

THE Physicians Report

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THE GOLDEN HOUR IN DISASTER RESPONSE

When someone experiences a cardiac event, time is of the essence. Fortunately, Advanced Cardiac Life Support (ACLS) and trauma algorithms, using simplified checklists and rehearsals, ensure standardized choreographed medical assessments and interventions. When the patient also receives definitive, hospital-based care within the first hour—the “Golden Hour”—morbidity and mortality are positively impacted. These timely and practiced actions override situation-induced stress, confusion, and debate. As a result, many lives are saved.

This same approach can be applied to disaster preparedness. The complex and unfamiliar nature of disaster mass casualty incidents (MCI) spawns chaotic responses right from onset. Extreme cataclysm so often forecasted by “experts” can result in futile, “doomsday” inaction generating plans and training that are less than adequate. Assumptions that FEMA or the National Guard or a “Big Trauma Medical Center” will “save us” muddy the planning and response waters still further, causing confusion or delay in decision-making.

However, just as with cardiac patients, a series of rehearsed decisions and procedures carried out within the first 60 minutes of a disaster will profoundly affect outcomes downstream.

Don’t misunderstand me. Excellent, well-conceived hospital plans exist, often buried in thick binders or thumb drives. As useless to everyday caregivers as the tax code, these industrious treatises are the result of many dedicated hours compiling best practice, research, org charts. Senior-leadership validation and staff education are then needed to integrate this effort into the overall health-care culture. These well-intentioned Emergency Operations Plans and Continuity of Operations Plans are rarely shared with staff or local emergency response agencies, and those tasked with carrying out these plans in most hospitals or other care settings wear multiple hats with little time made available for this purpose.

So, what realistically can be done to meet the demands of preparedness?

The Physicians Report has attempted to explore the topic from the perspective of a physician, CEO, COO, clinic manager, or risk manager who needs to ensure a practice has a plan if/when a disaster or crisis, big or small, arises. Much can be learned from areas of the country that frequently face extremes. They all share common preparedness priorities, strategies, and tactics. The most frequently encountered approach is collaborative, inclusive planning that incorporates private, public, and volunteer assets and entities. In disasters, hospitals are expected, on top of already heavy daily workloads using just-in-time staffing models, to deliver high-standard patient care and ensure staff safety 24/7/365 while facing seemingly overwhelming odds in the worst of circumstances.

As a retired obstetrician, I know that safe labors and healthy-baby deliveries depend heavily on highly reliable teamwork. That stems from practiced simulation and communications. In my current role as Director of Community Disaster Medicine for Boston’s Beth Israel Deaconess Medical Center Fellowship in Disaster Medicine, I encourage communities and hospitals to take the same approach in disaster/MCI preparedness.

Efficient, safe, effective patient care will require “all hands on deck.” Just-in-time training and calling 911 for help will be used as disaster responses, but those action-plans alone are insufficient. Both catastrophic world and local events occurring seemingly every day are stark reminders we cannot fall into complacency because “nothing bad ever happens here” or we have been all requirements.

When contemplating how to achieve the Golden Hour in disaster preparedness, areas to be explored include who should be trained, the importance of information management, what training and planning works best, and who should sit on Emergency Management committees.



Robert Mitchell, MD, BDLS Medical Director, Disaster Medicine Project, Director of Community Disaster Medicine, Beth Israel Deaconess Medical Center Fellowship in Disaster Medicine, and Affiliate of the Harvard Humanitarian Initiative

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Mary-Lou Misrahy

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CONTRIBUTING WRITERS
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NEW RULE REQUIRES PROVIDERS AND HEALTH-CARE FACILITIES TO HAVE EMERGENCY PREPAREDNESS PLANS

On September 8, 2016, CMS announced a rule requiring providers and health-care facilities to have emergency plans. Seventeen provider and supplier types which serve Medicare/Medicaid patients will have one year from November 16, 2016, to comply with new national emergency preparedness requirements. This is intended to ensure adequate planning for natural and human-caused disasters, and coordination with federal, state, tribal, regional, and local emergency preparedness systems.

The following are links to information about the rule, provider types subject to the requirement, and templates for planning:

Rule: tinyurl.com/hsngghl

Provider types: tinyurl.com/jfjt82f

Template: tinyurl.com/gvqa3ba

The Assistant Secretary for Preparedness Response/Technical Resource Assistance Center and Information Exchange (ASPR/TRACIE) has a dedicated resource page, asprtracie.hhs.gov/cmsrule, with additional links to resources to help you start or update your planning process. ASPR/TRACIE works closely with CMS to gather and share relevant resources and help with assistance requests.

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What Should Be in a Disaster Plan?

HELPING HEALTH-CARE FACILITIES PREPARE TO MEET THE NEEDS OF COMMUNITIES THEY SERVE

by Ashley Wargo, MPA, Preparedness Associate, Hagerty Consulting

Communities are vulnerable to a full spectrum of risks. These range from natural hazards (hurricanes, tornadoes, flooding, earthquakes, etc.) to technological risks (hazardous materials incidents, nuclear power plant incidents, etc.) to other man-made perils (terrorism, cyber incidents, mass shootings, etc.).

With all of these hazards, health-care facilities have a critical role in ensuring that they remain operational so they can provide care to their existing patients at both the time of the emergency or disaster, and in the days that follow.

In addition, many facilities, particularly hospitals, also play a key role in responding to a mass casualty event (MCI). This dual mandate requires health-care facilities to be able to accommodate an unexpected surge of patients, many of whom may need critical care, while continuing to handle existing patients. And while every disaster will present a unique set of challenges, preplanning for these challenges and adopting an all-hazards approach to planning enables health-care facilities to be better prepared to meet the needs of the communities they serve.

THE PLANNING PROCESS

Creation of an operational and comprehensive disaster plan begins with establishing the plan's goals and objectives. These are the three major areas of focus—or the “Three Cs”—for health-care-facility disaster planning:

1. Continuity of Care – Continuing the physical care of those currently seeking medical attention, while ensuring the full continuity of operations for the facility and the ability to serve a disaster-response role.
2. Communication Channels – Managing internal and external communications channels as both become more crucial and more complicated than on a typical day.
3. Coordinated Response Protocol – Developing a protocol for response within an organization, while also looking outward to integrate into a community-wide response.

These critical aspects set the basis for plan development and

1. Considering the possible effect a hazard could have on a facility
2. Assessing the likeliness of the hazard to occur, and the overall risk that the hazard poses to the facility
3. Creating the plan to address the findings of the analysis
4. Updating the plan to reflect lessons learned from real-world events

As an example of this process, a facility along the East Coast will most likely experience hurricanes, but it may also be brought into the response of a mass casualty event, such as the recent nightclub shooting in Orlando, Florida, or the Boston Marathon bombing. Identifying these hazards at the beginning of the planning process ensures the creation of a full-spectrum plan that can be customized to each specific facility and community. During this process, it is crucial to identify all infrastructure capabilities, such as the availability and functionality of a backup power source. As Hurricane



Health-care facilities need to take what emergency management professionals refer to as an all-hazards approach to planning. Simply put, a disaster plan needs to achieve these goals and objectives in a way that is not specific to just one hazard.

form the crux of what health-care facilities need to achieve in order to fulfill their special dual mandate during a disaster.

The health-care industry is no stranger to these concepts. The Joint Commission, a United-States-based nonprofit organization that accredits health-care facilities—and with which many, if not most, health-care providers are familiar—has established standards for hospital emergency preparedness. In addition, federal efforts, such as the Hospital Preparedness Program and Public Health Emergency Preparedness Program, have been actively facilitating the establishment of local health-care coalitions. Each of these local coalitions can potentially serve as an invaluable knowledge resource for any health-care entity interested in furthering its disaster planning.

THE STARTING LINE – CONDUCTING A VULNERABILITY AND RISK ANALYSIS

Once goals are set and the need to plan for more than just one hazard is understood, conducting a vulnerability and risk analysis for each facility will set the focal points of the planning process. This four-part process involves the following steps:

Sandy highlighted, loss of power for a health-care facility—a hospital in this case—can force emergency evacuations of patients at an incredibly inopportune time. Walking through an analysis of the facility's vulnerabilities and risks creates the baseline from which all planning can begin.

TAKING AN ALL-HAZARDS APPROACH TO DISASTER PREPAREDNESS PLANNING

As noted earlier, health-care facilities need to take what emergency management professionals refer to as an all-hazards approach to planning. Simply put, a disaster plan needs to achieve these goals and objectives in a way that is not specific to just one hazard (i.e., a plan applicable only to hurricanes), but rather one that provides the facility with the ability to cope with an emergency of any size, duration, and type. In many ways, this is intuitive. Preparing a health-care facility for a water-disruption event is applicable to earthquakes, severe weather, and even cyber incidents. We can see how critical this is when we look at recent events that affected health-care facilities around the country. Hurricane Sandy in New York and New Jersey; the 2011 tornadoes in Joplin, Missouri; the 2013 West Fertilizer Company explosion in Texas; and the Boston Marathon bombing in Boston, Massachusetts, are key examples of the

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Health Care an Increasingly Common Ransomware Target

Data Breaches: A Guide to Prevention and Recovery

by Bryce Matsuoka, President/CEO, AboveCloud



An e-mail with an infection is sent to a hospital. Only one of what could be hundreds of staff members needs to be hooked and open the malware-infected phishing e-mail. And then, kaboom!

All hospital computers are frozen, with their data encrypted and locked up for 10 days, until hospital executives agree to pay a \$17,000 ransom for a key to unlock the hacker's encryption of their electronic records.

Sound like a Hollywood movie? It did happen in Hollywood this year—but not at a movie studio. It actually took place at Hollywood Presbyterian Medical Center.

HEALTH-CARE RANSOMWARE ON THE RISE

Disasters come in all shapes and sizes—and unfortunately, an increasingly common disaster that physicians, practices, and hospitals must prepare for and respond to are data breaches. Health-care data hacks are on the rise. And more specifically,

attacks using ransomware to monetize targeted network intrusions.

- The Office of Civil Rights reported 253 health-care data breaches in 2015 with a combined loss of 112 million records.
- Of the top 10 breaches, the top six affected at least 1 million people.
- The worst breach last year, Anthem Blue Cross, involved 78+ million records hacked.
- Smaller medical clinics are not immune either. In July, an undisclosed ransomware strain hit a Colorado-based allergy clinic. Allergy, Asthma & Immunology of the Rockies, P.C. (AAIR) divulged details of what appears to be a ransomware infection that may have

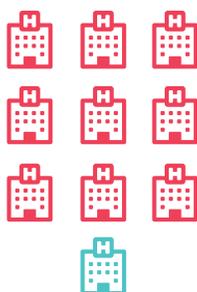
directly affected systems containing electronic protected health information (ePHI) of almost 7,000 patients, including patients' names, medical test results, and Social Security numbers.¹

At the end of last year, Garry McCracken, Vice President of Technology at WinMagic Data Security, told Forbes that 2015 “was the year of the health-care breach.”

And this year continues the trend. Studies show that data breaches cost the health-care industry \$5.6 billion a year. The average cost per record lost or stolen in 2015 for all US businesses was \$217, with health care leading all industries at \$398 per record, according to Ponemon

91%

of health-care organizations have experienced at least one data breach in the past two years.



Half

of all health-care organizations have little or no confidence in their ability to detect all patient data loss or theft.



Institute's 10th annual Cost of Data Breach 2015 study.

A breach, as Ponemon defines it, puts at risk an individual's name—plus a Social Security number and/or medical record, financial record, or debit card. These could be in either electronic or paper format. The study identified three main causes of data breaches:

- Malicious or criminal attack: 49 percent
- System glitch: 32 percent
- Human error: 19 percent, including lost or stolen hardware

And the trend is getting worse. One US patient record in three is predicted to be breached in 2016.

WHY TARGET HEALTH CARE?

Why target patient records? Because of the money. The most valuable personal information on the black market is not a social security number. It's not a credit card

number. It's not a driver's license. The hottest information is a person's medical record, which sells for as much as \$363 per record, according to data from the Ponemon Institute, which is more than any other piece of data from any other industry."

The reason? Think opposite of the Hippocratic oath. Medical records can do more harm. Thieves sell them to scam the system for illegal health services and prescriptions.

And crooks know that ransomware attacks against a hospital or health-care system puts health and lives at risk, which means criminals have more chance to get a quick payment to restore operations and restore safety—not to mention regain a positive public image and reputation.

It's also no secret that the health-care industry was slower to move to digital records, and many organizations made

the switch only in recent years so are still getting up to speed with security technology.

Another fact that puts health-care organizations at risk is that vulnerable medical devices are running outdated operation systems. So, health-care records hold the most value on the black market, and when breached, they cost hospitals, clinics, and solo practices the most in dollars and lost business.

And then there is compliance with the Health Insurance Portability and Accountability Act (HIPAA), with fines starting at \$100 and going up to \$1.5 million for each violation. Already in 2016, HIPAA has reached settlements totaling \$8.4 million, exceeding any other prior year. There have been three prison sentences for HIPAA violations, and medical licenses have been revoked. Plus failing another audit, such as Meaningful Use, can lead to an OCR (Office for Civil Rights) audit.

"It's accelerating," stated Bill Ho, CEO of Biscom (a provider of secure document delivery solutions), in a CNBC article posted in August. "We've definitely seen more [fines] recently, [with] the Office of Civil Rights coming out and saying, 'You're in violation.'" He added, "The OCR is starting to play hardball." Do IT security and data breaches have your attention yet?

HOME SECURITY: AN ANALOGY FOR DATA PROTECTION

Are you doing what you can to protect your house? Your home security efforts can illustrate how to address the challenge in business. For instance, are you locking your doors with quality deadbolts? Do you have a video monitoring system that records who comes and goes? Are alarms triggered when a break-in occurs? Who in your house has access to the security codes and family jewels, and who knows where the jewels are hidden?

The house analogy is useful for thinking about the steps needed to protect your

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For Small Practices, There's No Such Thing as a Small Disaster

A Thorough Plan Can Make a Big Difference

by Clint Kelly

None of us go to work thinking this will be the day of disaster. But not even small businesses, such as clinics and private family practices, are immune from risk and loss. In reality, a small practice operating with fewer patients and narrower margins can be more vulnerable to loss than a large health-care provider with a network to help absorb unexpected losses.



A thoroughly prepared disaster plan in place before disaster strikes can be as important to the long-term success of a small practice as is the operational balance sheet is.

No one starts the day thinking this is when the computers will go down, the clinic will catch fire, or a burst pipe will disrupt the ability to serve patients. But to have anticipated what could go wrong, and to have practiced our response to those scenarios, will go far in ensuring we don't become a grim statistic.

FEW SMALL PRACTICES ARE READY TO WEATHER DISASTER

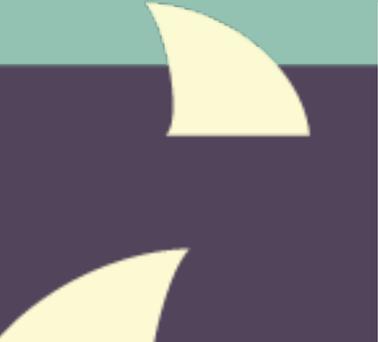
The US Small Business Administration reports that most small businesses are not fully prepared for disaster. Those unable to reopen within just a few days following a disaster have a much higher chance of business failure. The inability to recover and to maintain patients' confidence after business interruption and property loss leads to permanent closure. SBA statistics say that at least a fourth and as many as half of small businesses never reopen their doors after a disaster. When that happens, not only do you lose, but so does the community that has come to trust in you and to rely upon your services.



Digestive Health Specialists (DHS), a gastroenterological practice based in Tacoma, Washington, since 1972, made the creation of a corporate disaster response plan a business priority. With 40 providers and more than 300 staff members at seven clinics, five endoscopy centers, a lab, a scheduling call center, and a billing department, senior leadership

in the event of a loss of some or all of our facilities and/or our key information systems.”

DHS identified areas of vulnerability, and in leadership meetings developed hypothetical scenarios which will soon include more formalized review procedures and tabletop exercises



SBA statistics say that at least a fourth and as many as half of small businesses never reopen their doors after a disaster. When that happens, not only do you lose, but so does the community that has come to trust in you and to rely upon your services.

recognized it made good business sense to be prepared, especially when their business mantra is “patients first.”

accessible to all employees. Key is building awareness of what could happen and how to respond in specific situations.

COLLABORATION AND FILLING THE GAPS

“The disaster preparedness plan was a collaboration between operational leaders,” says Jack Schwartz, director of Information Systems and Innovation at DHS. “It was in response to gaps in our ability to provide care for our patients

DHS has also built redundant clinical work-flow procedures and computer systems capabilities. Alternative emergency facilities for patients and staff are in place to prevent interruptions in the quality of care.

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The Seattle Office of Emergency Management lists the three most common reasons people give when asked why they don’t plan for disasters:

- It won’t happen to me.
- It might happen, but it won’t be that bad.
- It will be so devastating that it won’t matter what I do.

This head-in-the-sand way of managing a business is doomed to fail. There is nothing small about whatever incident cuts you off from your patients and the quality of service they experience in your care. The assumption that planning is expensive, say the experts, can blind practice administrators to the reality that lack of planning costs more in the end.



JUST ASK YOURSELF ...

Do you know the right questions to ask in case disaster strikes? When you perform a comprehensive review of your emergency procedures, check to see if the following questions are included:

- Do you have a current backup of your most important data stored off site?
- Are your financial records readily available if your facility is damaged or destroyed? What about insurance records?
- Would your landlord be able to repair your facility in a timely manner, or would you have to relocate your business after a disaster?

- Are your employees familiar with their responsibilities for building and information security?
- How long will your patients be affected, and what will it take to get them back?
- What circumstances specific to your practice would prevent you from reopening within 24 to 48 hours?

Answering questions such as these before you’re in the throes of a crisis may spell the difference between suffering catastrophic loss and the ability of your practice to weather small disasters.



You've Got This!

Using Simulation to Prepare for a Mass Casualty Response

*by Theresa Demeter, Director,
InSytu Advanced Healthcare Simulation*

**You can feel your heart
pounding as you wait for the
first ambulances to arrive.**

**A large explosion at the mall
has resulted in many casualties.
You don't know yet the number
of casualties, or the cause of
the explosion, however some
type of terrorism is feared. You
can feel your fight-or-flight
response kicking in.**

What is the first thing you should do? Take a deep breath and relax. You've got this!

Thankfully, this is a simulation training exercise, one of your hospital's regular emergency-department drills, to prepare your entire team for mass casualty disasters. You are confident that simulating disaster response is moving you from a team of experts to an expert medical team. These team members not only have expert skills, but they also have a shared mental model of the workflow, they know where their emergency supplies are located, and they are committed to using their patient safety behaviors and tools so that even in a mass casualty incident, patients and staff are not unintentionally harmed through medical error.

LEARNING TO SAVE LIVES IN CHAOS

Saving a life is difficult enough, but doing so during the chaos of a mass casualty incident can increase the stress and the potential for error. Through simulation, health-care teams can prepare

for almost every situation they might encounter. While specific injuries may differ, the art of being prepared—knowing one's role, being facile with the flow, and having a shared mental model of how the team works together—equips teams to be able to work calmly, confidently, and safely even in the midst of a disaster.

As we know from the Greek lyric poet Archilochus, “We don't rise to the level of our expectations; we fall to the level of our training.” That sentiment has been tweaked by a Navy SEAL as “Under pressure, you don't rise to the occasion, you sink to the level of your training.” What these two very different people had in common is an understanding of the importance of “practicing not just until you get it right, but until you can't get it wrong.” Without the opportunity to regularly and thoroughly practice in the safe setting of simulation, health-care teams are more likely to feel stressed in the midst of a mass casualty event and revert to more familiar—but potentially chaotic—practices and behaviors, putting patient- and caregiver-safety at risk.

One of the best routes to safe quality care during a mass casualty incident is to conduct in situ (in position or on site), multidisciplinary simulation drills on a regular basis to allow teams to work through processes until they “can't get it wrong.”

REAL PLACES, REAL ROLES ARE KEY

In simulated clinical scenarios, using lifelike manikins increases the learning as caregivers practice both clinical procedures and processes at the same time. High-fidelity simulation manikins can replicate labor and birth, cardiac arrest, gunshot wounds, loss of limbs, and various symptoms such as vomiting, seizure, dilated pupils, and difficulty breathing.

But the manikins are really the least important component of a strong simulation program. To be prepared for a disaster

requires all of the caregivers, in their actual roles and in their real place of work, simulating with the greatest attention to detail and accuracy. To conduct truly multidisciplinary simulations, everyone relevant to the scenario must be included—physicians, nurses, blood-bank transporters, pre-hospital personnel, nutrition services, code team, environmental-services staff, and others. This ensures that everyone caring for the patient is on the same page and has the same opportunity to provide thoughtful feedback, suggestions, questions, and concerns.

It is not unusual to hear one caregiver say to another during a simulation debrief, “Wow, I didn't know that was your process. Had I known, I would have done things differently.”

Hospitals and caregivers must prepare for mass casualty disasters in as many ways as there are types of disasters. Mass casualty incidents can include natural disasters, train derailments, and population health crises, such as food contamination, pandemic flu or zika, terrorism, and mass shootings. The list is endless. To save lives, hospitals and emergency managers must



prepare an external, community response as part of a bigger strategy to mitigate the effects of mass casualty events. Internal considerations include how to best care for a large surge in patients with potentially devastating injuries, and, in the case of

a natural disaster such as an earthquake or a large storm, how the hospital can safely continue operations while potentially dealing with building damage, power and water outages, and stressed and distracted staff, patients, and visitors.

Committing to disaster preparedness is a daunting, time-consuming, expensive task. Simulation plays an essential role in that commitment.

A team from Northwestern University Feinberg School of Medicine used simulation to identify gaps in another type of disaster response—caring for a patient with Ebola. Associate professor of medicine Jeffrey H. Barsuk, MD, MS, noted, “At Northwestern Memorial Hospital, we have learned that preparing detailed guidance is not enough. We must conduct realistic drills and offer clinicians and administrators both practice and honest feedback on their performance.” The learning that occurred as a result of the simulation exercise reveals opportunities for organizations to address gaps and improve aspects of their preparedness efforts to respond successfully to real patients.¹

While simulation is an important tool for communities, organizations, and hospitals to implement as part of their disaster preparedness strategy, it is also important to use simulation to support patient safety at the individual and departmental levels and in other outpatient clinical settings. When implementing a disaster preparedness simulation in the emergency department, operating room, or other area of the hospital, it is useful to conduct the simulation in situ—in the actual patient-care setting—allowing health-care teams to refine workflow, ensure that supplies and equipment are appropriate and in good working order, and that the teams understand age-old workarounds and how they may be a barrier to safe patient care. All this enables the teams to have the opportunity to standardize their processes and responses.

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Planning for the Known and Unknown

Disaster Preparation Is an Ongoing Project

You can prepare for disasters by consulting with experts, reviewing online and print resources, and participating in local, regional, or national events. But you can also learn from your peers how to be ready for a large-scale or even a small-scale incident.

Here are case studies from a regional hospital, a cancer clinic system, and a solo physician practice highlighting the preparations they made to be ready for any disaster, how they got back up and running when they faced challenging situations, and some lessons they learned along the way.



Windstorm Blows New Life into Disaster Planning for CCNW



by Elaine Porterfield

When 100-foot-tall pine trees started swaying in a breeze, Adrienne Lara of Cancer Care Northwest knew they were in for trouble.

helpful, she says, to have had an updated plan so staff knew instantly key cell numbers to call. That would have reduced duplicate calls and would have kept response efforts flowing as smoothly as possible.

“Communications were huge,” Lara says. “One of the things our employees really needed to have was an updated emergency phone tree to get the word out. We eventually designated one person to communicate with everyone.”

Checking on staff is hugely important to find out if they're okay mentally and physically and have what they need to get through the emergency.

CELL PHONES AND PHONE TREES ARE VITAL LINKS

Access to cell phones meant they could send e-mails, text messages, and phone calls to keep the staff apprised of the constantly changing conditions in the region. That proved to be very valuable. “We sent one message from the top of the phone tree down, via cell-phone e-mail, to report on the status of our sites and situation,” Lara says. “We reassessed the status every hour and updated any information we were gathering for our staff. We were able to do that on a fairly consistent basis throughout the first day, and it was very helpful.”

They also learned the importance of an initial quick huddle to assess the situation. In their case, given that their employees work in eight separate locations in Eastern Washington and Idaho, their facilities manager proved to be one of the most important people on the job. He was able to stay on top of changing conditions at all their locations, Lara says, as well as interface with the authorities about emergency conditions regarding power and traffic.

As it became clear no one knew when power would be restored to their darkened sites, the managers helped chart a course forward. “They congregated at seven o'clock the morning after to decide what to do and which locations to open,” Lara

says. “We decided to have skeleton crews with a nurse, a provider, and a reception-scheduler at all our sites, even the ones we had technically shut down because there was no electricity. Patients were showing up anyway. We tried our best to address their needs, whether it was medication—administering shots people needed, or whatever—and tried to get absolutely critical care taken care of right away.”

TAKING A CUE FROM THE ER

They also realized the importance of immediately going into triage mode at all sites, like an emergency department, for efficiency and patient safety. “We have a lot of fragile patients with multiple needs,” she says. “The skeleton crews addressed whatever problems they could and triaged the rest. One of major takeaways we had from the storm was the importance of triage. If someone absolutely needed treatment, we needed to do that and postpone or reschedule the rest. We went to paper documentation because of the lack of power. However, not all our sites were down, so the sites without power were able to partially access electronic medical records through the sites that were still online.”

Pharmacists were key as well. She says, “One of other things we immediately had to deal with were medications that must stay cold. We had some small generators on hand at our sites, and we were able to use them in our pharmacies for running refrigerators. We did have a backup plan for system outages, which was great, and the pharmacists and staff were able to kick that plan immediately into place.”

They also learned the importance of factoring in greatly increased travel times for staff. With the power out, intersections with downed trees and no traffic lights were clogged, posing yet another difficulty.

Finally, they learned the importance of staff support. Many lacked power for days at their homes and had to scramble for child care—and food, since many grocery stores were closed. Lara herself was out of power for five days at home.

She was right: a devastating windstorm was sweeping through Spokane that would knock power out for days, shutting down patient care at several of Cancer Care's sites.

Although their organization had a limited disaster plan on hand, Lara, compliance officer for Cancer Care, concedes, “I don't think anyone had dusted it off in a long time. We were more or less shooting from the hip. We didn't have necessarily one big cohesive plan.”

From that windstorm on November 17, 2015, they learned a good many lessons to apply to disaster preparedness going forward, Lara says.

IDEALLY, DISASTER PLANS ARE LIVING DOCUMENTS

The first lesson was the importance of treating their disaster plan like a living document and updating it periodically, especially the emergency communications portion. When the windstorm hit, landlines went down, but cell phones still worked. It would have been

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Disaster Planning from a Physician's Perspective

Outpatient Clinics Are Ideally Situated to Build Community's Resilience

by Mary Jo Kintner, MD



It's a routine day at the office when suddenly a deafening rumbling rises from the ground. Seconds later the floor shakes and rolls under your feet, knocking you to your knees. All around you glass shatters, and books, ceiling tiles, and supplies fly through the air.

Outside, a retaining wall fails and collapses into your building. Electricity, phones, and the Internet are all out. Water, gas, and sewer lines are broken. Your clinic is soon filled with injured people, most of them frightened and disoriented.

This past June's "Cascadia Rising" exercise held throughout the region reminds us that we in the Northwest really are at risk for this kind of catastrophic event. Unfortunately, much of the media coverage promulgated the idea that FEMA, the National Guard, the Navy, the Red Cross, and other outside agencies will take care of us. As a result, our own medical community's participation in the exercise was miniscule.

In reality, we must take care of ourselves.

Some experts, including various emergency managers, as well as Team Rubicon, a volunteer organization of veterans and first responders and medical professionals who provide disaster relief throughout the world, say it will take at least four days for outside help to arrive, and maybe more like two weeks, depending on the severity of the disaster.

Unless we have organized, practiced plans for disaster, we risk a marked increase in injuries, loss of life and property, and a prolonged, unsuccessful recovery.

Outpatient clinics are ideally situated to build our community's resilience. If we encourage our patients to have extra medications, supplies, and plans for disasters, we can limit the surge of those needing medical care, prescriptions, and

other supplies. Patients can become part of the solution instead of adding to the problem.

Building a disaster plan for our medical community can be broken down into four parts:

- The first building block is personal preparedness: our own, our staff's, our patients.
- The second step is "MYN" or Mapping Your Neighborhood." Neighbors helping neighbors. Having a neighborhood care center to watch over children, the elderly, or others who are vulnerable allows people to stay close to home, in familiar surroundings, which limits anxiety and displacement.
- Thirdly, medical facilities, including



asked how many had disaster plans. Forty-three percent indicated they did have plans.

That's a good start. But unfortunately, the numbers got worse. None of the clinics indicated they were asking patients about their personal disaster preparedness, and none were providing any education on this topic. In addition, none were ensuring that patients had an extra two weeks of their critical medications in a home disaster kit.

During a town hall meeting on disaster preparedness last fall, I was approached by numerous people asking how they could obtain an emergency supply of their medications. Physicians frequently don't think about providing extra prescriptions for this purpose. And even if they do, insurance companies often are not willing to pay for extra medication without a tremendous amount of red tape. I suggest that physicians and their patients petition insurance companies to cover these needed medications. In addition, I advise patients who do have a backup supply to be diligent in making sure they monitor the dates so they aren't storing expired prescriptions.

Disasters have a much greater impact on our most vulnerable patients: children; pregnant women (and women in general); the physically or mentally disabled; chemically dependent; elderly; cognitively, visually, and hearing impaired; and those with chronic illness. These also are most likely to be disadvantaged socioeconomically. The psychological effects of disaster, especially anxiety and PTSD, tend to be greater in these patients as well. Therefore, I'd suggest identifying those at highest risk first and helping them to develop disaster plans, which can markedly improve their ability to cope. We could all learn from our nephrologist colleagues who routinely help their dialysis patients—for whom major

disasters are life threatening—make disaster plans.

Children are more susceptible to chemical and radiation exposures, fire, dehydration, and other dangers. Their immaturity and lack of experience makes them more vulnerable to psychological trauma as well. Elderly patients are more likely to have chronic medical conditions and become confused and disoriented. Pregnant women require excellent nutrition and supplements and are at risk for disrupted prenatal care and preterm labor. Disabled patients have individualized, special needs. Obtaining disaster information and instruction for non-English-speaking patients is also a special challenge. Each of these groups requires unique planning.

To help with the planning, ask yourself and your staff the following questions:

- What extra supplies might be needed?
- How do we best communicate with our most vulnerable patients?
- Where can they go for help?
- Who will care for them?

Training patients what to do during earthquakes, fires, and other emergencies is critical to alleviate fear, injury, emotional trauma, and possible abuse.

Our most vulnerable patients should be provided a written summary of their medical history, including medications, allergies, major medical problems, treatments, surgeries, etc. This is invaluable when power and electronic records are inaccessible, when dealing with communication or language barriers, and when there are hundreds of casualties at our doorstep.

Communication is key to a solid disaster response. The public needs to know what is happening, what to do, and where to go for help. This includes parents who

clinics, hospitals, nursing or assisted living homes, suppliers, and other businesses developing their own Disaster Response Plans (see "What Should Be in a Disaster Plan" on page 4) allowing them to stay in business, helping to care for the flood of injured people.

- Lastly, we coordinate our community: (1) clinics working together, sharing supplies, working space, and staff, (2) developing communication plans with staff, other clinics, hospitals, first responders, departments of public health and emergency management, and patients, (3) planning how to put volunteers to work efficiently, and (4) partnering with retirement and nursing homes, schools/universities, community organizations, churches, funeral homes, and other businesses.

This kind of planning will allow a robust response to any disaster and assist in a more rapid recovery.

In a recent survey of 64 local clinic administrators, one of the questions

Following a Call to Leadership Matrix Anesthesia CEO Moves Group to Impact Care for Many

Nearly everyone enters medicine with a passion to care for others, but sometimes that passion extends to improving care across entire populations.

So it was for Sean Kincaid, MD, who found himself drawn to leadership after his anesthesiology practice group merged with another in 2009, linking anesthesiologists at Overlake and Evergreen medical centers in a group now known as Matrix Anesthesia. Matrix continues to provide care at Evergreen and Overlake, as well as for surgery centers and medical offices throughout Kirkland, Bellevue, and elsewhere in the Seattle area's Eastside.

"I was intrigued by an opportunity to make a difference in a lot of people's lives," Kincaid says. "In anesthesia, you care for one patient at time, and that's very rewarding. But when you are in leadership of a medical group and you move it in the right direction, from both a business and a clinical standpoint, it benefits all. That's what drew me to it."



Today, Kincaid is in his fifth year as CEO for Matrix. He's served on the board since Matrix's inception, beginning as board secretary. "I was simultaneously involved in the Washington State Society of Anesthesiologists," he says. "I served as its president and on the board for many years, basically for similar reasons as to why I'm in leadership at Matrix—you can move an organization in the right direction to impact care for a lot of patients. That's very satisfying."

With more than 60 physicians and several nurse anesthetists, Matrix is one of the larger anesthesia groups in Puget Sound, and Kincaid enjoys the huge variety of care it provides, from anesthesia for complex, lengthy hospital-based neurosurgeries, to surgery centers for things such as simpler cosmetic or sports medicine procedures.

Kincaid, a native of Lynnwood, Washington, attended college and medical school in Texas. Almost right away he discovered the place in medicine he wanted to be. "I knew I liked the operating room environment—it's a very dynamic environment. But I didn't find that pursuing surgery suited my personality; anesthesia really did. It's fun. It's a lot of hands-on patient care, which is very satisfying.

"So, after a general surgery internship, I transitioned to anesthesia. I was mentored by a very well-respected neuroanesthesiologist, and then went on to a critical-care fellowship and a neuroanesthesia fellowship."

FAST FACTS

LOCATION: 18 SITES IN BELLEVUE, KIRKLAND AND SEATTLE'S GREATER EASTSIDE

MEDICAL STAFF: 69 PHYSICIANS AND 2 CRNAS

ESTABLISHED: 2009

MEMBER SINCE: 2010



"I think we all know we are a big group of very skilled clinicians. But increasingly, we need to demonstrate that. We need to have the infrastructure in place to show what our rate of post-surgery nausea is, or the rate of unintended ICU admission. Things like that can be hard to quantify."

SEAN KINCAID, MD, CEO, MATRIX

Prior to his current job, Kincaid worked at Harborview Medical Center, as well as on the faculty at the University of Washington School of Medicine, splitting his time between the operating room and neurosurgical critical care.

"When I came to Evergreen I was initially just doing anesthesia, but then I began to fill in at the ICU when they needed an intensivist," he says.

Matrix is an early adopter of a perioperative surgical home model, Kincaid says. It is modeled after the patient-centered medical home model where the primary care provider stands in the center of patient care, acting as a quarterback directing all services. Similarly, in the perioperative surgical home model, anesthesiologists lead team-based care from the time a patient enters the hospital or day-surgery

center, through the surgery itself, and then post-operatively. The goal is coordinated, effective, efficient care from admission to discharge.

"There has been a lot of talk recently at the national level about the perioperative surgical home," Kincaid says. "We have taken that concept to mean providing great medical care for surgical patients from the time the decision is made for surgery until the patient is transitioned back to regular life afterwards. That means taking care of conditions such as diabetes or obstructive sleep apnea so that these medical issues don't complicate the patients' surgical

care or result in readmissions. We want to make sure we have the necessary and most effective processes in place for surgery. That's been a big focus for us—more process-oriented care, rather than individualized, clinician-dependent care. We want standard expectations, for example, on what the best practice is for managing the diabetic surgical patient, to make sure we provide the right medical care. And we want good process for care transition if we hand off a medically complex patient to a hospitalist or intensivist following surgery."

One challenging issue for Matrix is how to efficiently integrate all sizes of business clients into their model. "I think the challenge for us is how do we serve the niche, boutique services, like smaller surgery centers or cosmetic surgery practices?" he says. "Where do they fit into our business?"

Matrix does well at understanding the many masters it serves, Kincaid

believes. "I do think Matrix does a good job of recognizing that we have several customers. One is providing great care to patients, but also providing a good service to the surgeon and to the hospital or facility where we are at. I think we are definitely a service industry."

Which brings up another challenge: demonstrating that excellence. "I think the very biggest challenge we face right now is really figuring out how to show we provide great clinical care. I think we all know we are a big group of very skilled clinicians. But increasingly, we need to demonstrate that. We need to have the infrastructure in

place to show what our rate of post-surgery nausea is, or the rate of unintended ICU admission. Things like that can be hard to quantify, but increasingly we are practicing in an environment in which payers, either the government or private insurers, want to know these things.

"Certainly, in the near future, we will look at alternative payment models and how to participate in bundled care. We are trying to anticipate where it will all go in the future."

He does get out from the boardroom and the operating room: "I'm married and have two young kids—an 8-year-old daughter and an 11-year-old son—and we love to travel. We love to spend time on the water when the sun is out."

And his family has thrown a happy disruption into their lives: "We just adopted a puppy, a Wirehaired Pointing Griffon named Sako. We just picked him up a week ago, and he's chewing on everything." 



Planning ahead for redundancy in communications will help to prevent any facility from being left without an effective way to communicate.

(What Should Be in a Disaster Plan, Continued from page 5)

dual mandate health-care facilities have to continue to provide care to existing patients while dealing with an influx of casualties.

APPLYING THE THREE CS

The criticality of disaster planning can make the task seem daunting. However, disaster planning involves breaking down the three broad goals (Continuity of Care, Communication Channels, and a Coordinated Response Protocol) into manageable planning components, keeping in mind the all-hazards approach.

Continuity of Care – Continuing care applies not only to the physical care of those currently seeking medical attention, but also to the full continuity of the facility's operations. This includes establishing plans to obtain medical supplies, equipment, and other resources; planning for a possible overall greater demand for these resources; and the possibility of established supply channels experiencing delays or not being operational at all. It also includes planning for the protection of medical and other vital records and equipment to ensure these assets are not lost in the event of damage to structures or systems. Federal law underlines the importance of having this component built into disaster plans. Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to have a contingency plan to ensure all electronic protected health information is available during disasters. However, in a disaster, not just patients' records are at risk. During Hurricane Sandy, NYU Hospital's generators failed, causing an immediate evacuation of the facility and resulting in the loss of years of innovative research. Prior planning for the use of redundant systems may have been able to prevent this loss.

An additional layer of continuity of care is integrating into a disaster plan the use of alternate care sites (ACS). These are

community-based locations that may provide additional treatment area(s) with a minimum specific level of care for patients. A major disaster could result not only in an increased demand for medical care, but it could also significantly impact a community's ability to meet the health and medical needs of the impacted population. In these situations, it may be necessary to identify, convert, and activate a location that is not currently providing health-care services. Additionally, a medical facility, where the usual scope of medical services does not normally include large-scale urgent care or traditional inpatient services, could be used as an ACS. A best practice in ACS selection is to use existing infrastructure that is already within health-care facilities, such as attached gyms, physical therapy offices, outpatient surgery centers, or cafeterias.

Communication Channels – During a disaster, communications channels become more crucial and more complicated than they are on a typical day. Internally, facilities need to create and communicate notification procedures to leadership and staff. This may include establishing phone trees, call lists, or other forms of reaching staff to report on the status of the facility and the need for staffing. In larger facilities, staff members will need a way to easily communicate with each other that accounts for the possibility of a surge of patients or the possibility of normal communication channels being unavailable. Externally, facilities will need a way to communicate with first responders, other facilities, and other response agencies. (Planning ahead for redundancy in communications will help to prevent any facility from being left without an effective way to communicate.)

Coordinated Response Protocol – Building a coordinated response structure involves health-care facilities not only looking within their own organizations, but also looking

outward to integrate into a community-wide response. (Health-care facilities need to be prepared to work with government agencies, first responders, and other health-care providers, depending on the needs created by the disaster.) These entities can interact with health-care facilities during disasters, either as support for the facility, as seekers of support themselves, or as seekers of information. For instance, if a hospital were to lose power during a hurricane, it would most likely seek external support so it could tend to the issue or so it could relocate those currently in the hospital's care. However, there could also be instances, such as a large sheltering event, when external entities may be seeking patient information about people residing in a shelter. The U.S. Department of Health and Human Services provides a decision making tool to help facilities navigate requests for patient information, while also avoiding any HIPAA or other regulatory violations. Working with external entities (such as health-care coalitions) during the planning process and sharing response procedures during blue-sky days helps to ensure internal confidence and improve response efficiency as staff members carry out these operations.

Building a response structure internally involves identifying staff members' roles and responsibilities, educating staff members on those roles and responsibilities, and practicing to make sure they understand their roles and responsibilities. It involves identifying key staff and leadership to be available during business and non-business hours and establishing whom to call, when to call, and how to call in the event of an emergency.

One of the more challenging situations a health-care facility may face is an unexpected evacuation. If a hospital loses power and generators fail, the hospital is left with no choice but to get patients to a facility that

(Continued on page 21)

HIGHLIGHTING THE SPECIFIC NEEDS OF HOSPITALS, LARGE CLINICS AND SMALL PRACTICES

PLAN DEVELOPMENT	HOSPITALS	LARGE CLINICS	SMALL PRACTICES
Roles and Responsibilities for Leadership and Key Personnel (during business and non-business hours)	X	X	X
Emergency Procedures	X	X	X
Staffing			
Notification	X	X	X
Sheltering, Feeding, and Transportation (for longer duration/higher severity events)	X		
Rotation Schedules (including appropriate rest periods for staff)	X	X	X
Volunteer Management	X	X	X
Communication			
Internal			
Notification	X	X	X
Leadership Communications	X	X	X
Staff Communications	X	X	X
Alternate Communications Plan (when primary methods are rendered unusable)	X	X	X
External			
Public Relations	X	X	X
Government Agencies	X	X	X
First Responders	X	X	X
Other Health-Care Facilities	X	X	X
Facility Layout Plans			
Patient Surge	X		
Decontamination Space	X		
Additional Family/Visitor Space	X		
Retaining Space for Staff Briefings/Breaks/Sleep	X		
Shelter-in-Place Procedures	X	X	X
Patient Discharge Procedures (including cancellation of elective procedures)	X	X	
Evacuation Procedures	X	X	X
Where to Relocate Patients	X		
How to Relocate Patients	X		
Equipment Plan			
Necessary Quantities	X		
Equipment Deployment Plan	X		
Training for Specialized Equipment	X		
Resources			
Hazmat Emergency Supplies	X		
Communications Equipment	X	X	X
Evacuation Equipment	X		
Inventory/Restocking Responsibilities	X	X	X
Donations Management	X		
Continuity of Operations			
Plans to Obtain Medical Supplies, Equipment, and Personnel	X	X	X
Alternate Care Site or Transfer of Patients	X	X	X
Protection of Medical Records, Vital Records, Research, and Equipment	X	X	X
Recovery Procedures			
Returning to Normal Operations	X	X	X
Damage Assessment	X	X	X
Supply Replenishment	X	X	X
Training and Exercise Plan			
Frequency of Trainings and Exercises	X	X	X
Varying the Severity of the Scenario in Exercises	X	X	X

Disaster Planning and Response Community Resources

Where to Go to Get Started on Your Plan



Endless information is available online and in print on the topic of disaster planning and preparedness. Every federal, state, and local agency publishes content to help physicians, clinic administrators, and staff members prepare for and respond to disasters.

But how do you know where to start? To make this information more accessible for our readers, we asked select organizations and agencies to provide their recommendations for resources. Now you can cut through the clutter and begin your disaster plan or update an existing one.

WASHINGTON STATE

WASHINGTON DEPARTMENT OF HEALTH (DOH) – WATRAC AND WA SECURES

Washington DOH utilizes systems already in place (e.g., the National Incident Management System [NIMS] and Incident Command System [ICS]) to coordinate efforts during emergencies. It also works closely with county health departments and regional health districts to address public health issues and respond to emergencies. Regional health districts do their part by conducting meetings, offering training, and helping with coordination in their areas.

WATrac is Washington's web-based health care resource tracking and alert system for statewide collaboration, not only during emergency responses, but also on a daily basis. WATrac allows health-care and public health partners to:

- View real-time data related to the status of health care in Washington.
- Post and share documents for WATrac members and nonmembers.

- Conduct online chat sessions 24/7; inviting WATrac users from all health-care sectors and in all parts of the state.
- Send emergency alert notifications via e-mail, text message, or pager.
- Use standard and ad hoc reporting to turn data into actionable information.

WA Secures works in a similar way to WATrac and serves as the state's public health alerting site. It is used to send messages to local public health jurisdictions, tribes, and emergency response partners statewide.

WA DOH – WASHINGTON STATE EMERGENCY REGISTRY OF VOLUNTEERS

The Washington State Department of Health maintains the Washington State Emergency Registry of Volunteers (WAserv), which is a statewide database of volunteers who are ready to respond to public health emergencies locally, across Washington, and in other states. WAserv allows health care, public health, and support professionals to go online, provide information about themselves, and indicate their willingness to volunteer in emergencies.

This registry serves as a resource for local health jurisdictions and emergency managers by allowing professionals to join existing programs that provide liability protection for emergency volunteers. These programs include the Medical Reserve Corps (MRC), the Local Volunteer Management Unit (VMU) in a volunteer's own country, and/or a volunteer's Tribal Nation affiliation.

MEDICAL RESERVE CORPS

The Medical Reserve Corps (MRC) is a national network of volunteers, organized to improve the health and safety of local communities. MRC volunteers include medical and public health professionals, as well as other community members who do not have health-care backgrounds. MRC units engage these volunteers in strengthening public health, improving emergency response capabilities, and building community resiliency. They prepare for and respond to natural disasters, such as wildfires, hurricanes, tornados, blizzards, and floods, as well as other emergencies affecting public health, such as disease outbreaks. 

RESOURCES

WASHINGTON	
Washington – Statewide Resources	
Washington Guide to Emergency Preparedness Resources	tinyurl.com/pjriylr
Washington State Comprehensive Emergency Management Plan	tinyurl.com/hhgrqbp
Washington State Emergency Registry of Volunteers & Health Alert Network (WAserv & WA Secures)	waresponds.org
Washington State Department of Health	
Emergency Communications Toolkit	tinyurl.com/h8lkd8t
WATrac	tinyurl.com/heuh3fb
Washington State Emergency Registry of Volunteers & Health Alert Network (WAserv & WA Secures)	waresponds.org
Project Access Northwest	projectaccessnw.org
Emergency Preparedness Fact Sheets	tinyurl.com/hrubh4y
Regional & County Health Districts and Resources	
King County Public Health	tinyurl.com/gmpe8vn
Snohomish Health District	tinyurl.com/j76q3c2
Spokane Regional Health District	tinyurl.com/zx8fent
Yakima Health District	tinyurl.com/zcj6dcr
OREGON	
Health Alert Network (HAN) connects hospitals, clinics, laboratories, public safety, EMS, and many other public health partners via secure web applications that facilitate information sharing throughout Oregon and SW Washington. The system is managed by the Oregon Health Authority - Public Health Division - Health Security, Preparedness and Response Program.	tinyurl.com/jo8qaxk
Hospital Capacity web system (HOSCAP) allows health care and emergency preparedness partners to share real-time status data.	
State Emergency Registry of Volunteers (SERV-OR) is a statewide registry system to help pre-credentialed health-care professionals volunteer their services during emergencies that result in significant health impacts.	
Health Security, Preparedness and Response Program:	Health.Security@state.or.us 971-673-1315
EMERGENCY CONTACTS	
Oregon Emergency Response System (OERS):	1-800-452-0311
On-Call Public Health Emergency Preparedness Duty Officer:	971-246-1789 (cell) 503-938-6790 (pager)
Oregon 24-Hour Disease Reporting (ACDP):	971-673-1111
Oregon Radiological Emergency Response:	971-673-0490
IDAHO	
Ready Idaho	tinyurl.com/z9es6r5
Southeastern Idaho Public Health – Healthcare Preparedness Program	tinyurl.com/hwplt87
Panhandle Health District – Public Health Preparedness	tinyurl.com/j2y8bv3
Southwest Idaho District Health – Emergency Preparedness	tinyurl.com/hgapg3k
Idaho Office of Emergency Management	tinyurl.com/zsn4nte
WYOMING	
David B. Edwards, MA, CHEP, CEM, Hospital Preparedness Program Coordinator, Office of Emergency Medical Services, Health Readiness and Response Section, Public Health Division, Wyoming Department of Health,	david.edwards@wyo.gov 307-777-6904 (office) 307-274-6274 (cell)
Sheryl Roub, Unit Manager, Public Health Emergency Preparedness Unit, Wyoming Department of Health,	sheryl.roub@wyo.gov 307-777-7146 tinyurl.com/j3wfe2m
James Smith, Improvement & Development Supervisor, Public Health Emergency Preparedness Unit, Wyoming Department of Health,	james.smith5@wyo.gov 307-777-6777
Public Health Emergency Response, 24/7 Telephone Response Line, Wyoming Department of Health	1-888-996-9104
Wyoming Activation of Volunteers in Emergencies (WAVE)	volunteerwave.org

(What Should Be in a Disaster Plan, Continued from page 18)

has the resources to care for those patients. This involves planning how to physically move patients and determining where they will be sent. Working with other health-care facilities before a disaster to establish agreements and procedures for emergency patient acceptance can greatly reduce the challenges presented by this scenario. Some patients may be able to be discharged instead of evacuated, depending on the current status of the situation. Establishing patient discharge procedures for pre- and post-disaster can greatly reduce the strain on resources in the event of an evacuation.

IT'S TIME TO PLAN!

Adopting an all-hazards approach to disaster planning is an essential component of health-care-facility preparedness. Health-care facilities and their staffs are uniquely positioned in a disaster to be called on to fulfill a response role while continuing to deliver vital services to the existing patient population. Taking the time to assess the facility's level of preparedness and undertaking the disaster planning process not only leaves the facility better able to respond to a disaster, but ultimately can save money, resources, and most importantly, lives. 



Ashley Wargo is a consultant with Hagerty Consulting. She works building public health capabilities around the country through planning, exercises, and PPE/decontamination procedures for biological events. Most recently, she has been dedicated to building out public health and medical resources to be deployed in large-scale disasters.

Hagerty is an emergency management consulting firm with more than 15 years of experience helping both public and private sector clients prepare for and recover from disasters. Hagerty has expertise in planning, training, and exercise in areas such as cybersecurity, continuity of operations, biological event response, and many others. For a full list of capabilities, please see www.hagertyconsulting.com.

(Ransomware Target, Continued from page 7)

business from a data breach and how to keep it running after a disaster occurs—which would be any time crucial data or mission-critical software couldn't be accessed.

The single most important step a hospital, clinic, or solo office can do is decide to prepare for a breach. Smaller clinics and solo practices often think, "It can't happen to me." They assume that protecting their "house" is too expensive, and doing so wouldn't make a difference anyway. They decide to take a chance, and if a breach comes, they will just react to it. Sadly, it's only a matter of time before they're hit.

A wiser approach is to be proactive and seek to understand the scale of potential problems. Take precautions, not only concerning who gets into the home, but also how to detect a breach. Teach the family (partners and staff) what to do to both prepare (create a plan beforehand) and prevent/detect future break-ins. Monitor the house and security-control upgrades. Be active in the neighborhood (network with peers) and keep evolving.

One of the first questions an IT security professional might ask is how old your IT system is and if you are maintaining it. Updating hardware and software is a cost of doing business, yet many health-care businesses are still running outdated servers and software. Do any physicians or staff members still use pagers or old flip phones? Some practices still limp along with Windows NT, which officially went out of support in 2006. That means more exposure and an increased risk of being hacked or catching malware or computer viruses.

In addition to having outdated operating systems, another potential problem is having medical scanning equipment that holds large images on outdated hard drives. Without active backups and security, this data can also be at risk.

But that's not the only way bad actors

compromise your systems. The two most prevalent methods these days are Advanced Persistent Threats (APTs) and ransomware. APTs are highly sophisticated and bypass virtually all cybersecurity "best practices" to maintain a compromised network presence. They are stealthy, targeted, and aim to monetize by observing behavior to maximize attacks on specific data. Ransomware, on the other hand, does not care what data it encrypts. Its sole purpose is to encrypt as much data and as many systems as quickly as possible across the network and anything it can penetrate. Thus, it acts swiftly to lock down all possible data. Medical facilities are targeted because of their need to continue to serve their patients.

SO WHAT CAN BE DONE?

Any retail store runs the risk of shoplifters stealing items. But when shoplifters enter a store, they typically act like normal customers. It's only when they perform some kind of behavior, such as concealing unpaid items and attempting to leave, that their behavior can be detected—and action must be taken to catch them before they leave the premises.

The same goes for cybersecurity. First, business risks (what is the critical data, and what would happen if this data were compromised?) must be determined for the medical clinic/practice/facility. A layered approach for protection, plus the ability to detect anomalies once they enter the network, are critical steps. Second, the vulnerabilities (bad behavior, such as poor documentation) to those risks must be identified. And third, these vulnerabilities must be mitigated automatically to reduce the risk to the medical practice.

The same approach applies when attempting to detect the APT or malware behavior—once it acts like a shoplifter—and to catch it before it departs with data or infects your systems. It's important to note that this is not a common-sense "Let's catch all the vulnerabilities out

there" approach. Instead, it is a targeted means of reducing the risk for your medical practice and protecting your data.

Data protection solutions are always evolving. Magnetic tape technologies were the standard for a very long time. However, challenges are inherent with these technologies. Both speed and reliability are outperformed by disk-based solutions, which are able to restore data more quickly, due to the ability to directly access the data without reading through an entire tape. Disk-based systems can be complex to manage, and the speed of today's networks makes Disaster Recovery as a service an attractive solution for medical practices with very small IT departments. But the process of backing up and restoring data in disaster recovery situations has stayed the same over the years.

The single most important step a hospital, clinic, or solo office can do is decide to prepare for a breach.

HIPAA: A GUIDE TO PROACTIVE STEPS

Guidance for the required minimal proactive steps needed to protect your business and patients, while remaining OCR compliant, can be found in the HIPAA regulations. The heart of HIPAA is all about having five plans, along with supporting procedures, backing up data, testing, and analysis. The five required plans include:

1. Data Backup Plan (the second backup must be offsite and on US soil)
2. Disaster Recovery Plan
3. Emergency Mode Operation Plan
4. Testing and Revision Procedures
5. Applications and Data Criticality Analysis

To pick the best solution for the first plan (Data Backup), you must first know your data and then decide what's most important. You must also determine your critical operations software applications.

Given that 70 percent of data is "inactive," a critical question concerns how fast you'll need the backed-up data (recovery time) and the time period that the backup should cover. Also consider what data you need first (patient records vs. scheduling vs. accounting) during a recovery to keep operations sustainable and what software applications need to be restored first, second, third, etc.

To understand the interaction of data and software, it's important to create a Business Impact Analysis (BIA). This is where IT professionals come into your organization and interview employees, mapping the workflow of the data and software used, and indicating on which hardware it is displayed. Key business roles within the organization must be included. Representatives for these roles attend a workshop to review the findings and validate accuracy.

The next step is to determine risk tolerance. What data is most at risk? What is your tolerance level for data and operations risk? You could apply a risk scale of one to 10 (one being the safest) to data and processes. For example, the BIA might find that the executive team's risk tolerance is a four, but they are operating at a seven. You must close this gap through risk mitigation techniques or reassessing the acceptable risk. Effective data backup/recovery (and security, for that matter) are based on defining the acceptable business risk.

From there, after you understand which solutions are to be used for backups, you create the Disaster Recovery (DR) plan. The basics of a data-breach plan for any sized health-care operation include:

- Disaster Recovery Planning stage
- DR Solution choice

- Implementation of DR solution (training)
- Testing of DR solution
- Sustainment mode

It's sobering to recognize that data breaches, either accidental or covert, will never be completely eliminated, and there are no technologies or best practices that can guarantee 100 percent protection. Still, when you seek professional security help and prepare for a breach, you stand the best chance of protecting your business and your patients. 

References

- ¹ "Colorado Allergy Clinic Reports Ransomware Attack," HIPAA Journal, July 6, 2016, accessed September 2, 2016, <http://www.hipaajournal.com/colorado-allergy-clinic-reports-ransomware-attack-3493>.



Bryce Matsuoka, CEO/
President of AboveCloud, has more than 25 years of technology consulting and corporate experience in health care, finance, retail, and other industries. The AboveCloud team helps health-care practices

simplify HIPAA compliance to become audit ready, protect data from cybercrime, and proactively manage information technology.



MOST COMMON BREACH GAPS

- 1. No plan testing and practice** – Some organizations have a breach and recovery plan, but they don't test the plans or practice them.
- 2. No business impact analysis** – Trying to protect everything may lead to overspending. A tiered approach is a best-practices way of providing protection at appropriate levels.
- 3. Not understanding an organization's data requirements**, e.g., who needs to access the data, how much data a particular user should see, how authentication will be handled, how the data is mapped, and how the database will be protected against viruses, deletion, corruption, and eavesdropping.
- 4. Using default passwords.** Hackers can easily look up a default password for all hardware.
- 5. Giving contractors old laptops or tablets** that don't have bank-level security.

DISASTER RECOVERY ISSUES AND CHALLENGES Hospitals

- More records plus more complexity plus more people equals more risk.

- Data recovery plans for large hospitals require sophisticated solutions so that backup recovery is virtually instantaneous across multiple sites.
- Increased ransomware attacks place a heavier load on keeping current backups while ensuring that regular testing of disaster recovery implementation occurs.

Clinics

- Fewer resources to manage security risks.
- Typically follow traditional methods of IT (minimal expenditure).
- May not have outdated systems and processes.
- May not have adequate data-breach policies.

Small/solo practices

- Minimal budget to sustain plans once developed.
- Most likely to have outdated systems and processes.
- Backup response time not as critical.
- Responsibility for IT given to office/practice manager instead of an IT expert.
- Even if an IT expert is assigned to handle IT services, the approach is often a reactive one, making the practice susceptible to outdated backups and security concerns.

RISK MANAGEMENT

CME IN 2016

All CME is offered at no charge to our members

PROVIDER NEWS



Suicide Prevention Training for Washington Providers

Suicide claims more than 1,000 lives a year in Washington State, yet many medical providers have little to no training in recognizing and responding to patients at risk. RCW 43.70.442 requires all physicians and affiliated providers to complete, at least once every six years, a minimum of six hours of training in suicide assessment, treatment, and management that is approved in rule by the relevant disciplining authority:

For a list of courses approved by the Medical Quality Assurance Commission (MQAC), along with other resources, see “Suicide Prevention” under the “Popular Topics” tab in the Risk Management section of the Physicians’ Insurance website

www.phyins.com/risk-management/suicide-prevention

WA State Law Requires HIV Screening

Effective June 9, 2016, Washington State providers must include HIV testing in routine health screenings for people ages 15 through 65 and for all pregnant women, unless the patient declines. Incorporating the screening into routine care is expected to lead to earlier diagnosis and reduced transmission.

ONLINE



EMTALA: What Physicians Need to Know

This one-hour, one-credit monograph Internet activity will provide data and analysis of actual claims of EMTALA (Emergency Medical Treatment and Active Labor Act) violations, showing what factors caused the patient claim to win and the hospital to lose. It will also show the array of penalties that may be levied against hospitals and physicians for EMTALA violations. The speaker will present Best Practices for Emergency Departments to reduce the risk of adverse events and claims from EMTALA violations, including the difficult situations of psychiatric patients in crisis, non-English speaking patients, and laboring patients without prior obstetrical care.

EMTALA: Regulation and Best Practices for Nurses/Hospitals

Hospitals work hard to care for patients and follow the law. But growing patient numbers and declining availability of emergency department services put hospitals at risk for an EMTALA violation. The issues are not new—just more urgent than ever. This one-contact-hour video addresses the common and persistent challenges surrounding capacity and capability, stabilization for transfer, medical screening exams, and on-call employees. Behavioral patients add another layer of complexity, especially with closures of psychiatric units. Health-care attorney Normand F. Pizza, JD, will present the legal ramifications of inappropriate transfers, failure to stabilize, and failure to screen lawsuits. EMTALA statutes and regulations will be reviewed, and examples of best practices will be presented.

Search for and view online courses at www.phyins.com/onlinecme

LIVE EVENTS

2016 Risk Management Summit: Fostering Resilience

For hospitals, large clinic administrators, risk and quality professionals

Friday, October 21

7:30 AM – 4:30 PM

DoubleTree Hotel Seattle Airport, Seattle, WA

The majority of us are facing provider wellness issues. Control this trend before it controls your practice. Health-care professionals face increasing stress, resulting in burnout and dissatisfaction at accelerated rates. Learn tangible solutions to help your team remain resilient during this hectic time in medicine.

This conference teaches practical strategies to improve provider resilience and satisfaction. Through an introduction to collaborative care teams, how to develop partnerships with patients and their families, and how to recognize and address burnout, health-care professionals are equipped to achieve success in these areas through education, peer support, and mindfulness.

Free to our members; available to nonmembers for \$299.

www.phyins.com/summit2016

Delivering Good Outcomes: Hands-on Skills for Improving Management of Postpartum Hemorrhage and Shoulder Dystocia

Suited for obstetricians, family medicine physicians who do ob, emergency medicine physicians

Friday, November 4, 2016

8:15 AM – 12:30 PM

Swedish Cherry Hill Simulation Lab
500 17th Ave, Seattle, WA

When a routine delivery turns into an emergency, you need the confidence that can come only from skills built into muscle memory. But how can you achieve those skills in situations you face infrequently? Simulation training is a proven and powerful answer.

Physicians Insurance, in partnership with InSytu Advanced Healthcare Simulation, has brought together clinical expertise with hands-on simulation training in a supportive, state-of-the-art learning environment.

This half-day workshop will give you practice in managing postpartum hemorrhage and shoulder dystocia. Using high-fidelity simulation manikins, you'll receive real-time feedback from faculty and share insights with colleagues.

tinyurl.com/j5v8guu

Adult and Pediatric Emergency Airway Management: Hands-on Techniques to Sharpen Your Skills

Suited for emergency physicians, hospitalists, intensivists, ICU and critical care physicians, and certified registered nurse anesthetists

Friday, November 4, 2016

12:45 PM – 4:45 PM

Swedish Cherry Hill Simulation Lab
500 17th Ave, Seattle, WA

When every second counts, optimal airway management skills can save a life. Simulation training is a powerful way to refresh and improve airway skills in a supportive setting. This half-day workshop will focus on adult and pediatric patients experiencing an airway emergency.

Physicians Insurance, in partnership with InSytu Advanced Healthcare Simulation, has brought together clinical expertise with hands-on simulation training in a state-of-the-art learning environment. You'll have plenty of time to practice and receive real-time feedback from faculty on techniques including:

- Bag mask ventilation, oral airways, nasal airways
- Direct laryngoscopy and introducers (Eschmann stylets), exchange catheters (Cook catheters)
- Laryngeal mask airway and intubating LMA
- Videolaryngoscopy
- Fiberoptic intubation
- Percutaneous cricothyrotomy and jet ventilation

Free to our members; available to nonmembers for \$199

tinyurl.com/hafuptd

WEBINARS

The following new webinars, as well as numerous resources for practice and facility management, can be found at www.phyins.com/practicemanagement:

Provider Business Resources:

Real Estate Strategies for Medical Providers

As part of your disaster preparedness planning, you may wish to consider a possible practice relocation—especially in an emergency—so care is accessible where it is needed. This webinar will address various aspects of why real estate matters, including how physical environment affects organization operations, how real estate's large expense can be an asset or a liability for the organization, and considerations in making long-term decisions. Health-care real-estate trends and how to get started developing a real-estate strategic plan will also be covered.

tinyurl.com/h8vc56s

De-Mystifying MACRA: The Medicare Access and CHIP Reauthorization Act of 2015

tinyurl.com/jfon8c6

MIPS Proposed Rule: Big Changes to Medicare Physician Payments Starting in 2017

tinyurl.com/zb5xk8d

GOOD SAMARITAN LIABILITY BILL INTRODUCED IN THE US SENATE

Protection Sought for Physicians Treating Patients in Federally Declared Disasters



On June 27, Senators Bill Cassidy, MD (R-LA) and Angus King (I-ME) introduced S. 3101, the Good Samaritan Health Professionals Act of 2016, demonstrating increased support on Capitol Hill for legislation that has been a longtime priority for physicians and their medical professional liability carriers. The bill provides civil liability protection to licensed health-care professionals who volunteer their time and talent to treat victims of federally declared disasters. The bill applies protections only to those treating disaster victims after a state has requested a federal disaster declaration. Such a declaration ensures that the protection of current state medical liability systems remains in effect until the declaration expires.

Senator Cassidy has proven leadership on this issue and is recognized and appreciated as a gastroenterologist with personal experience following the devastation of Hurricane Katrina in 2005. He led the effort to convert an abandoned KMart store into an emergency medical facility so disaster victims could have access to medical volunteers in their greatest time of need.

The proposed bill S. 3101 is identical to H.R. 865, the Good

Samaritan Health Professionals Act, which was introduced on February 11, 2015, by Representative Marsha Blackburn (R-TN) and David Scott (D-GA). To date, the number of bipartisan cosponsors has grown to 47. Physicians Insurance is currently engaged in a lobbying effort to secure bipartisan support from our congressional delegations in Washington, Oregon, and Idaho.

Advocacy works! Since Physicians Insurance's participation in the PIAA's Annual Fly-In in Washington, DC, in May to meet with several members of Congress, five new bipartisan cosponsors endorsed H.R. 865, and S. 3101 was introduced in the Senate.

The PIAA is the leading national insurance trade association in the medical professional liability arena that advocates on federal and state, regulatory, legislative, and NAIC issues. Anne Bryant, Physicians Insurance's Senior Director of Government Relations, is the newly elected Chair of the PIAA's Government Relations Committee. For more information, visit: piaa.us

For more information on H.R. 865, visit congress.gov/bill/114th-congress/house-bill/865

Physicians Insurance is proud to promote and support the Good Samaritan Health Professionals Act of 2016. In times of crisis, such as natural disasters—earthquakes, volcanic eruptions, landslides (including the recent Oso [WA] landslide), wildfires, periodic floods, and other tragedies in the Northwest—as well as senseless acts of terrorism, it is vital that patients across the nation have timely access to quality medical resources.

Unfortunately, current federal law does not provide adequate protections to health-care providers who spontaneously volunteer their medical services during calamities, nor does it protect those volunteers who cross state lines. Further, many state laws that aim to encourage medical volunteerism are ambiguous and inconsistent, especially when applied to catastrophic disasters. This forces medical volunteers to limit services or generally decline participation. The 9/11 Commission Report and the model Uniform Emergency Volunteer Health Practitioners Act of 2007 cite examples of health-care volunteers who were deterred or who delayed offering assistance due to liability and licensure concerns.

For more information on the 9/11 Commission Report (tinyurl.com/gs2z4cb)

For more information on the model Uniform Emergency Volunteer Health Practitioners Act of 2007, see tinyurl.com/jngla5t

Locally, Physicians Insurance supports and promotes free clinics, prescription drug assistance programs, and local medical societies' Project Access programs. Our goal is to improve community health and access to care, as well as to support our many member physicians who volunteer their time to provide no-cost services to low-income, underinsured, and uninsured patients in their communities. We maintain our belief that better access to quality care improves patient safety and generally reduces liability exposure for health-care professionals.

Physicians Insurance will continue to work with the PIAA and others in the health-care community to build additional bipartisan support for the Good Samaritan Health Professionals Act of 2016. Our aim is to ensure that all disaster victims have timely access to quality medical care following catastrophic federally declared disasters. [PR](#)

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



(Disaster Planning, Continued from page 15)

need to find their children in emergency situations. We need situational awareness and regular updates on conditions. It's vital to know who is in charge, who can work, when and where, which clinics are still functional, where we can get extra supplies, and where to find extra staff, along with how to coordinate with hospitals, alternative care facilities, first responders, and emergency managers. Communications should be redundant: cell phones, texting, social media, hand-held phones, satellite phones, ham radio, courier services, and poster boards are all options. Testing and practicing our communications before a disaster is critical.

All this planning may seem overwhelming, and finding time in your already hectic schedules may seem impossible. But fortunately, help is available. (See “Disaster Planning and Response Community Resources” article on page 20.)

Here are a few resources to get you and your staff started:

- In Kitsap County, emergency managers are developing a “train the trainer” program to help outpatient medical clinics become prepared for disasters, kitsapdem.org/preparedness.aspx.
- In Pierce/King County, the Northwest Healthcare Response Network, nwhrn.org, in Pierce/King County is developing modules for online clinic disaster planning.
- In South Snohomish County, the Disaster Medicine Project, facebook.com/DisasterMedicineProject, is hosting a Clinic Disaster Planning workshop on Tuesday, October 25, from 8:30–12 at Swedish Edmonds Hospital: snohomishcountywa.gov/622/Preparedness.

We can't prevent disasters, but by participating in thorough coordinated disaster planning, we can be ready to serve everyone, including the most vulnerable, through robust response and recovery efforts. [PR](#)

Mary Jo Kinter, MD, is a family medicine physician who retired from Edmonds Family Medicine in 2015. She became interested in disaster planning while serving on the Ethics Committee at Swedish Medical Center–Edmonds. She is currently chair of the Ethics Disaster Subcommittee. Her volunteer work also includes working with Dr. Robert Mitchell on the Disaster Medicine Project to promote outpatient clinic preparedness.

Four Years Later



A Hospital CEO's Reflection on Superstorm Sandy

Located on the barrier island of Long Island, New York, the physicians and staff of the NuHealth health-care system know they are at risk when hurricanes and other major storms make landfall, unleashing their force on anything in their paths.

That's why they are vigilant in their disaster preparations and recovery plans. NuHealth's 19-story building—the tallest structure on the island—with its 530-bed, tertiary care trauma center and community health system, is a hub for EMS Telemetry Control and the Nassau County Fire and Police Academy. Its roof is full of antennas that provide communications for an array of integrated state and federal emergency agencies.

In 2012, despite NuHealth being ready for almost anything, Superstorm Sandy's impact was astounding. Now, nearly four years later, CEO Victor Politi, MD, reflects on the experience. "Superstorm Sandy taught us a lot," he says. "Like all hospitals and health systems, we must be vigilant in our preparations, but given our location and risks, we must be even more cognizant of staying ready."

Dr. Politi adds, "Our team is more aware now of how vulnerable we are here on the island. We take it very seriously when major storms are forecast."

Well in advance of Sandy, NuHealth had been actively tracking the storm. Adhering to FEMA's federal disaster training guidelines, they had developed comprehensive plans. A key step in following those plans was establishing an incident command center. NuHealth kept it functioning for three weeks—before, during, and after the storm.

When it became clear Sandy would make landfall literally on top of them, NuHealth enacted its five-day plan, including contacting suppliers (food, gas, etc.), testing generators, and taking other steps to ensure the hospital could function for 10 days to two weeks without any deliveries.

It also evaluated patients to determine who could be safely discharged and/or transferred to other hospitals not in the storm's path. This, Dr. Politi explained, was done so NuHealth could receive a potential surge of patients with storm-related injuries. They contacted union representatives to make sure staff members could hold shifts overnight so they would be on premises to work the next morning. They also helped staff make transportation plans.

Another important step was coordinating with federal, state, and county emergency management. Because NuHealth's facility is located above the flood plain, it was designated a central care destination so it could handle patients from hospitals and nursing homes at risk for flooding.

When the dust finally settled, estimates of Sandy's devastation, as of 2015, indicated about \$75 billion in damage, a total surpassed only by Hurricane Katrina. At least 233 people in eight countries were killed along the path of the superstorm—117 of them in the US. This makes it one of the costliest natural disasters on record in the United States, according to IHS Global Insight, a forecasting firm.

REMEMBERING WITH PRIDE

Thinking back on the experience, Dr. Politi is pleased with

“Our staff members were both victims and first responders, but they really stepped up. They came to work despite being in very difficult conditions.”

how his organization performed. “I’m very proud to be a part of the NuHealth team everyday, but especially during times of crisis!” He notes that many of his staff members live on Long Island, and many of their homes were either seriously damaged or destroyed. “Our staff members were both victims and first responders, but they really stepped up. They came to work despite being in very difficult conditions.”

Dr. Politi adds that the support people give and receive in small towns is well-known, but, “This is the big city, and people really were there for each other.”

Other examples of having each others’ backs could be seen in the legions of carpools getting staff members to and from work, in physicians transporting patients, and in the NuHealth leadership team serving staff meals. Staff members also willingly worked in capacities they never had before, and Dr. Politi says they performed admirably.

POST STORM SURVEY

After the Sandy experience, NuHealth's post incident survey of physicians and staff revealed that communication was the number one weakness—especially the inability to communicate with staff about work scheduling. This was due to power outages making it difficult to recharge cell phones. Ultimately, they sought assistance from the state Department of Health to help facilitate communication and so they could adequately contact and deploy staff.

Another area targeted for improvement was transportation—specifically getting staff to and from work. This was due to impassable roads, as well as gas shortages on the island. The NuHealth team has addressed this by purchasing new four-wheel-drive vehicles and working with gas stations to get special gas vouchers so health-care staff can be at the head of the line in emergencies.

Along with pride in his team, Dr. Politi takes a pragmatic view of how a leader—be it a CEO, COO, or physician—should look at disaster preparation. “I’m an ER doctor, so it didn’t get to me personally,” he says. “It’s just another mission we had to accomplish.” He adds that with every problem, there’s a solution. “You just sit down and come up with a plan. And you must be able to think around obstacles and plan ahead for the known and unknown.”



Although Dr. Politi, his team, and the community found nothing to joke about concerning the hurricane and its impact, he wryly observes, “Seven babies were delivered during the hurricane, but none were named ‘Sandy’.” 



LESSONS LEARNED

Other lessons learned from Superstorm Sandy:

- It’s important to adhere to established management structure and known protocols. “A major crisis is not the time to try new things,” Dr. Politi says.
- Lean Six Sigma principles, which rely on collaborative team effort to maintain performance, were invaluable to run the incident command center during the disaster, as well as in recovery efforts.
- While NuHealth took steps to accommodate a surge of patients—e.g., patients needing dialysis, those who couldn’t get to their primary care provider or to the pharmacy—Dr. Politi says that in their sheltering plans, they should have arranged for more staff members needing housing for a longer period of time.
- Having a pool of even more credentialed physicians ready in advance would have been very helpful to handle the additional patient load.

(You've Got This, Continued from page 11)

AN OPPORTUNITY TO SLOW THINGS DOWN

Researching, planning, and implementing a simulation scenario, such as a mass casualty event, allows health-care teams to have the opportunity to slow everything down and, through their combined experience, thoughtful reflection, and a tenacious desire to get it right, methodically inspect all the components that impact patient care. The customized macro-simulation process can be designed to meet the needs of the team members where they are at.

For example, in the emergency department it might be that a protocol doesn't exist or hasn't been revisited in years. Or the protocol might be so massive and detailed that it is too unwieldy to be useful. For this reason, a simulation will often start with the protocol. The simulation then lifts the protocol from the paper and gives teams the opportunity to refine it based on real-world needs, resources, and challenges. One hospital going through this macro-simulation process was able to simplify

an outdated 15-page protocol down to one page with three clear job aids.

To implement a disaster response simulation, equip the participants for success by helping them understand the goals and by sending them advance information, such as a learning module, so they can prepare for participation. Each simulation session should be designed to be as realistic as possible and include only those individuals who would care for the patient at that particular moment in an actual situation. For instance, since it probably would not be realistic to have five nurses caring for a patient while two others leaned against a wall to observe, the simulation should not be designed that way. Participants should attend the simulation during a time when they will not be called away for other responsibilities, and they should show up dressed and prepared as if they were coming to work.

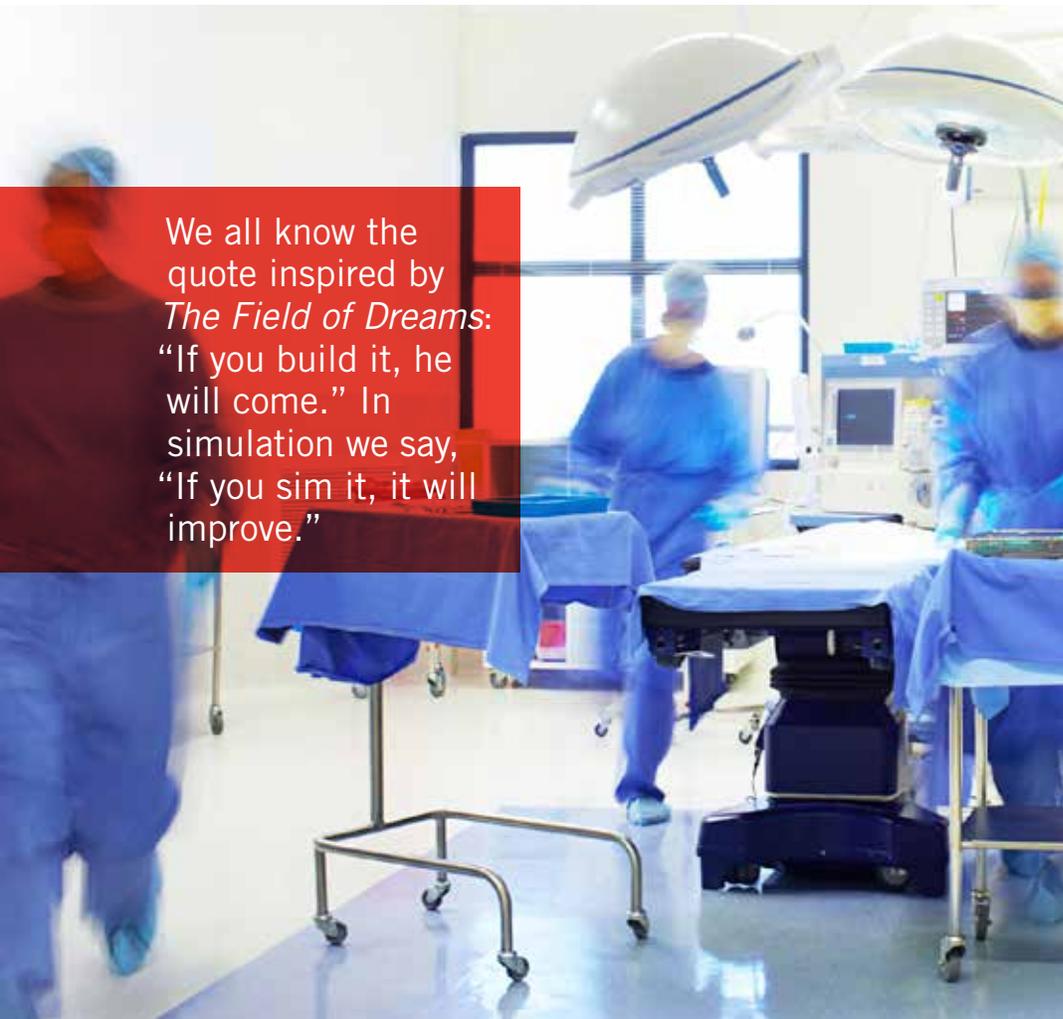
It is helpful to start each session by giving participants an opportunity to review

pertinent information, such as protocols and roles, making sure they are familiar with any simulation equipment they will encounter. They should also understand the end point of the scenario. It is helpful to have a simulation facilitator who can start and end the exercise and call a time-out when a question arises that should be considered. Often simulation sessions are video-recorded for later analysis. So that participants can feel more comfortable during the simulation, they should be given the opportunity to sign consent forms prior to the session and understand all the ways the film may be used.

At the end of the session, simulation leaders guide the team through a debrief to understand what went well, in addition to barriers to quality care, supply and equipment issues, and gaps in safety behaviors, roles, communication tools, and leadership. If video recordings have been made, they are reviewed at this time. In a large emergency department these one-to-two-hour simulation sessions may need to be repeated over the course of several days to insure that most of the caregivers can participate. This helps to create the shared mental model.

DEBRIEF FOR A "GOLDMINE" OF ACTION ITEMS

The debrief—information gleaned from the simulation process—is a goldmine of process-improvement action items. Some are easy wins that can be addressed even during the course of the simulation; others may need more discussion, research, resources, or to be re-simulated in a just-in-time training exercise. All information should be captured through an action-item list so that valuable nuggets are not lost. The multidisciplinary team of simulation planners should regularly refer to the action-item list to ensure completion. If simulation findings are not addressed, then the program's quality and the improvements to disaster preparedness are at risk.



We all know the quote inspired by *The Field of Dreams*: "If you build it, he will come." In simulation we say, "If you sim it, it will improve."

We all know the quote inspired by *The Field of Dreams*: “If you build it, he will come.” In simulation we say, “If you sim it, it will improve.” As director of a large, multidisciplinary simulation program conducting simulations across the country, I regularly hear the heartfelt comments of simulation participants. Here are a few:

- “I’ve supported a large number of quality/safety initiatives, but none with such an impressive impact on patient safety as simulation.”
- “I could have read about this a hundred times and not had the significant learning sink in, but now, six months after our simulation, I can still tell you how it’s done.”
- “I realized through watching our simulation video that my deficit was in communicating to the rest of the team. I now know how to be a better communicator.”

The art of simulation is both simple and complex. Allowing teams the opportunity to slow down an event to thoughtfully practice, identify gaps, and improve team performance is the best way to prepare for that moment when you hear the call, “There has been a disaster.”

But this time, you’ve got it! 

References

- ¹ Agency for Healthcare Research and Quality, “Healthcare Simulation to Advance Safety,” U.S. Department of Health and Human Services, February 2015, accessed August 17, 2016, <http://www.ahrq.gov/research/findings/factsheets/errors-safety/simulproj15/index.html>.



InSytu Advanced Healthcare Simulation has been conducting in situ, multidisciplinary macro-simulations since 2008, with more than 1,500 sessions successfully completed.

For more information, call 206-215-5907 or e-mail theresa.demeter@insytusimulation.com



(Small Disasters, Continued from page 9)

“For smaller disasters, we execute our communication and incident management plan,” says Schwartz. “Impacted on-site frontline managers take the lead. Communication includes all practice leadership, with guidance provided as necessary.” Resolving a recent water leak on the floor where billing and scheduling were located, for example, was handled by the software manager and the building site manager. They kept the clinical and finance directors informed, and it was decided to relocate staff, move work stations, and reroute phones while building maintenance workers made repairs.

“For larger disasters affecting multiple facilities, key information systems, and major impact to patient care,” says Schwartz, “we set up a command center in a conference room, complete with computer and telecom equipment. We maintain an off-line phone list to contact any leader or key staff member to assist with the recovery, as well as to provide progress updates to all of our leadership and the Board of Directors.”

When DHS experienced an enterprise-wide phone outage late one afternoon, leadership followed their disaster protocol. An alternative communications department was established to inform patients via social media that facilities remained open. The incident took several hours to resolve, yet interruption to patient service was minimized.

Again, says Schwartz, anticipating an incident before it ever takes place helps boost everyone’s confidence level. “Designated people take charge. You follow recovery checklists to maintain key work-flows. Regular updates on the recovery process keep people informed. Everyone jumps in and does their job, and that greatly reduces the urge to panic.”

ROOT CAUSE ANALYSIS FOR ALL SIZES OF DISASTER

Not only does DHS employ a simple matrix for categorizing disasters and appropriate responses—minor incident, small disaster, large disaster—but following an incident, there is a root cause analysis and mitigation phase in which leadership gathers input from all key staff members.

In his previous position at Seattle Children’s Hospital, Schwartz saw the power of preparation and creating a plan in case of emergencies. “When you have 500 to 600 nurses charting patient care electronically and that system goes down, it can have an incredible impact on patient care. You need to have ways in place to restore service as soon as possible.”

Schwartz acknowledges that with busy schedules, it can be difficult to devote time to a disaster recovery/business continuity plan. But as disaster-prepared small business owners will tell you, it’s better to be ready for the unexpected today than to be a casualty of neglect tomorrow. 

Trial Results



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



ALLEGED LACK OF INFORMED CONSENT/NEGLIGENT SURGERY

SPECIALTY: Gynecological Oncology

ALLEGATION: A 59-year-old female alleged lack of informed consent and improper surgery in the performance of a total robotic hysterectomy, bilateral salpingo-oophorectomy, and bilateral lymph node sampling. Ultrasound findings included an enlarged uterus and fibroid. Intraoperatively, it was observed that the uterus was indeed very large, the endometrial cavity small, and a pedunculated posterior fibroid displaced most of the uterus. The fibroid could not be removed vaginally and had to be bivalved to be removed. Pathology demonstrated uterine leiomyosarcoma. The plaintiff alleged failure to discuss the possibility of bivalving and failure to obtain consent for this technique, which she alleged allowed for the recurrence of the uterine leiomyosarcoma and a worsened prognosis. The plaintiff claimed lost wages, past and future medical expenses, and pain and suffering, medical specials, and general damages.

PLAINTIFF ATTORNEY: Robert Christie, Christie Law Group, Seattle, WA

PLAINTIFF EXPERTS: Robert H. Young, MD, Pathology, Boston, MA; Donald Goldstein, MD, Gynecology/Oncology, Boston, MA; Steven Anthony, MD, Medical Oncology, Tyler, TX

DEFENSE ATTORNEYS: Ryan Beaudoin, Witherspoon Kelley, Spokane, WA, and Mark Wagner, Hart Wagner, Portland, OR

DEFENSE EXPERTS: Maurie Markman, MD, Medical Oncology, Philadelphia, PA; Steven Brisbois, MD, Obstetrics/Gynecology, Spokane, WA; Philip DiSaia, MD, Obstetrics/Gynecology, Irvine, CA; William "Buck" Peters III, MD, Obstetrics/Gynecology, Seattle, WA; Steven Hajdu, MD, Pathology, Burbank, CA

RESULT: Defense Verdict. Spokane County Superior Court, Judge Clarke

FAILURE TO DIAGNOSE

SPECIALTY: Emergency Medicine

ALLEGATION: A 19-year-old female alleged failure to diagnose compartment syndrome post anterior cruciate ligament (ACL) repair when seen in the Emergency Department with complaints of left lower extremity pain and swelling. An examination and testing for deep vein thrombosis and infection were performed, and it was determined the patient's complaints were related to post-operative swelling and poorly controlled pain management. She was instructed to follow up with her surgeon. The patient was seen by her surgeon two days later, who recorded normal pressure tests. However, an MRI demonstrated fluid collection near the two posterior compartments. The patient

underwent surgery, and the surgeon stated in his Operative Report that the patient had compartment syndrome. The patient alleged a delay in diagnosis left her with an injury to the distribution of the sciatic nerve, which resulted in further procedures, disability, past and future medical specials, and pain and suffering. The defense contended that the care and treatment of the patient was appropriate and the patient did not have compartment syndrome.

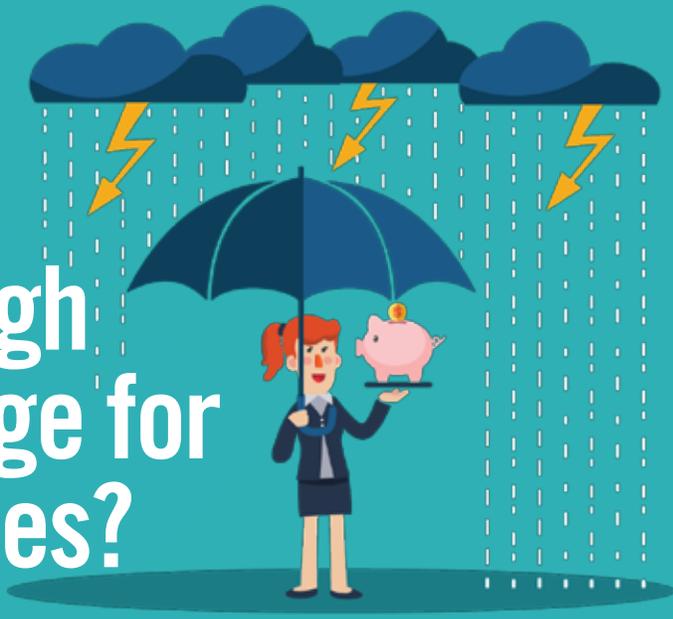
PLAINTIFF ATTORNEY: Bryan Smith, Tamaki Law, Yakima, WA

PLAINTIFF EXPERTS: Michael Smolens, MD, Emergency Medicine, Torrance, CA; David Cossman, MD, Vascular Surgery, Los Angeles, CA; David Musnick, MD, Physical Medicine and Rehabilitation, Bellevue, WA

DEFENSE ATTORNEYS: Chris Anderson and Eric Norman, Fain Anderson VanDerhoef Rosendahl and O'Halloran, Seattle, WA

DEFENSE EXPERTS: Fred Abrahamian, DO, Emergency Medicine, Los Angeles, CA; Jim Krieg, MD, Orthopedics, Philadelphia, PA; Daniel Neuzil, MD, Vascular Surgery, Baltimore, MD; Stuart Rosenblum, MD, Anesthesiology, Portland, OR

RESULT: Defense Verdict. King County Superior Court, Judge Rogers 



Do You Have Enough Insurance Coverage for Disasters and Crises?

This may seem like a simple question. But the answer must be nuanced. Ultimately it comes down to your tolerance for risk, how much risk you want to transfer through insurance, and how much you are willing to retain or mitigate.

No single insurance policy can cover every bad thing that might happen to your business. But a combination of policies can cover a broad range of hazards, including region-wide earthquakes, structure fires, cyber-attacks, power outages, and stolen laptops. An important first step is to contact your agency representative to help you prepare for the risks you face and to understand the best combination of coverage to fit your business—be it a solo practice, medium-sized clinic, or a hospital.

Your standard Business Owners Policy (BOP) is a combination of common Property and General Liability coverages. On the property side it provides protection if your office is damaged by a fire, explosion, burglary, broken water line, or other covered peril. Coverage can be broadened by adding additional limits or enhancement endorsements. Spoilage of perishable items, such as medications or vaccines, is an important example of a coverage enhancement. The policy can protect you from the loss due to a power failure or mechanical breakdown of your equipment. If you have large quantities of

perishable medicine, it's important to talk with your agent to make sure your spoilage limit is adequate.

Have you thought about what you would do if a fire damaged your building and you were unable to see patients? Business-income coverage is built into your Business Owners Policy. The standard policy includes up to 12 months of lost business income due to suspension of your operations from a covered loss. The policy also includes the extra expense you would incur getting your operation up and running at a temporary location. If you haven't addressed this unfortunate but very possible scenario, having a conversation now about Extra Expense coverage and how to respond to a disaster will help you get your doors open sooner when the unexpected happens.

In the Pacific Northwest, the threat of a major earthquake is also a very real possibility. Earthquake coverage is excluded by almost all BOP policies. This must be purchased separately and includes specific underwriting to your location and the construction of your building. Even if you don't own the building, you can purchase earthquake coverage to cover your contents and your loss of income.

Cyber Liability is a rapidly evolving area of risk management. As covered in

“Health Care an Increasingly Common Ransomware Target” on page 6, data hacks are a very real threat to clinics and hospitals of every size, and now a number of options are available to fit your needs. For smaller clinics, many companies are now offering small limits of cyber coverage as a coverage enhancement to a BOP.

For larger clinics, a number of dedicated cyber insurance products are available to cover such items as your first-party costs associated with handling a breach, third-party liability for unauthorized access to patient information, regulatory fines, and even cyber extortion coverage. Contact your agent to determine which level of coverage is right for you.

Many different risks are out there. From the major earthquake to the minor-but-still-disruptive burglary, the best bet is to work with your agent before disaster strikes to ensure that your business not only survives but also makes a full recovery.

For more information on insurance exposures in large and small disasters and crises, contact Reid Ekberg, President, Pilkey-Hopping & Ekberg, Inc., rekberg@pheinsurance.com, 253-284-9343.

Or Janet Jay from Physicians Insurance at janet@phyins.com, 800-962-1399.

(Case Studies, Continued from page 13)

“It’s important to be double-checking on staff,” she says. “That’s one of the things we talked about afterwards. People were traumatized by this. They had to be constantly thinking about how to warm themselves and their families at home, how to feed themselves and their families, or bathe. It was just so tiring and took a lot out of us. Checking on staff is hugely important to find out if they’re okay mentally and physically and have what they need to get through the emergency.”

FEMA Training and Elevator Failure Are Teaching Ops for Trios Health

A mass shooting at a school or a nightclub. Wildfires.

Dust storms or blizzards leading to multiple pileups on a highway: all true-life scenarios that can impact hospitals anywhere.

Trios Health in Kennewick, Washington, has recently revamped its emergency management plan to prepare for any such crisis that may come along. The idea is to train and drill for as many potential disasters as possible, so that the health-care facility is fully equipped to face the unthinkable, says Christy Kuhn, director of emergency management.

“The result of our emergency plan overhaul is a more interdisciplinary approach, very hands-on with frequent mini drills so we exceed all requirements,” says Kuhn. “Our focus is on engaging staff and increasing their competency, which in turn increases their confidence regarding all aspects of emergency management.”

ELEVATOR FAILURE IS A TEACHING OPPORTUNITY

The importance of being prepared hit home last spring when a computer failure halted all elevators for hours in a seven-story Trios building that houses, among other departments, oncology and interventional pain services.

“It was an eye opener,” Kuhn says. “This incident really gave us the opportunity to improve our emergency plans even further.”

Kuhn is the author of the new 126-page emergency plan for Trios Health, and she’s glad she and Trios staff rethought just about every aspect of disaster preparedness. That includes going old-school with printed emergency manuals, useful in the event the computers go off-line. Pages are tabbed and laminated so employees can easily flip to the section pertaining to their department or to the emergency situation at hand.

But they realize simply finding and opening an emergency manual might take too long at the onset of a disaster, so they’ve made quick access to some crucial first steps even easier. She explains, “We have emergency numbers inside badge holders, as well as labor-pool locations to which staff members need to report.”

FEMA/HOMELAND SECURITY TRAINING THAT MIMICS AN EMERGENCY AS MUCH AS POSSIBLE

As part of their preparedness, Trios has sent staff to a free federal disaster drill held at a former military base in Alabama, and that’s really helped polish their overall emergency skills, Kuhn says. “Put on by FEMA and Homeland Security, it’s as close as you can get to an actual major emergency event. You get two days of classroom work and two days of disaster simulation with actors who take you through a myriad of events. They keep throwing things at you, such as an active shooter in the ER or a HAZMAT situation in one location, while a woman is delivering a baby in the hallway in another unit. The incident command center coordinates with frontline staff in the hospital as well as with community emergency services. This training program has really been essential in exposing our team to potential scenarios and how best to maneuver through the challenges each presents.”

One of the things they’ve stressed in preparing for an emergency is figuring out the best way to support employees so that they can provide care, Kuhn says. That includes helping them make their own personal emergency plans for their families and homes, such as designated meeting points, along with emergency kits and critical supplies to keep in cars, including bottled water, first-aid kits, and protein bars.

As for Trios itself, “We have a child-care provision as part of our emergency plan,” Kuhn says. “That includes a supervised area so our employees can drop off their own children and know where they are and that they’re safe.”

Additionally, Trios has thoroughly considered how best to support a variety of patient care staff, too.

“For example, if we’re not prepared because we don’t have enough gloves, and we have a flu epidemic, how can we provide patient care in a safe manner?” Kuhn asks. “Emergency preparedness is not just about having the clinicians well trained and prepared, but of equal importance is our support staff, whose role is just as vital. We need to think about how we’re going to feed people as time passes because our patients and staff will be tired and hungry. We have worked hard

to ensure we have access to enough food and water to handle a crisis lasting up to 96 hours.”

On top of that, they've had to consider the fact they have the tallest building in the area, populated with many vulnerable and incapacitated patients, so Trios has tried to think of every possible scenario should there be a need to evacuate. Kuhn says, “We have assigned floor captains, each of whom have two-way radios, and we have stair chairs and practice how to use them in the event of an emergency.”

That helped when the elevator outage stranded many ill patients in the Trios building last spring, including a number on oxygen and with other mobility challenges, she says. But they realized during their response to the elevator failure that better equipment was required.

“We had to rely on two-way radios to communicate,” she says. “Currently, the ones we have work only within a certain range. It wasn't far enough.”

The elevator incident, although unfortunate at the time, ended up being a great training situation that underscored the importance of teamwork and effective communication.

Trios consistently trains and drills regardless of what else is going on in a given unit or department, Kuhn says. “It's always ongoing; you never stop. It's just moving on to the next thing and then the next thing.”



Annette Seay, office manager for Grand Pediatrics in Spokane, lives in the countryside and takes weather warnings pretty seriously.

So, when the weather service predicted a major windstorm last fall, Seay started to think about what might happen if the storm turned really bad, causing problems such as power outages for an extended period.

“We probably have a hundred thousand dollars' worth of vaccines in our office at any given time that need to be kept cold,” she says. “I just knew we needed a generator.”

Joseph P. Kincaid, MD, is the sole pediatrician for the practice, working with two advanced registered nurse practitioners and a certified pediatric nurse practitioner. Concerned about the impending storm, Dr. Kincaid himself went to the hardware store. “I was able to buy the last remaining generator at Home Depot,” he says. “I felt really lucky we could get it.”

It was a good move. Late in the afternoon of November 17, 2015, the windstorm hit with ferocity, leaving behind power, phone, and utility outages that would last for weeks in some areas. At Grand Pediatrics, the office would remain dark for five days, three of them office days packed with a total of 250 appointments.

“The next day, the region looked like a battlefield,” Seay said. “There were so many trees lying in the middle of our roads. Huge trees. It was just horrible.”

But in her office, those vaccines would remain safely chilled, thanks to the generator. Dr. Kincaid came to the office every seven hours, day and night, to refuel it.

“We heard afterwards that a lot of practices lost their vaccines because they didn't have a generator,” Seay says. “We did have a backup plan in place before the storm. In case we ever lost power we would take our vaccines to another medical office. But that wouldn't have worked since all the other locations lost their power as well.”

BACK-UP COMMUNICATION PLANS ARE CRITICAL

What turned out to be one of the most critical parts of their previously written emergency plan was a partnership with their Seattle software scheduling company to send patients and their families a prewritten message to let them know the practice was closed, Seay said. She was able to contact the software company via cell phone to deploy the message. Patients and their families then received the message by e-mail on their smart phones. She says that was a key takeaway from the storm: having an avenue to contact patients in case of an emergency.

“I give a lot of props to our software company for being able to help us by sending the message out,” she says. “We wouldn't have been able to get hold of patients otherwise.”

Meanwhile, Dr. Kincaid says he's pretty happy he owns a generator, now that fall storm season is here. [PR](#)



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THE PHYSICIANS REPORT | FALL 2016

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