A PHYSICIANS INSURANCE PUBLICATION

THE Physicians Report

FALL 2013 | PHYINS.COM

Business of Medicine

It's Business NOT As Usual

Depending on which headlines you read, as a country either we are moving forward toward a new and improved era in health care, or we are on the brink of widening the chasm between effective health outcomes and financial sustainability. Numerous articles and books describe solutions, and countless blogs, tweets, and posts argue the merits of one over the other. Regardless of which side of the debate you're on, one thing is for certain—it can no longer be business as usual.

The right care—at the right time, in the right place, delivered by the right level of practitioner—is now the underlying meme permeating discussions at every corner of health care. Health plans, medical groups, hospital systems, retail pharmacies, and liability carriers are all working collaboratively to define a new model. And in some areas of the country, early adopters are already seeing dramatic results (Advocate Health in Chicago is the current poster child for clinically integrated networks posting enviable cost and health outcome improvements).

Even with new and effective models being realized, the challenge before us all may not be one of ideas, but of implementation. Inherent in any successful change management effort is building up enough critical momentum where the initiative takes on its own self-sustaining energy. And to achieve that level of momentum, significant investments in time, energy, money—along with consumer adoption—will need to take place.

But all is not doom and gloom, as some headlines would have you believe. Renowned business guru Peter Drucker once said, "The best way to predict the future is to create it." From where I sit, I see many opportunities for small and big steps forward. I see a health care environment ripe for innovation and many professionals rolling up their sleeves to make it happen. And I think that business not as usual is the right perspective to have as we create the health care system of the future.

Mary-Lou Misrahy,
President and CEO
Physicians Insurance

WE'D LIKE TO HEAR FROM YOU!

Send us feedback and tell us more about what you would like to see in upcoming issues. E-mail us at **editor@phyins.com.**

READ *PHYSICIANS REPORT* ONLINE
www.phyins.com/Fall2013

CONTACT *PHYSICIANS REPORT*
editor@phyins.com

HOME OFFICE:
Seattle, WA

FEATURES

FEATURED TOPICS

RISK MANAGEMENT

GOVERNMENT AFFAIRS

COMPANY NEWS

WHERE AND HOW? YOUR CHOICE.

We want you to receive all the tools, resources, and news from us the way you prefer to get them. Complete the postcard mailer inside this issue to tell us how and where to send you resources.

Weathering the Business Side of the Triple Aim

"Just 30 years ago our biggest worries included successfully moving patient accounts and insurance claims to a computer system," recalls Marcy Shimada, CEO of Puget Sound Family Physicians and Edmonds Family Medicine. "There was no scrutiny of medical records or documentation requirements. But while there was a lot less paperwork, there was also less evidence-based treatment." Duane Lucas-Roberts, CEO of The Vancouver Clinic, remembers stability in payment methodology. He says the major business goals then were no different than today: achieve long-term financial strength—and breadth and depth of physician leadership—and attract and retain good people. "But today, accomplishing these things is much more challenging for most."

Things have indeed become much more complex. Some solo and small practices now struggle to keep their doors open as they face the often prohibitive expense of maintaining a practice. Larger groups need to decide whether to focus on physician growth and clinical integration with outside systems. For sure, during the last ten years, health care has gone through tectonic changes. And as we face a new national imperative to reign in the costs of health care while improving outcomes, the pace and impact of change will continue to increase.

A PERFECT STORM

Several significant forces are currently shaping the business environment of medicine. These forces include consolidated and reconfigured practice models, hospital mergers, growth in

the trend of hospitals buying practices and employing doctors, changes to reimbursement models, the Affordable Care Act, federal mandates on meaningful use, and newly installed HIPAA directives. When combined with each other, these forces can produce a perfect storm. Lucas-Roberts sees these forces influencing the widely accepted tenets of the Triple Aim: access, cost, and quality.

A study published in the *Annals of Family Medicine* predicts that by 2025 the United States will need at least 52,000 new primary-care doctors.[1] Today, 56 percent of America's patient visits are to primary care physicians (family medicine doctors, internists, and pediatricians), but only 37 percent of physicians currently practice primary care medicine. And only 8 percent of the nation's medical school graduates are going into family medicine, which could further constrain access.[2] "The economics of medicine are less attractive now," says Lucas-Roberts. "There are many [career] opportunities for our most talented young people, not just medicine. The prohibitive cost of medical school, and the lack of substantive income during 7 to 10 years of training, results in high debt that sometimes tops $200,000." Many new physicians begin their years of practicing under a tremendous financial burden.

The business of medicine can add another layer of burden to the practice of medicine. Today's administrative requirements mean the physician has to be part accountant, tech geek, and lawyer—or hire a skilled force of professionals to keep the practice in compliance. A physician practice needs to be accountable for office appointments, phone visits, e-mailing with patients, and paperwork. Shimada says that for some physicians, the paperwork load is hard and can become depressing. "Primary care doctors want long-term relationships with patients, sometimes lasting for decades," she says. "Anything that takes primary doctors away from their patients eats away at their satisfaction." Lucas-Roberts adds, "Many senior physicians have lost their joy. Half their time is spent with patients. They spend the rest on notes, patient forms, workers' compensation, complying with insurance, and phone calls." In particular, he says, "the demands on solo practitioners and small practices are onerous; it is difficult for them to remain tenable."

"I'm not so concerned about HIPAA," notes Shimada. "We *should* be protecting patient privacy." However, coding patients' ailments and treatments is a big component of that endless paperwork. ICD-9-CM has 14,000 codes, and the upcoming ICD-10-CM has approximately 150,000. Shimada anticipates that this huge increase may help researchers "slice and dice data, but it won't help patients get better or get better faster."

"Anything that takes primary doctors away from their patients eats away at their satisfaction."

MEDICINE IS A TEAM SPORT

Is there a silver lining to these pressures? Challenge forces innovation. Newly optimized models for access are emerging—solo, small/large group, and hospital employment are the obvious structures. But the expanding roles of physician assistants, advanced registered nurse practitioners, and other clinicians often referred to as midlevel providers create new avenues for patients to access care. This larger team of care providers may be part of the solution. In fact, Shimada strongly believes medicine is a "team sport," so she poses a question for solo practitioners: Is this the best way to practice medicine? She points out that peer review—which informs how we practice the complex art of medicine—and office-next-door consulting are less available in solo practices yet so valuable to high-quality patient care. She questions if, in this era, it is possible to produce better medicine without these elements. Is there a practical way that solo practitioners and small practices can incorporate a team approach into their practices to decrease administrative burden and expense, while improving

care? Susan Turney, MD, CEO of MGMA-ACMPE, offers advice for small practices: "It is crucial to have the right resources, staff, infrastructure, and IT to accomplish your goals."

LEVELING THE PLAYING FIELD

Even if access and quality are improved, the longer-term viability of the system may still be at stake. Current cost and reimbursement models are not yet designed to reward improvements in patient and population health. Nor are these models designed to reinforce value. "It is not a level playing field," says Lucas-Roberts, referring to the challenges faced by small practices and by larger systems. A recent *Denver Post* article claims that "more than 50 percent of doctors are now employed by hospitals, and fast consolidating hospital chains often add large fees to procedures and tests that are frequently carried out in what were independent practices."[3]

Some argue that facility fees that are three or four times higher in a hospital setting are necessary to pay for their robust infrastructure—to purchase and maintain standby services that

{Continued on page 24}

ADVICE FOR SOLO AND SMALL PRACTICES IN THE EVOLVING HEALTH CARE LANDSCAPE

FROM SUSAN TURNEY, MD, CEO OF MGMA-ACMPE

We spoke with Dr. Turney about solo and small practices—their challenges, their place in the medical community, and what they might do to evolve and sustain their practices.

PI: Given significant, ongoing change, does medicine still have a role for solo and small practices?

ST: Yes, there are benefits to any model of care. There are variations across the country. Care is local, and one size does not fit all. I believe there is room for everybody, and ignoring the important role solo or small practices serve will only hurt the system. One challenge for these smaller practices is to evolve and meet the demands of a new and upcoming care model, which requires investment and maybe a new way of thinking about their practice.

PI: What is central to the survival of solo and small practices today?

ST: Understand the foundation and capacity of your practice. If it includes both doctors and a practice executive, work hand in glove to evaluate what works and what does not. It is crucial to have the right resources, staff, infrastructure, and IT to accomplish your goals. It requires a team approach.

PI: Once they understand their practice capacity, what can they do about it?

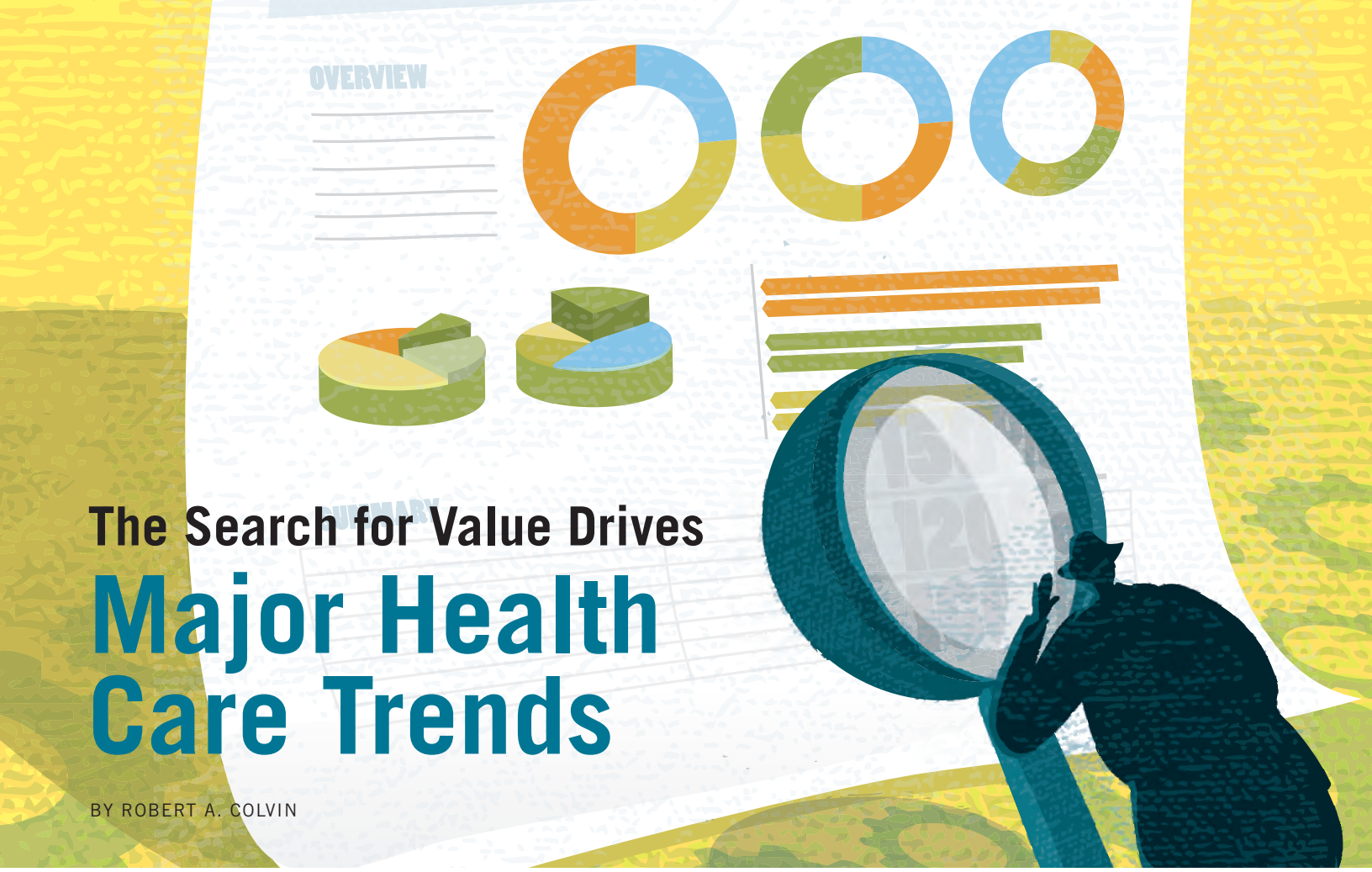
ST: You can increase your capacity by building a team of physicians, nurse practitioners, and physician assistants. Then, strive to meet your patients' needs by going over practice walls into the community to tap into and utilize a diverse sphere of available resources—home health, urgent care, hospitalists, nursing home facilities, and family support. Put your feet on the street—discover and use best practices, and share outcomes and knowledge with peers.

PI: Does your organization help practice executives and doctors meet today's demands?

Yes. MGMA helps members navigate change. Informed by professionals in the field, we develop and provide a tool chest of best practices to help them navigate challenges such as risk assessment compliance mandates and IT matters.

PI: You have been in the field for a long time. Is this the most challenging era you remember?

ST: Health care delivery has always been challenging; as an industry, we have been going through transformation for decades. The pressures of current technologies and regulatory issues are newer, including the problems created by overlapping, nonstandard mandates. However, I wake up every morning feeling optimistic. I think the challenges the medical world is facing can and will inspire great innovation.



The Search for Value Drives

Major Health Care Trends

BY ROBERT A. COLVIN

The Affordable Care Act hits primetime as this publication goes to print. No one can accurately predict the long-term impact it will have on American health care. However, we must agree it is an ambitious experiment to address many of the ills plaguing care delivery in our country today, not the least of which is limited or no access for 50 million citizens. Combine limited access with clinical outcomes that are often worse than those of other developed countries, and then add our unsustainable high costs, and you have a U.S. health care system that fails miserably at providing value. It is this search for value that is perhaps the next great frontier for health care, as business and medicine combine to create a new, sustainable, and scalable model.

DRIVERS OF HEALTH CARE TRENDS

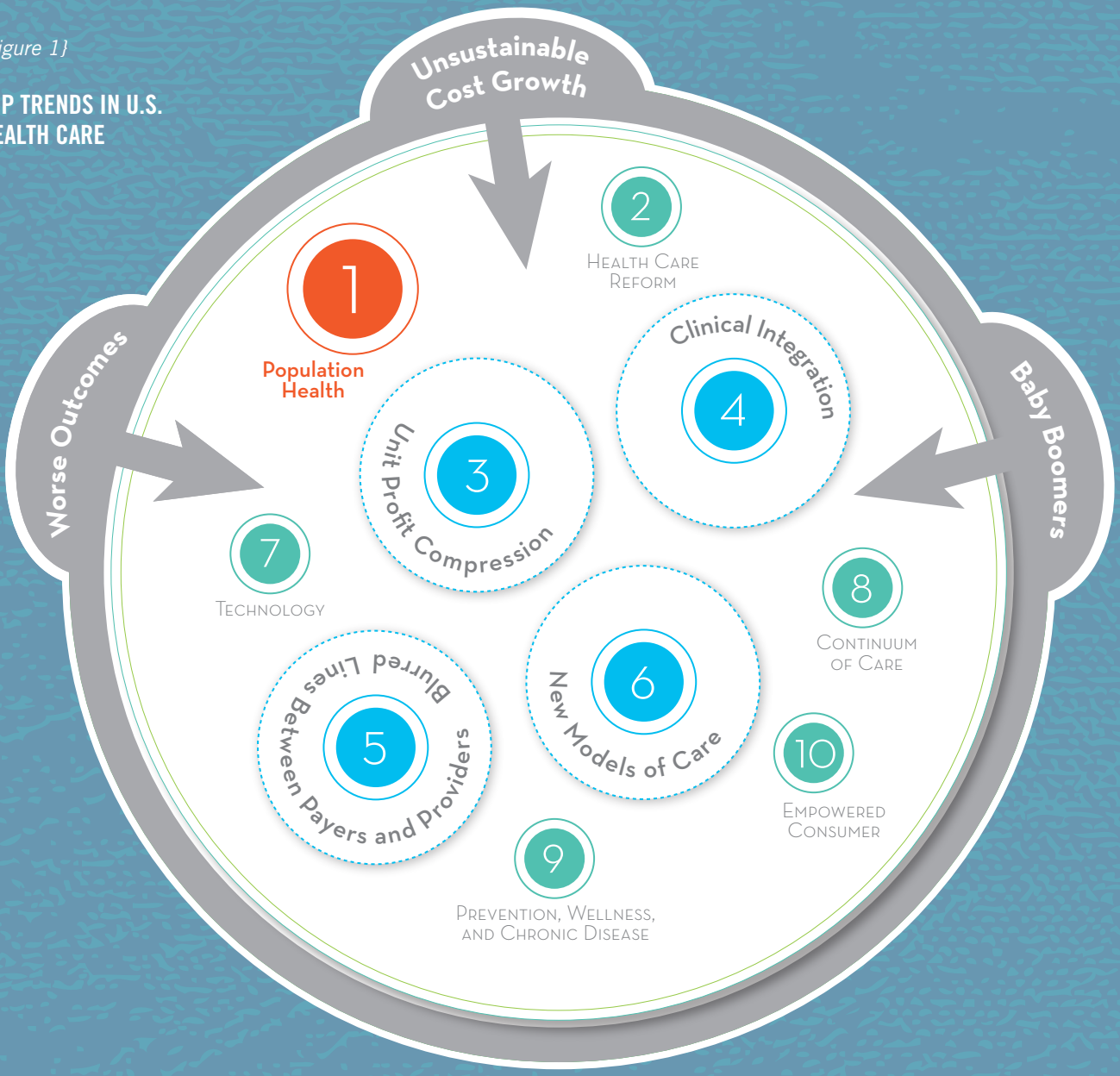
As hard as it is to swallow, American health care has inferior health status when compared to many developed countries around the world. Yes, we have more gun violence, auto accidents, and obesity, per capita, than any other developed country. We also have a much more heterogeneous population with wider variation in economic and social factors than many of these nations. However, we also pay significantly more for drugs and medical devices, have dramatically higher administrative costs, and have overall utilization rates that are off the charts. Combine this with the huge bolus of Baby Boomers coming into a period of high health care needs and our national health care costs reach a truly unsustainable point. *(See Figure 1, page 8)*

So, just how untenable are our costs? As our health care consumption moves past 18 percent of total gross domestic product (GDP), we dwarf the average of 11 percent spent in other developed countries. So what? Well, 7 percent of our GDP, the relative excess we are spending, amounts to more than $1.1 trillion a year. The chart in Figure 2 (page 9) puts this in perspective. Presently, our "excess" health care spending is nearly twice the entire annual expenditures of the U.S. military, including the war in Afghanistan. (And remember, U.S. defense spending represents nearly half of the total defense spending in the world.)

However, a more troubling comparison shows that our excess health care spending is nearly equal to all money spent annually on public education in the United States. Certainly, as we struggle to adequately fund public education and continue

{Figure 1}

TOP TRENDS IN U.S. HEALTH CARE



to compete in a global economy, we must significantly reduce health care costs and reallocate resources. We must create value in health care—there is no going back.

KEY TRENDS AFFECTING VALUE

Figure 1 shows ten major trends moving through health care today. Each has the potential to impact the value equation. Four trends will have a major impact on physicians and practices in coming years.

• **New Models of Care:** All components of health care will need to do more with less (see Unit Profit Compression below). Primary care will see a rapid expansion of urgent, retail, and virtual clinics. Physicians of all specialties will need to leverage their time and skills by leading teams of nurse practitioners and other skilled professionals. Hospital-centric models will continue to be replaced by more efficient ambulatory platforms, and shared information must reduce duplication and inefficiencies.

• **Blurred Lines Between Providers and Payers:** As hospital systems see payers maintain higher financial margins and payers pursue more cost control, the lines between these two will blur. Already around the country there are numerous examples of hospital systems forming insurance arms and payers opening clinics and buying hospitals. Accountable care organizations (ACOs) and clinically integrated networks

(CINs) will provide both partner opportunities and potential competitive battlefields for these two. The best of these ACOs and CINs will likely combine elements of both.

• **Clinical Integration:** This is taking various forms but is being driven by pressures to stabilize incomes, reduce costs, optimize clinical outcomes, expand the care continuum, and gain market position. ACOs and CINs will take center stage for the next year or two, and the most successful of these will achieve high levels of integration and overall effectiveness. Others will be primarily pursuing defensive positions or chasing incentive dollars and will soon crash. Hospital systems will pursue CINs both as contracting and physician alignment vehicles. Physician groups should recognize that a long-term, tightly aligned CIN relationship may actually be preferred by many health systems versus physician employment as they accomplish a majority of their long-term goals without additional employment expense.

Cost and market pressures will continue to drive mergers of hospitals and health systems, with many hospitals under 150 beds lacking sufficient economies of scale to remain viable on their own. Acquisitions in recent months by Tenet of Vanguard and Community Health Systems of HMA are certainly not the end of this trend to merge hospitals.

• **Unit profit compression:** This has been referred to in the points above but may be the most basic. With the Affordable Care Act, millions of additional people will be added to the health care system. We can afford little, if any, new money to pay for this new care. Thus, payments for each unit of patient care must be reduced over time, i.e., unit profit compression.

Reimbursements for primary care will be stabilized for a period of time, and therefore, to encourage care of the newly insured populations, we must expect reimbursements for non-primary care specialists, hospitals, and ambulatory facilities to be reduced fairly significantly and over a relatively short period of time. Whether the system can extract similar margin reductions from the drug and insurance industries will depend a great deal on growing pressure from corporate America to rationalize overall health care costs.

IMPLICATIONS FOR PHYSICIANS AND PRACTICES

Physicians and practice administrators need to continually evaluate their own markets and consider the long-term implications of status quo and change. The most efficient care models, which fully leverage a physician's time and skills, will be in demand in every future scenario. The ability to positively impact patients efficiently with quality outcomes is the new imperative—and a cornerstone for all other changes.

{Figure 2} **WHY OUR HEALTH CARE COST IS UNSUSTAINABLE**

Physicians may choose health system employment or employment with larger groups, but it makes sense only to the degree those organizations are able to weather the storms they too are about to encounter. Certainly, many hospital systems are and will be experiencing their own challenges with significantly reduced per unit reimbursement. The opportunity to strategically align with health systems or payers through CINs or ACOs may provide many of the benefits of larger group employment while allowing physicians to retain more independence.

There is enough evidence that the status quo is not sustainable and the pace of change over the next five years will be as great as anytime in the last 40. Physicians, practice managers, hospital administrators—all need to be at the forefront of addressing every major trend and collaborating on solutions. If we can bend the cost curve, change practice patterns, and even influence population health choices, the American health care system can and will improve as a result.

BOB COLVIN is a principal at Health System Advisors. He has over 25 years of experience leading hospitals and health systems in strategic solutions, ranging from a 500+ bed academic medical center to for-profit facilities, suburban facilities, and small rural hospitals. His experience includes operating a large multispecialty physician group, regional ambulance services, home health agencies, and community primary care clinics. Bob.Colvin@HealthSystemAdvisors.com

Exit-Planning Stress Test

SUCCESSION PLANNING GUIDANCE FOR A WIN-WIN DEPARTURE

BY BEN WOODBURY

The uncertainty of the Affordable Care Act has raised many new and recurring questions pertaining to the business side of medicine. Exchange patient referrals, accountable care, and technological concerns continue to loom on the horizon, but one notoriously overlooked question has been quickly thrust to the forefront of conversation: What is my exit strategy?

A past *Medical Economics** article on planning for doctors appropriately stated:

> If you are in practice with one or more colleagues, the departure, disablement, or death of a stockholder or partner can lead to bitter disputes and unforeseen complications. And if you're the one leaving, you can lose your shirt.

Succession planning is often the largest gap seen in practice planning today. The importance of stabilizing and maximizing the value of the practice, transferring it under carefully controlled conditions, and minimizing the cost cannot be overestimated. Failure to do so will almost always be economically and emotionally devastating.

While each situation is unique, below is a list of four suggestions that can help.

CREATE A PROPER BUY-SELL AGREEMENT

Buy-sell agreements are the cornerstone in the succession plan of any business. A buy-sell agreement is a formal document outlining the specific conditions and formulas by which a new physician may become an owner or an existing owner may depart the practice due to retirement or otherwise. The buy-sell agreement facilitates an orderly purchase or sale of an ownership interest within a practice at the occurrence of a specified triggering event. Typical triggering events include but are not limited to retirement, death, long-term disability, divorce, bankruptcy, loss of license, and the receipt of an outside offer to buy.

There are three major types of buy-sell agreements:

- **Entity Purchase:** The practice is designated as the purchaser. Upon the occurrence of a triggering event, the practice itself buys the agreed-upon number of the departing owner's shares.

• **Cross-Purchase:** The owners are designated as the purchasers. Upon the occurrence of the triggering event, each remaining owner buys the agreed-upon portion of the departing or deceased owner's stock.

• **Wait and See:** A unique option that allows the owners to wait until a triggering event occurs to see which buyer—or combination of buyers—will be best for the practice.

Each of these buy-sell arrangements has pros and cons. Choosing the correct path will be based upon entity type, number of providers, and scope of the practice.

ESTABLISH A FAIR AND ACCEPTABLE BUSINESS VALUATION

When it comes to a medical practice transaction, four significant elements determine its value:

- Equipment, tangible personal property and other assets
- Patient accounts receivable
- Real property
- Goodwill

The first three are easily quantifiable, but the last is not. Medicine is a service and patients repeat their business with the physician who provides his or her care. Unless a physician is part of a large organization, the individual physician is the brand and shifting that brand (goodwill) to another physician can take planning, time, thoughtfulness, and foresight. One of the best ways to maximize goodwill is to plan for a provider who is already associated with the practice to buy the practice. If you are currently a solo practitioner, planning should begin at least 10 years in advance. Each stage of the multi-phased process of finding the right successor, negotiating terms, then developing and executing the transition, can take several years to complete. The most successful—and lucrative—outcome for each party includes thoughtful, long-term planning.

For many physicians, the purchase or sale of a practice will be one of the largest and most complex transactions of their career. The agreement, regardless of whether it takes the form of an entity purchase, cross-purchase, or wait-and-see buy-sell, should specify a purchase price for the shares. That price should be established by (1) a stated fixed dollar amount, (2) a formula, or (3) a required appraisal. The preferred tax method is by a formula.

Understanding the factors that go into pricing a practice can help ease the process, and ensure that both buyers and sellers receive a fair deal.

BE CLEAR ABOUT WHAT'S INTENDED

An attorney will begin working with a boilerplate document that is fully customizable. Financial arrangements can be as imaginative as the parties involved would like or need them to be.

A few common areas to clarify:

• **Malpractice:** Tail coverage is rarely overlooked, but often misunderstood. The specifics of the tail coverage and the responsibility of premium payments (if required) need to be spelled out in writing and included in the buy-sell agreement.

• **Real Estate:** Many physicians own not only their practice but also their building. Irrespective of what the transaction entails, real estate should be addressed by its own buy-sell agreement. One particular complication is when the exiting owners are selling their equity in the practice, but holding their equity in the building. Remember that the practice and the building are mutually exclusive.

• **Disability:** Premature death is generally the first trigger discussed, but long-term disability should be of equal concern. Depending on age, physicians can have just over a 1 in 4 chance of becoming disabled before retirement.**

"The best thing you can do, in order to get the best price for your practice, may be to avoid slowing down in anticipation of retirement. When you sell a practice that has substantial recurring revenue, you'll receive a higher price. If a practice has few active patient charts because the physician has slowed down, there's little or nothing to sell."

DONALD JAY KORN, "EXIT STRATEGIES: PLANNING FOR PRACTICE SUCCESSION," *DOCTOR'S DIGEST*, MAY/JUNE 2005, 110.

{Continued on page 21}

THE MODERN-ERA MEDICAL OFFICE

and the Insurance that Protects It

THE SCENARIO

Sara is a respiratory therapist who frequently provides home health visits for her clinic's elderly patients. Just back from vacation, facing a day of overdue field visits, she starts her Monday in a rush. She pulls her car up to the curb and runs into a nearby coffeehouse to grab her daily caffeine fix. Returning outside a mere seven minutes later, she finds that her car—the clinic's car—is gone! In the car was her new clinic laptop—which had yet to be encrypted—and all the patient files she had loaded onto it for a week of catchup. Sara's Monday just got much, much worse.

THE IMPACT

What are the ramifications of what Sara just experienced? For starters, the car was clinic property used for field visits, as was the laptop. Plus, her unencrypted laptop contained all the patient data she had downloaded from the clinic server the previous night, so personal information, billing information, health-related information and more was available on the hard drive.

After throwing her coffee to the ground, Sara prepared herself to face her clinic manager with the bad news of the stolen car, as well as the icing on the cake: a HIPAA breach. In addition to the expense of a lost vehicle and laptop, her clinic will need to report a breach not only to the Office for Civil Rights, which enforces HIPAA, but also to the affected patients and possibly the local media. Incidentally, had her laptop been encrypted in accordance with the standards in the HIPAA security rule before it was provided to her, there would be no breach to report.

THE SOLUTIONS

Running a safe practice these days takes more than just professional liability coverage. The modern medical business has many other risks it must prepare for and mitigate. For instance, clinic property is vulnerable to theft, whether on-site or off-site. And data influences so much of the way the world works. If your practice data is compromised due to faulty IT systems, employee negligence (intentional or not), or a malicious outsider seeking bank account numbers, how do you begin to repair the damage to your business and reputation?

• **Cyber liability insurance** might sound like science fiction, but it is quickly becoming a new must-have for all kinds of businesses. In the medical field, the increased reliance on electronic records and HIPAA scrutiny is forcing everyone to handle data with greater security. Policies vary, so look closely to see if you're protected for data breach response, as well as third-party claims, network asset protection, multimedia (e.g., copyright, libel, and slander), and cyber extortion (because data has even been held for ransom). In the case of Sara's clinic, her Physicians Insurance medical liability policy would cover up to $50,000 for defense costs in responding to a federal agency investigation under HIPAA. For those policyholders who choose to include a data compromise endorsement on their medical liability policy, that coverage would help defray the costs of notifying patients and for providing credit monitoring up to $50,000. A comprehensive cyber liability policy would cover the resulting HIPAA fines and penalties, claims from affected individuals, and credit monitoring and other costs that are greater than $50,000.

• **Business owners policies** provide protection for the business's personal property, the building if clinic-owned, and $1 million general liability coverage. While this insurance is often geared to general businesses, there are unique medical endorsements you should explore to make it more worthwhile for you—including equipment breakdown, spoilage of materials like vaccines, and coverage for valuable papers like patient records. In the scenario described above, this coverage would have replaced the clinic's laptop and anything else in the vehicle that was clinic property—up to the business's personal property limit.* For businesses whose staff rely upon company-owned cars, an additional Business Auto Policy would provide replacement of the vehicle.

For our members' convenience, Physicians Insurance provides ancillary insurance products through Physicians Insurance Agency. Since Physicians Insurance has an interest in our members' success, you can count on our agency to lead you in the right direction when it comes to additional coverage you might be considering. We can help you be clear about all the benefits included in your medical professional liability policy, so that this coverage maps to your clinic's unique needs.

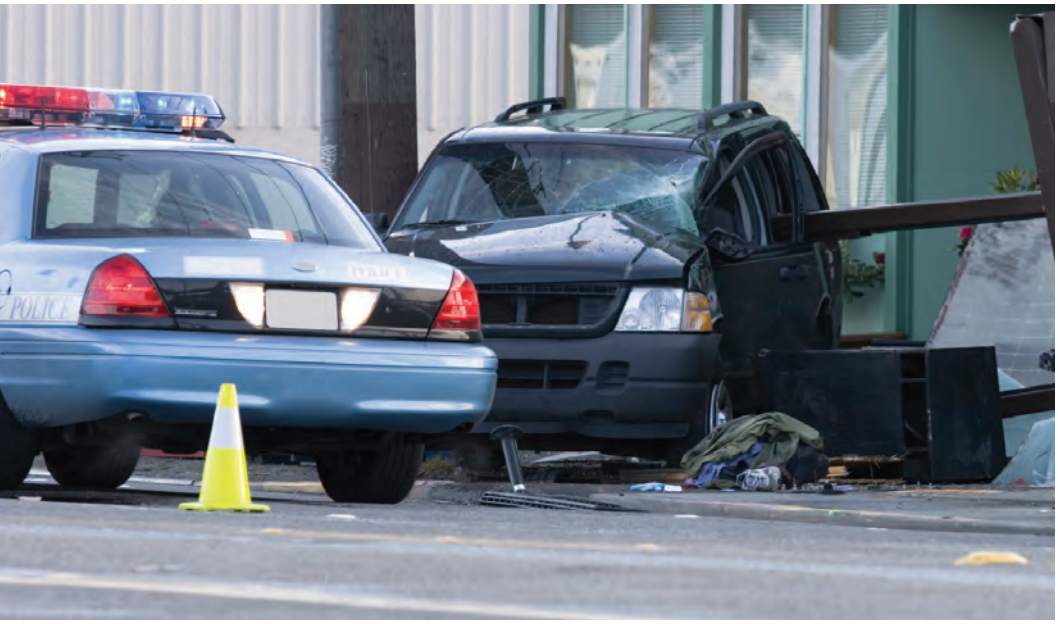
**Policy limits vary based on the value of business assets.*

A Portfolio of Protection

The following insurance products provide additional protection for your business:

- Billing Errors & Omissions Insurance
- Business Buyout Coverage
- Business Owners Policy
- Commercial Liability Insurance
- Cyber Liability Insurance
- Directors & Officers Insurance
- Disability Insurance
- Employment Practices Insurance
- ERISA Bonds
- Health Insurance
- Life Insurance

Visit **www.phyins.com/ModernMedicalOffice** to learn more, or contact Janet Jay at Physicians Insurance Agency at (800) 962-1399.



"We Didn't See *That* Coming!"

Typical business claims covered by different types of business policies

Just as adverse events can happen in medicine, adverse business events can happen to practices and hospitals. These risks are often unpredictable and can be significant in both cost and the ability to provide continuing care for patients. The following examples depict different types of unanticipated events and the coverage that helped the physician and practice recover after the outcome.

EVENT: Storm caused power spike, crashing insured's computer system
IMPACT: Clinic rendered nonoperational for 48 hours, employees unable to work or serve patients, data lost, and patient records lost
BENEFITS PROVIDED: Reimbursement for emergency IT services to restore clinic operations as soon as possible and data recovery services to restore lost patient records
PRACTICE TYPE: Primary care clinic of 75 employees
COVERAGE IN PLACE: Business Owners Policy with Equipment Breakdown
RESULT: $67,136 paid

EVENT: One of four physicians, in a physician-owned clinic, died in a fatal car accident
IMPACT: Remaining physicians needed to quickly put resources in place to provide overflow patient care, as well as consider how to act upon their buy-out agreement and legal next steps
BENEFITS PROVIDED: Tax-free financial policy payout to clinic that covered the buy-out of the widow's inherited interest, costs associated with sourcing temporary support to help service patients, the expense of hiring a new partner, and associated legal fees
PRACTICE TYPE: Dermatology clinic
COVERAGE IN PLACE: Business Buyout Coverage
RESULT: $1 million paid

EVENT: Employee theft—bookkeeper stole funds for 9 months before being discovered
IMPACT: Loss of revenue and burden of investigating all prior accounting
BENEFITS PROVIDED: Forensic accounting services to

Don't lose out on your EPL coverage!

AVOID This Costly Mistake

Timing is one of the top reasons insurers deny employment claims. Many employment practices liability (EPL) policies have a notification requirement. Some simply state that you must report a claim when reasonably practicable. Other policies give a specific period, such as the 60-day notification requirement on Physicians Insurance's EPL endorsement attached to most of the medical professional liability policies.

Avoid missing your notification deadline by reviewing your EPL endorsement and any excess EPL policy you have. Note the notification requirements. Then, check the policy's definition of a claim. You may be required to report certain incidents promptly, regardless of how frivolous they may seem.

Know your policy's definition of a claim AND its notification requirements. When in doubt, call your EPL insurer.

determine scope of loss, reimbursement of lost funds, and assistance with recovery action against employee
PRACTICE TYPE: Palliative care center of 42 employees
COVERAGE IN PLACE: Business Owners Policy with Employee Dishonesty
RESULT: $32,785 paid

EVENT: Solo physician became temporarily disabled after a spinal cord injury
IMPACT: Physician was unable to see patients for 6 months
BENEFIT: Financial policy payout to clinic that covered business expenses to keep clinic running, including salary continuation to retain staff and the hire of a temporary physician to see patients
PRACTICE TYPE: Ophthalmology group with three employees
COVERAGE: Business Overhead Expense Insurance
RESULT: $60,000 paid over 4 months; clinic able to continue operating at 95% patient retention/revenue during physician's absence

EVENT: Building's hot water pipe burst at night
IMPACT: Extensive physical damage to multiple offices throughout building, affecting carpet, walls, furnishings, and office equipment; clinic was nonoperational and patients had to be directed to other clinics
BENEFITS PROVIDED: Reimbursement for emergency cleanup, repair, and reconstruction of damaged property; replacement of damaged assets; and reimbursement of lost revenue
PRACTICE TYPE: Obstetrics and gynecology clinic of 60 employees
COVERAGE IN PLACE: Business Owners Policy
RESULT: $132,025 paid

EVENT: RAC audit revealed an incorrect ICD code used repeatedly over several years' time
IMPACT: Repayment demand of $627,000 and fines and penalties totaling $250,000
BENEFITS PROVIDED: Defense cost reimbursement and shadow audit to review findings
PRACTICE TYPE: Orthopedic surgery center of 18 physicians
COVERAGE IN PLACE: Billing Errors and Omissions Policy
RESULT: Fines and repayments were reduced to $250,000 total

EVENT: Vehicle drove through front of clinic and driver fled the scene
IMPACT: Extensive physical damage to front of medical office waiting area
BENEFITS PROVIDED: Reimbursement for cleanup, repair, and reconstruction of property; replacement of damaged furnishings
PRACTICE TYPE: Ophthalmology clinic of 27 employees
COVERAGE IN PLACE: Business Owners Policy
RESULT: $17,542 paid

HIPAA: Sept 23 Has Come and Gone. Now What?

MAINTENANCE, ENFORCEMENT, AND MORE
Q & A WITH LESLIE MESEROLE, JD

Leslie is a principal in the health care practice team of Riddell Williams P.S. She has experience working with hospitals and health systems, physicians and physician groups, public hospital districts, and other health care related entities in business transactions and regulatory compliance matters. Leslie's regulatory compliance practice focuses on fraud and abuse, HIPAA compliance and patient privacy, IRS rules applicable to exempt organizations, physician compensation, and Medicare participation and reimbursement.

Q Will you please explain the increases in Health and Human Services auditing, investigating, and penalties, which are now part of the Final Rule?

A Sure. The Final Rule implements the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which promotes adoption and meaningful use of health information technology, strengthens civil and criminal enforcement of HIPAA, and adds breach notification requirements to HIPAA. The Final Rule includes higher penalties and mandates formal investigations of possible violations due to "willful neglect." It defines willful neglect as conscious, intentional failure or reckless indifference to the obligation to comply with the HIPAA rules that are violated.

Q When does an audit process kick in?

A First of all, the HITECH Act requires Health and Human Services (HHS) to perform periodic audits of covered entities (CEs) and business associates (BAs) to evaluate their compliance with HIPAA requirements. The Office for Civil Rights (OCR) established a pilot audit program to meet this mandate, including a protocol to assess controls and processes that CEs are using. These audits began in November 2011. In the future, OCR will audit BAs as well. The audit protocol is located on the HHS/OCR Web site under Enforcement.

Q More and more, we are moving toward electronic record keeping. What are some of the specific HIPAA requirements regarding these practices?

A The Security Rule requires CEs to conduct risk analyses, on an ongoing basis, of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic personal health information (PHI). They must identify certain things, e.g., where PHI is stored, received, maintained, or transmitted, as well as threats and/or vulnerabilities that would create a risk of inappropriate access. They must evaluate and document all privacy/security measures that are in place, assess the magnitude of all potential impacts, determine risk levels for all threat and vulnerability combinations, develop a list of corrective actions to mitigate each risk level, and document their risk analysis findings.

Q When should a covered entity or a business associate perform an internal audit?

Updated HIPAA Materials

Our resources can help ease the way to compliance—they sure helped Christie Smith in Lacey, WA:

> "I want to say THANK YOU for having the information on your Web site for HIPAA updates for 9/23. You really saved my bacon. Looking at the previous HIPAA notebook and the one I recently compiled, it is like going from kindergarten to graduate school! Things have progressed so much and gotten so very complicated."
>
> **Christie Smith,**
> Practice Manager
> Pioneer Family Practice

Visit **www.phyins.com/HIPAA** to get the resources you need.

A Periodic audits are the only way to know that you are 1) complying with all HIPAA rules, and 2) thoroughly and correctly documenting your compliance activity. Now, under the Final Rule, which became enforceable on September 23, 2013, CEs must perform and document a four-factor objective risk assessment when they experience an improper use or disclosure of PHI to determine whether a breach of unsecured PHI has occurred and if the breach notification requirements must be met. Health care providers must appoint a privacy official and a security official (possibly the same person) who is responsible for developing and implementing all of the policies and procedures of the entity, and who would be the focal point of any internal investigation related to a breach.

Q What must the covered entity or business associate be able to show in the case of an impermissible use or disclosure of PHI?

A The Final Rule addresses how CEs and BAs must determine if a breach of unsecured PHI has occurred and requires notification to affected individuals, HHS, and/or the media. The amended definition of "breach" in the Final Rule emphasizes that an impermissible use or disclosure of PHI is presumed to be a breach unless and until a CE or BA demonstrates, through its four-factor risk-assessment, that there is a low probability that the PHI has been compromised. In that case, the CE documents its analysis, and the breach notification requirements are not triggered.

Q What are the four factors in the objective risk assessment?

A When an entity learns of an impermissible use or disclosure of PHI, it must first determine whether it is a breach. Then it must conduct a four-factor objective risk assessment to determine whether there is a low probability that the privacy or security of PHI has been compromised. A risk assessment must include the following four factors: 1) the nature and extent of the PHI involved (e.g., identifiers such as social security or credit card numbers, the likelihood of re-identification, and the nature and degree of any clinical information used or disclosed), 2) the identity of the unauthorized person who impermissibly used the PHI or to whom the impermissible disclosure was made (Does the person using or receiving the PHI have an obligation to protect the privacy and security of the information?), 3) whether the PHI was actually acquired or viewed (or was there only an opportunity to view the PHI, e.g., sending a patient's medical information to the wrong address, but the envelope is returned unopened), and 4) the extent to which the risk to the PHI has been mitigated (e.g., reassurances that the information involved has been destroyed or will not be disclosed again).

Q If my risk assessment department determines that there is not a low probability that the PHI has been compromised, what do we do next?

A If you are not able to demonstrate that there is a low probability that the PHI was compromised, then you must determine if the compromised PHI was "unsecured," which means the PHI is not unusable, unreadable, or indecipherable to unauthorized individuals. If the compromised PHI was unsecured, breach notification is required.

> "THE MOST RISK-AVOIDANT THING YOU CAN DO IS ENCRYPT"
>
> **LEON RODRIGUEZ,**
> DIRECTOR OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' OFFICE FOR CIVIL RIGHTS

Q When might a covered entity expect an OCR investigation?

A The Final Rule requires HHS to conduct an investigation when a preliminary review of a complaint (e.g., by a patient or another health care organization) or another indication of noncompliance indicates a possible HIPAA violation due to willful neglect. It also gives HHS discretion to conduct a compliance review or investigate any other complaint where a preliminary review of the facts indicates a degree of culpability less than willful neglect.

{Continued on page 25}

Groundbreaking Ob-gyn Education

Physicians Insurance is proud to offer education about a new standard of ob-gyn care. In August, we created a recorded webinar with Dr. Steven Clark presenting his just-published algorithm for managing Category II fetal heart rate patterns. In early October, in conjunction with EvegreenHealth, we held a conference in Kirkland for Dr. Clark to address our members and other obstetrical providers with this game-changing FHRT guideline.

E-Learning Course

MANAGING CATEGORY II FETAL HEART RATE PATTERNS: A STANDARDIZED APPROACH

Obstetrical practitioners know the challenges in managing Category II fetal heart rate patterns during labor. Interpreting these tracings remains one of the most critical issues in obstetrics. We are pleased to announce a course describing a tool that can help you and your patients.

This webinar features obstetrical patient-safety leader Dr. Steve Clark highlighting his just-published article in the August 2013 *American Journal of Obstetrics and Gynecology*. He explains and demonstrates a simple, rational, evidence-based algorithm developed by him and a team of experts. You will learn through examples of challenging fetal strips how to achieve compliance with the current standard of care in managing this difficult clinical situation.

WHO SHOULD TAKE THIS COURSE:
Obstetrical care providers

THE ON-DEMAND WEBINAR OF DR. CLARK CAN BE ACCESSED THROUGH OUR WEB SITE AT:

www.phyins.com/FHRTwebinar

Dr. Steven Clark with Physicians Insurance CME Planning Group members Dr. Angela Chien of Evergreen Women's Health Center and Kym Shepherd of Physicians Insurance at the October 3rd event in Kirkland, WA

"Dr. Clark, as always, is on the cutting edge of information in our field. He has collaborated with other ob-gyn docs and developed a highly beneficial tool for those of us in the trenches. This presentation is a must."

DR. KATHARINE BARRETT-AVENDANO, DO
OBSTETRICIAN AND GYNECOLOGIST, THE WOMEN'S CENTER
BELLEVUE, WA

"Dr. Clark's calm, clear, focused, and specific talk to discuss what has been essentially random decision making will help us and our patients immeasurably. The algorithm that he and his colleagues devised summarizes the best available evidence and gives us clear guidelines to help make clinical decisions."

ELLEN KAUFFMAN, MD
OBSTETRICIAN & GYNECOLOGIST, MEDICAL DIRECTOR,
OB COAP FOUNDATION FOR HEALTH CARE QUALITY

New Courses to Meet Your CME Requirements

TEAMWORK, COMMUNICATION, AND PATIENT SAFETY IN THE EMERGENCY DEPARTMENT

Emergency physicians operate under great time pressure within a high-risk, high-volume environment. This self-study course helps mitigate the risk by using evidence-based communication tools. The course demonstrates through case examples how to put the tools into practice, facilitate team effectiveness, and enhance patient safety. An interactive quiz at the end of each case reinforces key topics discussed throughout the course.

WHO SHOULD TAKE THIS COURSE:
Emergency medicine providers

PATIENT COMPLAINTS AND SERVICE RECOVERY: STRATEGIES FOR SUCCESSFULLY HANDLING CUSTOMER SATISFACTION ISSUES

Poor communication can damage a patient's confidence in the interest, competence, and attitude of the health care team. When confidence is undermined, any complication or adverse result can lead to a complaint—and if the complaint is not handled appropriately, litigation can result. This one-hour webinar will address the issues that lead to patient dissatisfaction and will present strategies to prevent the errors that result from communication failures.

WHO SHOULD TAKE THIS COURSE:
Health care providers and their staff

WWW.PHYINS.COM/CME

85 PERCENT OF ERRORS RESULT FROM **COMMUNICATION FAILURES***

* KERRY PATTERSON, JOSEPH GRENNY, RON MCMILLAN, AND AL SWITZLER, *CRUCIAL CONVERSATIONS: TOOLS FOR TALKING WHEN STAKES ARE HIGH*, SECOND EDITION (MCGRAW-HILL, 2012).

When You Come to a Fork in the Road…

Don Wee says, "Know your plan and take it!"

As expected from a critical access hospital, Tri-State Memorial Hospital offers a wide range of care to its local community, from surgical services to medical clinics. CEO Don Wee is always busy keeping this 24/7 operation running smoothly, and you can tell that his energy comes from a focus to put patients and families first and a passion to make good things happen—even in times of uncertainty.

ON AMBIGUITY: "Rely on the strength of the organization."

Wee says that the biggest challenge is that change is coming fast, yet the new rules are still not clear. While at the federal level decisions are being made, at the local level we are often in a wait-and-see pattern, which makes planning difficult.

So, how does a modern-era hospital CEO keep things running "all systems normal" during not-so-normal times?

Wee says he relies upon the strength and collaboration of his managers, his senior team, and physicians for the day-to-day operations, and he counts on the board of directors for strategic momentum. It helps to have very engaged physicians and a committed board. Overall, they function as a team united by a patient-focused approach.

For smaller, independent hospitals like his, Wee admits that ambiguity is easier to handle. "In our case, the board is unified, strong, and tightly focused on the community's well-being. That helps us make decisions and then move forward and take action."

ON CHANGE: "Let's push off from the dock and just do it."

There are a lot of predictions about the impact of the Affordable Care Act, and the increased numbers of people to be cared for, but it is still an untested plan. Wee believes the ACA's ultimate effectiveness will depend upon how user-friendly, or cumbersome, the system is to access and use. A bigger issue will come later—the employer part of the equation. How this piece drives the economics of medicine is a bigger issue that will get settled further down the road."

Wee says their approach to moving forward during times of change is to have a strategy, then have a contingency plan to that strategy. "This is a plan with multiple layers, which includes planning for the worst-case scenario. But you always need to be quick, nimble, and responsive while staying patient-focused." For instance, even while payment models change, at the end of the day you still have to take care of patients' needs —even if you have to simultaneously operate in the old and new models.

No matter how things play out, Wee says the ACA is here and he doesn't see it being overturned anytime soon. "I don't know of any government program that got abandoned once it was up and running," he says.

ON REPEATED "MOST WIRED" AWARDS: "Technology without compassion does no good."

"We make sure we have the most efficient, cutting-edge technology that can be put to good use at our hospital," Wee says. This technology investment is being recognized; for the past several years, Tri-State has made *Hospitals & Health Networks* magazine's Most Wired list as one of the nation's most technically advanced hospitals. But Wee cautions, "The technology is not

Fast Facts

WHO: Tri-State Memorial Hospital

ESTABLISHED: 1955

LOCATION: 7 locations throughout Oregon and SW Washington

TOTAL STAFF: 430

LOCATION: Clarkston, WA

Don Wee, CEO, Tri-State Memorial Hospital

any good without compassion and respect for the patient. No matter the tools used, it's important to remain sensitive to the needs of patients and their families."

What else have they been recognized for? Peruse the *Consumer Reports 2013 Safer-Surgery Survival Guide* to see Tri-State listed among the top-ranked surgery facilities in Washington State. Additionally, Healthgrades has given Tri-State a five-star rating and ranked them among the top ten in Washington in joint replacement for several years running, and within the top 10 percent in the nation for superior joint replacement outcomes since 2011.

MOST IMPORTANT THING TO BRING TO WORK? "A positive attitude."

Wee says the staff's positive attitude creates the biggest impact on patients and on each other, which is why a strong focus on customer service is essential. Wee sees customer service as one of the three legs of the triangle leading to good outcomes, the other legs being operations and quality. If one of the three is lacking, they aren't delivering at the level they're aiming for.

"We want perfection when it comes to patient satisfaction, so we keep it as an ongoing focus," says Wee. "We're always benchmarking customer service, using tools for feedback, and working to keep improving. We set our own bar to meet and exceed."

{Exit-Planning Stress Test, Continued from page 11}

When thinking about disability, in addition to plans for a buy-out, consider these questions:

1. Will the practice pay an owner who is unable to work for an extended period of time? What if that time period is permanent?

2. What happens if an owner can return to work but has to cut back hours?

3. What if the practitioner can work full time but cannot perform at the same level due to mental or emotional deficits? What if substance abuse is involved?

All points of clarification will depend of the nuances of your particular practice. Early brainstorming is helpful before meeting with a qualified attorney.

STRUCTURE THE FUNDING IN A WAY THAT MAKES SENSE

Ideally, buy-sell agreements are fully or at least partially funded. Frequently used funding vehicles include life insurance, disability insurance, and various investment products. After determining the value of the business, the practice and its advisors will next need to determine the best way to fund all agreed-upon triggering events.

Regardless of the financial vehicle used, practices must ensure that funding arrangements are affordable, unbiased, and straightforward for all parties involved. Young physicians have difficulty affording expensive buy-ins due to significant debt incurred from medical school, and medical practices have difficulty affording expensive buy-outs due to declining profitability. Unplanned funding obligations can affect the overall morale of newer physicians, impede physician recruitment and, ultimately, lead to the decline of the practice.

FINAL THOUGHT

Retirement should be a very exciting time, yet there are myriad decisions to be made. Developing a thoughtful exit strategy in anticipation of any kind of departure makes sense. To reduce the stress of such transitions, retain a qualified team of professionals specializing in health care—attorneys, accountants, financial advisors, and certified valuation experts—to help prepare for the future. Succession planning takes time and foresight, but working through even the most complicated of issues always starts with simple dialogue.

* Michael Hodes, "Why You Need a Buy-Sell Agreement Now," *Medical Economics*, November 26, 1990.

** U.S. Social Security Administration, Fact Sheet: Social Security, 2013 Social Security Changes, accessed October 8, 2013, http://www.ssa.gov/pressoffice/factsheets/colafacts2013.pdf

BEN WOODBURY is a partner with Leeds and York, where he works to protect and preserve his clients' valuable assets through risk management and cost-saving programs.

SB 483: A Mixed Bag of Reform

Oregon Legislative Update

BY JEFFREY R. STREET, JD, AND TRACY A. HOOPER, JD, HODGKINSON STREET, LLC

Earlier this year, the Oregon Legislature passed Senate Bill 483, which was signed by Governor John Kitzhaber, and entitled Resolution of Adverse Health Care Incidents. The new law is intended to provide a framework for early, confidential resolution of disputes related to "adverse health care incidents."

Loosely based on the system pioneered by the University of Michigan, SB 483 strives to reduce costs and time delays encountered by aggrieved patients who wish to assert claims for compensation. The law ostensibly provides some benefits to health care providers as well by making disputes under the new procedure exempt from reporting to state licensing boards and the National Practitioner Data Bank. A health care provider's participation in the new dispute resolution system is entirely voluntary. The law also charges the Oregon Patient Safety Commission (created in 2003) with making rules and procedures to implement the new system, establishing quality-improvement "techniques," and developing evidence-based "prevention practices" to improve patient outcomes. The new law applies to adverse health care incidents that occur on or after July 1, 2014.

There are potentially significant flaws with this new statute. SB 483 is an outgrowth of the desire to have meaningful tort reform that would improve our existing litigation system. However, instead of reforming the system we already have, SB 483 adds a completely new framework for resolution of health care disputes while leaving the existing system in place with no changes. Some hail this as a new breakthrough that will produce great benefits. Others see this as nothing more than window dressing that will do little to change the current tort system and will add another layer of administrative and procedural burden.

It appears the key potential advantage to patients is a streamlined system that leads to open discussion and quick resolution of claims at relatively low cost. The advantage to health care providers may be the possibility that some claims can be resolved without adverse reporting consequences and licensing board investigations. Once

The following links provide the full text and a simplified outline of SB 483.

Full Text

www.phyins.com/SB483

Outline

www.phyins.com/SB483outline

this law becomes effective, Physicians Insurance will assist physicians and clinics to evaluate whether to participate in this process after an adverse incident occurs. There are many important unanswered questions, and the company will work with you to make a decision in your best interests. The unanswered questions include the following:

- How will the new law impact the number and type of claims made against Oregon health care providers? Who will determine whether or not the claim involves "serious physical injury" as required by the statute?

- Is the law consistent with National Practitioner Data Bank reporting requirements? Does federal law governing National Practitioner Data Bank reports preempt state law on the same subject? Will the National Practitioner Data Bank object to the new Oregon law and assert that settlements under the new program are reportable events?

- Given the statute's fast-track approach to dispute resolution, will lienholders, including but not limited to Medicare, be willing or able to meaningfully participate in negotiations?

- Without formal discovery, will the rules give the defense the ability to adequately evaluate a claim, such as by requiring patient cooperation in securing access to the patient's health care information?

- How will the Oregon Patient Safety Commission create rules to implement the new system? How will the commission use information it collects about adverse health care incidents? For example, can the information be used to limit or deny hospital privileges?

- How can settlement documents be executed and enforced given the statute's confidentiality provision? If court approval is necessary, how will that be obtained if no public legal claim has been made or lawsuit filed?

Significantly, SB 483 was the result of a collaborative effort of the governor's office, the Oregon Medical Association, and plaintiff attorneys. Despite multiple requests to be included, neither insurance companies doing business in Oregon (including Physicians Insurance) nor the defense lawyers who represent health care providers had a seat at the table while the law was being drafted. Just prior to the legislature's passage, members of the Oregon Medical Association (OMA) endorsed the bill with a vote that passed by a very narrow margin.

CONCLUSION

In summary, the new procedures create a framework in which a patient can put a health care provider on notice of an adverse health care incident. The notice is not deemed a written claim or a demand for payment, but can then lead to a discussion of the event. The discussion may then lead to an offer of compensation to the patient or a denial of any compensation. The patient also has the option of going to mediation. If the matter is settled at any point in the process, the new law provides that the settlement is not reportable to state licensing boards or the National Practitioner Data Bank. If the matter is not settled, the patient can still go through the conventional litigation process.

PHYSICIANS INSURANCE REMAINS ENGAGED

- We will continue the dialogue established with the Oregon Medical Association regarding its interpretation of the new statute and the recommendations it plans to give to its members.

- We will initiate a dialogue with the American Medical Association to see if it has taken an official position or has any statement to make in regard to SB 483.

- We will contact the National Practitioner Data Bank to determine its position as to whether cases resolved under SB 483 are considered "reportable events." Specifically, we will be asking the National Practitioner Data Bank for an advisory opinion as to whether it will honor the non-reporting provisions of SB 483, or whether it objects to such provisions.

- The governor's office consulted with several plaintiff attorneys at length as SB 483 was drafted and raised. We will seek to interview these attorneys to make sure we understand the full intent of the new law and to see if we can find areas of common ground in cases where the new procedures are implemented.

- The law provides that a task force will be appointed to evaluate the implementation of the new law and to report to the legislature regarding its findings. The task force can recommend additional legislation. We will continue to encourage the governor to include medical professional liability carriers and defense attorneys in the process as well as follow the rule-making process under way.

{Weathering the Business Side of the Triple Aim, continued from page 6}

might be needed to provide prompt, accessible, quality care in one location.[4] Those who oppose such disproportionately higher facility fees say they run counter to our nation's goal of reigning in health care costs and point out that higher prices do not necessarily translate into better care. How long can this imbalance of fees between large and small be maintained? If the marketplace rebalances and smaller, more affordable options increase success at attracting patients, what will happen to the mega systems that can no longer afford their infrastructure?

> "Today's administrative requirements mean the physician has to be part accountant, tech geek, and lawyer, or hire a skilled force of professionals to keep the practice in compliance."

Either way, the sobering fact is that the quality outcomes of our health care system are disproportionally low when put side by side with the amount of money we spend. This places the United States in the unenviable position of spending more on health care than any other country, yet ranking 26th for life expectancy.[5] How can we lower costs and improve care? Is there a way to combine the best of both larger and smaller care models?

SHIFTING OUR VALUES

"As a whole, we have invested enough in bricks and mortar. We should use what we have, not always build new buildings and add duplicate state-of-the-art machines," Shimada says. She points out that increased revenue also goes into advertising—TV, radio, print—assuring the public that particular facilities

Duane Lucas-Roberts, CEO, The Vancouver Clinic, Vancouver, WA

Marcy Shimada, CEO, Puget Sound Family Physicians and Edmonds Family Medicine, Edmonds, WA

are the biggest and the best, something our culture demands. Advertising can drive a patient to an ED marketed with a "no wait time" promise, even if a lesser-known ED is more affordable and provides excellent care. Perhaps there is a different way to promote a practice and improve health outcomes at the same time. Shimada says that her facilities' marketing consists of outreach activities like blood pressure checks at the Taste of Edmonds event and doctors discussing bike helmets with kids at schools.

Even with strong leadership and a culture of collaboration, solo and small practices need more to survive. As changes unfold, there will be a "sifting, a winnowing," as Lucas-Roberts says. Some, but not all, will be able to keep patient care at the center of their work and survive in the business of medicine today. As Turney advises, "One challenge for these smaller practices is to evolve and meet the demands of a new and upcoming care model, which requires investment and maybe a new way of thinking about their practice."

Successful organizations know that longevity relies on keeping administrators, staff, and clinical providers healthy and successfully engaged. Leaders have a strong hand in creating a culture of support, respect, and the opportunity for everyone to feel that they make a difference. "This includes promoting personal health and productive work habits in everyone," observes Shimada. Without such a culture, successful implementation of plans is difficult. As Peter Drucker (writer, professor, management consultant, and self-described "social ecologist") said, "Culture eats strategy for breakfast."

Dealing with change takes courage and mindful decision making, and not in a vacuum. It is heartening to see how some practice executives check their egos in the parking lot and acknowledge that the way forward lies in respect and collaboration. For example, constant dialogue between administrators and physicians can lead to a quality experience for their patients. "The key is that running a medical organization is not a one-person show," says Lucas-Roberts. "Having a broad physician-leadership base is critical. You cannot have too many physician leaders; the more they are involved in administrative aspects and decision making, the

{HIPAA Q&A Continued from page 17}

Q How painful are the penalties when a covered entity is found in violation of HIPAA regulations?

A It depends. The HITECH Act established higher penalty amounts, which will now be enforced by the Final Rule. The new penalty process incorporates a four-tiered penalty structure. The tiered amounts are tied to whether the violator knew of the violation, had reasonable cause for the violation, was neglectful, and, in the case of neglect, implemented corrective measures within 30 days. The amounts range from $100 per violation to $50,000 per violation, with a cap of $1.5 million for violations of the same requirement in a calendar year.

Q Should those involved in health care assume that there is now an adversarial relationship between the medical community and HHS?

A Though enforcement and penalties have increased, HHS really does stress compliance from a preventive measure standpoint. The Office of Civil Rights – the HHS division that conducts civil investigations of potential HIPAA violations – includes quite a bit of guidance for implementing the HIPAA requirements on its website. In addition, the Final Rule gives HHS the discretion to resolve a violation through informal means, such as an entity demonstrating compliance or completing a corrective action plan. The Final Rule calls for HHS to provide technical assistance to CEs and BAs to help them comply voluntarily with HIPAA rules.

Q How does the Final Rule (also called the Omnibus rule) affect companies providing services to covered entities?

A A Business Associate (BA) is a company that provides services to or on behalf of a CE where the services involve access to PHI, for example, an IT firm that manages a practice's electronic health records system. CEs and BAs must have a written agreement that provides the BA's assurances that it is HIPAA compliant. The Final Rule, which has a compliance date of Sept. 23, 2013, requires BAs to comply with certain requirements of the Privacy Rule and the Security Rule; they must now have much more robust compliance programs and documentation. HHS has the same ability to audit BAs as it does to audit CEs, and to impose civil money penalties against BAs. In addition, if a BA engages a subcontractor to perform some of the services that the CE has contracted with the BA to perform, the BA must enter into a formal agreement with the subcontractor that includes HIPAA compliance. Note: the Final Rule became effective March 26, 2013; CEs and BAs must comply by Sept. 23, 2013.

"I THINK WE'RE GOING TO FIND THAT THERE WERE A LOT OF COVERED ENTITIES THAT DIDN'T REALIZE THEY HAVE BUSINESS ASSOCIATES AND BUSINESS ASSOCIATES THAT DIDN'T KNOW THEY WERE BUSINESS ASSOCIATES."

LEON RODRIGUEZ,
DIRECTOR OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' OFFICE FOR CIVIL RIGHTS

{Weathering the Business Side of the Triple Aim, continued from page 24}

better. I work for them, not the other way around." The changes over the last decade have indeed strengthened the relationship between physicians and administrators. To survive, they must work, together, on what is in the best interests of the group for the long term. "We need to manage the present in the context of what we want to become five years down the road."

1. Kaiser Health News, "Study Predicts Shortage of Primary Care Doctors will worsen," Kaiser Health News' Daily Report, Nov 21, 2012, http://www.kaiserhealthnews.org/daily-reports/2012/november/21/doctor-shortage.aspx.

2. Sachin Shah, "Help for Primary Care," Doctors for America, March 13, 2012, http://www.drsforamerica.org/blog/help-for-primary-care.

3. Michael Booth, "Facility Fees Inflate Hospital Prices for Common Services: Triple the Price for Same Health Service, as Mergers Bloom," the *Denver Post*, May 14, 2013, www.denverpost.com/ci_23236112/facility-fee-inflate-hospital-prices-common-services.

4. Beth Thomas Hertz, "Facility Fees Can Change the Economic Equation: Differing Reimbursements for the Same Care Present Multiple Challenges for Healthcare System, Practices," *Medical Economics*, Jan 10, 2013, http://medicaleconomics.modernmedicine.com/medical-economics/news/user-defined-tags/facility-fees/facility-fees-can-change-economic-equation.

5. Simon McKeon, "We Need to Integrate Research and Health Services, The Conversation, Oct 3, 2012, http://theconversation.com/mckeon-review-we-need-to-integrate-research-and-health-services-9742.

Physicians Insurance
A MUTUAL COMPANY

During the summer of 2013, a team of physicians and health care professionals joined members of the Physicians Insurance team to talk about our brand. Based on those conversations, physician and clinic manager focus groups, and expert guidance from branding agency Hansen Belyea, we are proud to announce a new look for Physicians Insurance.

"We didn't set out to change our logo," said David Kinard, AVP of Marketing and Communications at Physicians Insurance. "We wanted to make sure our communications and member materials were as relevant, potent, and usable as possible. What we learned was that our logo didn't match the contemporary needs and expectations of whom we were serving."

"The logo update maintains many elements from the prior version," notes Mary-Lou Misrahy, CEO of Physicians Insurance. "The medical cross, building block elements, and focused space for our members at the center of what we do—those things are still paramount to who we are, and what our members can count on from us."

To better steward member resources, the new logo will be phased in during the remainder of 2013 so we can make use of materials with the prior logo on it.

ANNOUNCING OUR NEW GENERAL COUNSEL

NATIONAL SEARCH IS COMPLETE

Catherine Walberg, Senior Vice President and General Counsel

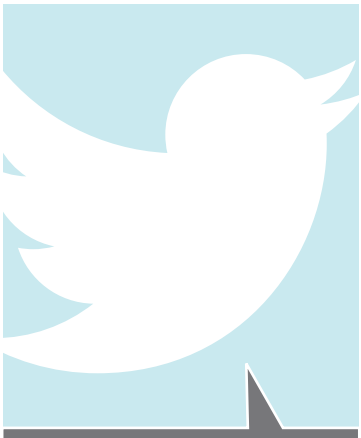
We are pleased to announce Catherine Walberg is the new Senior Vice President and General Counsel for Physicians Insurance. It was paramount to find the right person to continue with the legal strategies we have successfully developed and executed under the leadership of Gary Morse, who is retiring at the end of 2013. After a thorough national search, we found that individual.

Catherine comes to Physicians Insurance from her role as SVP and General Counsel for Kansas Medical Mutual Insurance Company (KaMMCO). Like Physicians Insurance, KaMMCO is physician-owned and physician-directed, and both companies have a similar mission. Catherine, who received her BA and JD from the University of Kansas, started her legal career in private practice representing physicians and hospitals in health care-related issues. She then served as deputy secretary and litigator for the Kansas Department of Aging and served on various committees and groups, including the American Bar Association's HITECH Task Force & Security Rule Subcommittee. Catherine brings a wealth of experience, leadership, expertise, and enthusiasm that will enable Physicians Insurance to continue to successfully carry out our strategic initiatives and accomplish our mission.

"For 10 years I have collaborated with Catherine on projects through the Physician Insurers Association of America. The high quality of her legal analysis and deep understanding of issues faced by physicians, hospitals, and patients assure me that I am leaving the company's legal department in good hands."

GARY MORSE, OUTGOING SVP AND GENERAL COUNSEL

CONNECT TO THE VALUE YOUR PHYSICIANS INSURANCE POLICY PROVIDES



Follow us on Twitter for news and information on patient safety @PhysicianInsure

LOOKING FOR USEFUL PATIENT-SAFETY INFORMATION? VISIT OUR BLOG.

TAKING CARE: SAFER PRACTICES, HAPPIER PATIENTS

Physicians Insurance members just got another channel to access expert information on risk management issues. Earlier this year we launched a blog to provide additional patient-safety expertise. We post new entries regularly, but you can scan the archives to learn what Susan Baumgaertel, MD, an internist from the Polyclinic in Seattle, has learned is the key to helping patients with weight loss. Or what John Furman, PhD and executive director at the WHPS, can tell you about the impact of provider addiction on your clinic. And what Randy Benson from the Washington State Rural Healthcare Quality Network explains is transforming rural care.

Additional topics our blog has covered include managing patient complaints, noncompliant patients, communicating with hearing-impaired patients, and improving care through your bilingual staff.

Visit www.phyins.com/taking-care

Create Your Members-Only Online Account

www.phyins.com

Access resources such as:

- **Dozens of free, accredited CME courses (live and online)**
- **More than 100 HIPAA documents and tools**
- **On-demand COIs, 24/7**
- **Online claims reporting**
- **And more**

WELCOME TO OUR NEW MEMBERS!

The Oregon Clinic
Oregon

Whatcom Occupational Health
Bellingham, WA

Physicians Insurance
A MUTUAL COMPANY

PO Box 91220
Seattle, WA 98111

ADDRESS SERVICE REQUESTED

PRSRT STD
US POSTAGE
PAID
SEATTLE, WA
PERMIT NO. 794

ANNOUNCING A WSMGMA EVENT

HEALTH BENEFIT EXCHANGE FORUM: THE NEW MARKETPLACE

A forum for medical practice administrators about the Health Benefit Exchange and its role in new health plan models.

This event brings together medical practice professionals with representatives from private health plans and public insurers for a one-day program. It will provide administrators the latest updates, trends, and guidance to help practices prepare for and adjust to changes.

The agenda includes a presentation from the Washington Health Benefit Exchange, a Washington Healthplanfinder demonstration, a legislative update on health care reform in Washington, and presentations from all of the health plans participating in the Health Benefit Exchange in Washington. The day concludes with a panel discussion among all presenters.

WHEN: Wednesday, November 13, 2013 | 8:30 a.m. – 4:00 p.m.

WHERE: Grand Hyatt Hotel, 721 Pike Street, Seattle, WA

REGISTRATION FEES	WSMGMA MEMBER RATE	NONMEMBER RATE
Before November 1	$150	$200
After November 1	$175	$225

REGISTER at www.wsmgma.org, or print and submit the online registration form via:

FAX: (206) 441-5863

E-MAIL: rep@wsma.org

MAIL: WSMGMA
Attn: Rachel Perkins
2033 Sixth Ave, Suite 1100, Seattle, WA 98121

QUESTIONS? Contact Rachel Perkins, Meeting Coordinator, at (206) 956-3646 or rep@wsma.org.