t; it’s not something that can be taught or learned.

However, the key takeaway here is that for most of the operational and workflow-related problems we face when

addressing the profitability and sustainability of a medical practice, process improvement in fact is the answer. Continuous process improvement in general – and LSS specifically – is a scalable model that is as applicable to the solo provider as it is to the 1,000-physician healthcare system and we strongly encourage anyone to consider how to implement these tools within their practice.

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## IN MEMORY OF JAMES GOOSIE: 1984-2016



We are profoundly saddened by the sudden and unexpected passing of our friend and colleague, James Russell Goosie. He was 32 when he passed away on Sept. 11, 2016.

James, or “Rusty” to his friends, got his start in healthcare a decade ago, when he became billing manager at Caris Healthcare in 2006. A hard

worker, James eventually joined DoctorsManagement in 2012 and made an immediate impact on our team. Even as he quickly worked his way up from billing consultant to management consultant, James also devoted time to his family’s business, a local Snappy Tomato Pizza franchise. As if all this weren’t enough, James constantly sought to improve himself, pursuing a master’s degree from Colorado Technical University through a distance learning program.

In his free time, James enjoyed spending time with friends and family, often by a lake or at the beach. He married his spouse Morgan in 2014, and the couple adopted three foster children. The experience made James an advocate for all foster children, particularly those suffering from neonatal abstinence syndrome, which can occur when children are exposed to addictive opiate drugs while in the womb.

Opioid abuse was another cause that James was dedicated to, working with local activists, healthcare groups, and legislators to improve care for addicts while mitigating the

impacts of opioid abuse on Tennessee’s communities and healthcare delivery system. James’ efforts garnered attention from federal officials, and James recently had a chance to meet with U.S. Surgeon General Vivek Murthy, MD, when Dr. Murthy visited Knoxville.

James will be remembered for his generosity, his tireless work ethic, friendly nature, deep faith, and inspirational focus on self-improvement. He earned his Master of Business Administration, with an emphasis in healthcare administration, at the end of 2015. James will also be remembered for the example he set with his selfless advocacy work on behalf of the neediest and most helpless citizens of Tennessee.

James had a large family who will miss him. He is survived by his spouse Morgan; their three foster children, Zachariah, Charity, and Jade; his parents Pam and Fred Hickman; his three sisters Savannah and Shelby Hickman, and Jennifer Pique, and his aunts, uncles, cousins, and in-laws. All of us at DoctorsManagement will miss James deeply, and we hope his family is comforted by the knowledge that he had an even larger work family here at DoctorsManagement.

### Memorial contributions

If you would like to make a memorial contribution, please visit this GoFundMe page which has been established to provide for the care of James and Morgan’s children: <https://www.gofundme.com/2r7h3vyw>.