A PHYSICIANS INSURANCE PUBLICATION

THE Physicians Report

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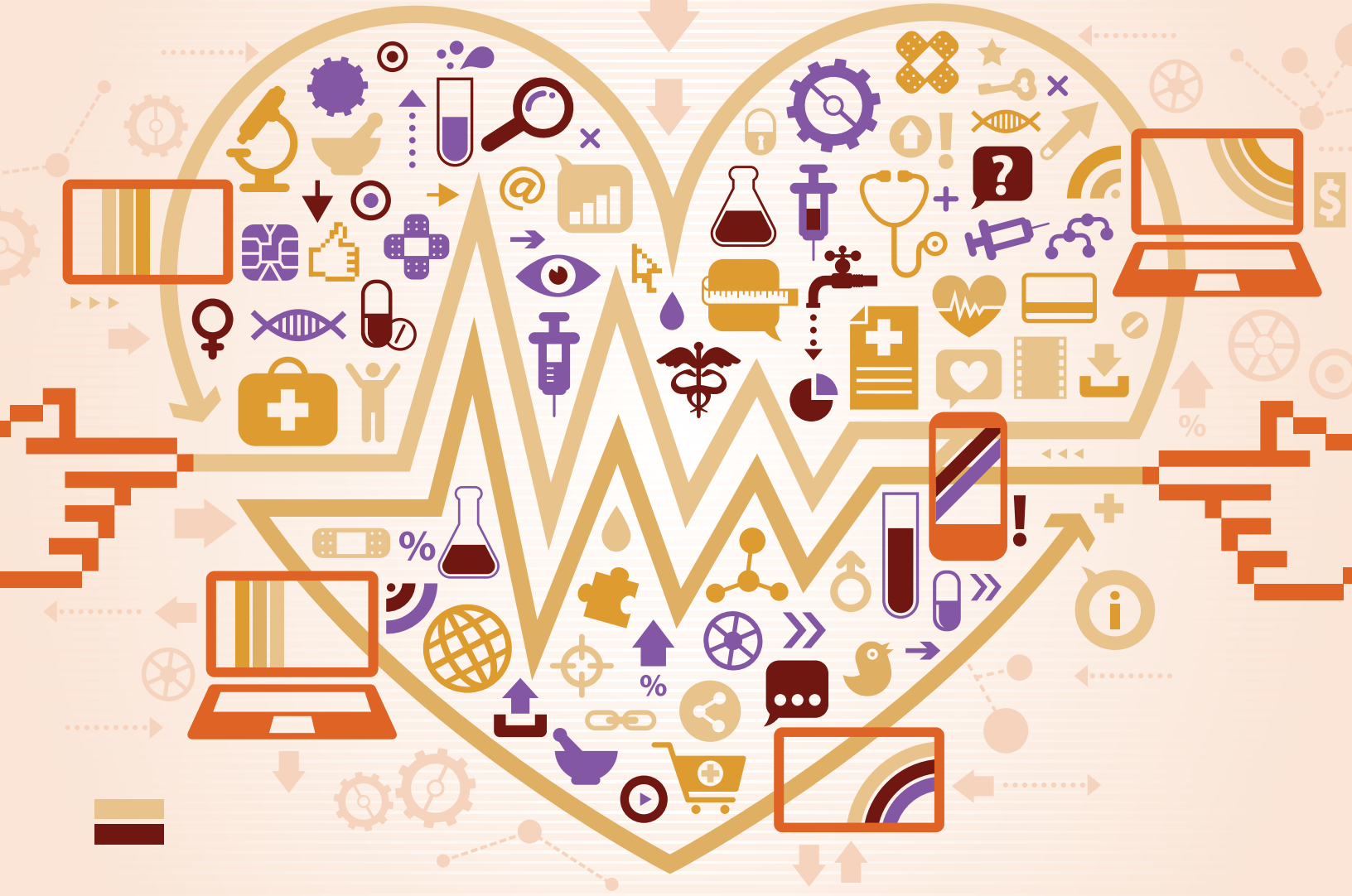
Making Medicine Better



I SPENT THE FIRST HALF

of my legal career working in child advocacy for the Department of Justice. In 2009, I left that practice for a career in health care, and I discovered that many of the issues families were facing in the legal world carried over to the health care world. Mental health concerns, transportation and distance to services, and cultural and language differences were not only barriers to legal follow-through; they were also barriers to good health outcomes. The ACA, in concert with an already changing medical landscape, is just beginning to recognize that making medicine better means leaving the old-fashioned ways behind and embracing a new way of treating the entire person from every angle in order to improve the patient experience, health outcomes and reduce costs. So how do we, as a community of health care providers, accomplish this? With a lot of help!

Mental Health. Our coordinated care organization Willamette Valley Community Health has begun the process of integrating behavioral health consultants in our medical clinics. Within days of our first psychologist joining our team (we recently added a second), our medical providers noticed that they could spend more time addressing the physical and medical needs of patients and turn over the mental and behavioral health concerns to the psychologist. Now the patient gets the highest care from the providers best trained to help them, and behavioral barriers to proper follow-through on medical advice are declining along with subsequent ER visits.

Transportation. Our department of RN case managers has started tracking "no show" rates among some of our more complex patient populations. With a little creative thinking from our clinic and CCO, taxi fare reimbursement, transportation services, and even nontraditional health care workers are helping families get to their appointments. We do not stop there. Where traditional transportation would only take them to and from the appointment, now we recognize that a stop at the pharmacy to pick up the prescription reduces poor follow-through and subsequent trips to the ER. In this issue, you will hear about how innovative services like telemedicine shrink the miles by providing a "new-fashioned" house call to those outside of practical service areas. This, along with virtual medicine, provides cutting-edge technology and services to a population who might otherwise lack access.

Cultural and Language Barriers. Our pediatric practice in the Mid-Willamette Valley has a high percentage of non-English speakers. While many clinics use phone interpreting or outside services to interpret, we hired an entire department within our clinic. The bonds that form between our patient families and interpreters allow the provider to have a more complete and nuanced conversation about health and the other things that make staying healthy hard. Behavioral problems, school trouble, housing issues, and transportation problems are just some of the things that we are better able to address as a result of that bond.

What Makes Medicine Better. When all parts of the person are cared for, the work of the physician will produce a better outcome. We are fledglings today when it comes to connecting all of these parts. As CCOs get more creative and payers recognize the benefit of clinics hiring more case managers, interpreters, behavioral health consultants, and nontraditional health care workers, patients will have a better experience, health outcomes will improve, and costs will decrease. This all makes medicine better.

HOLLY ELMORE, CEO, CHILDHOOD HEALTHCARE ASSOCIATES OF SALEM

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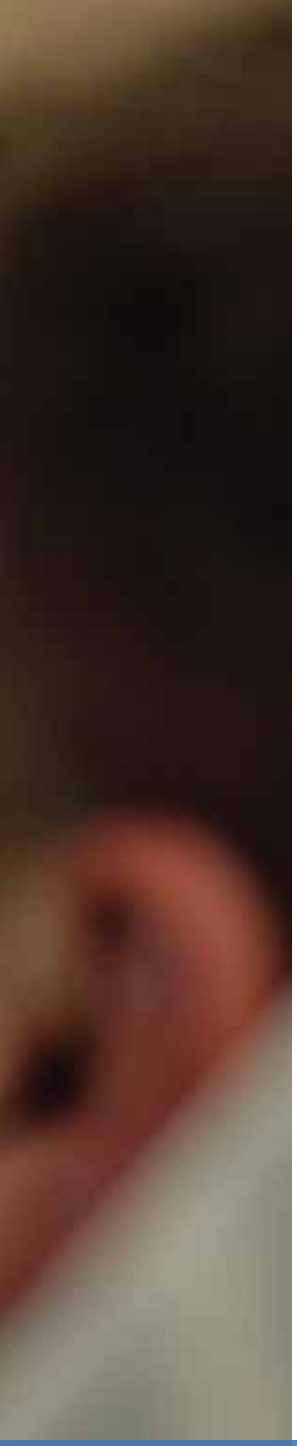
Robotic Telemedicine

A Powerful Ally in Remote Diagnosis and Recovery



Margie Udahl, 73, has been a small-town Eastern Washington resident all her life. Born and raised on a ranch near Wilbur (pop. 880) and now a resident of Davenport (pop. 1,700), she appreciates the neighborly concern and slower pace that often come with rural living.

Widowed eight years ago, Udahl had tried living in Spokane and decided there was just "too much commotion." But Davenport and its wheat fields, about thirty-six miles removed from the big city, suited her fine. Besides, as a paratransit bus driver, she made four or five round-trips to Spokane most days, taking people to medical appointments and grocery shopping.

That all changed a year and a half ago when she was rushed to Davenport's Lincoln Hospital, a twenty-five-bed acute care facility. "A doctor met me in the doorway of the ER and hollered 'Stroke alert!' I've never seen so many doctors and nurses [converge] in one spot!"

Remote Physician Presence in Real Time

One doctor on Udahl's medical team surprised her. A neurologist in Spokane's Providence Sacred Heart Medical Center "stood" at the foot of Udahl's bed within minutes of her arrival at Lincoln. He was there as a remote presence via a computer monitor atop a remote-controlled platform. Not only could he converse with Udahl, but he could also see her in real time and receive her vital signs over monitoring equipment integrated into the stand. Udahl, who could see and speak to the specialist as well, quickly got over the initial strangeness of talking to a machine and believes the swift intervention and resulting diagnosis saved her life.

"It was like he was right there in the room with me," says Udahl of the robotic unit dubbed Hawkeye. "My doctors needed some important information, and the Spokane specialist gave it to them. I don't think I'd be here today if they hadn't gotten the proper medication to me in a short amount of time."

Because the patient population in the Davenport area skews older—65 percent of Lincoln admissions are Medicare and Medicaid patients—the incidence of heart attack and stroke are not uncommon.

Udahl's primary care physician and family practitioner Rolf Panke, MD, says the ability to bring subspecialists to his patients telemedically means that he can practice medicine at a higher level. "We see a lot of everything at a rural hospital, including a lot of wound care, and many of our patients would prefer to stay local and not go to the big city," he says. For those in critical situations who do want to bypass the local hospital and get airlifted to Providence, an early diagnosis via Hawkeye and immediate administration of clot-busting drugs mean that by the time many of those patients arrive in Spokane, their earlier symptoms are already gone.

> "It was like the doctor was right there in the room with me."
>
> MARGIE UDAHL
> PATIENT

"The telemedicine partnership with Providence means less travel time, less delay, and lower cost," says Panke. It provides a valuable co-management partnership for the seven physicians affiliated with Lincoln.

It also means more efficient post-operative care delivered from anywhere. "Through Wi-Fi and Hawkeye, I can care for my patients remotely," notes Panke. It is a time savings that is especially important to a physician with a heavy patient load.

Lincoln Hospital CEO Tom Martin agrees flexibility is a hallmark of having another set of eyes named Hawkeye in the facility's toolkit. "A physician can drive the robot and interact with his patients from elsewhere in the hospital or from anywhere," he says. Physicians can also examine incisions remotely and track how well they are healing.

"Having the increased access to Providence hospitalists and interventionists not only broadens the physician's practice," says Martin, "but it helps validate the admission

(Continued on next page)

(Robotic Telemedicine, Continued from page 5)

to community hospitals of high acuity cases." And critically ill patients appreciate being sent to Spokane at the optimum point to assure the best chance of full recovery.

Keeping Rural Doctors Connected

Telemedicine technology also enables the medical providers at Lincoln to feel less isolated, and they like knowing that their patients are receiving the same care as they would in Spokane.

Martin calls the program a big win for all parties. The cost of the program was offset by a 21 percent increase in admissions, most of whom would have previously chosen to go to Spokane. This increase provided a needed shot to Lincoln's financial stability amounting in one year to an additional $1 million in patient admissions. Patients and their families appreciate that telemedicine means that in many cases, patients can stay close to home and remain under the care of their local primary care physician. Providence benefits through improved utilization of their resources.

Along with telemedicine, a successful Cardiac Level 1 protocol was launched through collaboration between the two health care systems. With the emergence of telemedicine, the program has advanced even more. Patients who present at Lincoln with cardiac symptoms have the added benefit of being seen by a cardiac specialist from Providence in their initial assessment.

Video-Based Interface Is No Game

Five-foot-four-inch Hawkeye is manufactured by InTouch Health. It is found in more than 500 clinical locations throughout the world (Lincoln was the first community hospital in the Spokane region to purchase one). A physician connects via the Internet and maneuvers the robot with a joystick. Using its camera and 360-degree infrared sensors at the patient's bedside, the doctor views vital signs and charts and interacts with the patient and family members, as well as doctors and nurses, through a video-based user interface.

Integrated into the robot are diagnostic implements such as electronic stethoscopes, otoscopes, and ultrasound equipment. Labs, x-rays, and EKGs can all be swiftly communicated to the remote presence physician while the remote physician's biographical credentials

> "Having the increased access to Providence hospitalists and interventionists not only broadens the physician's practice but it helps validate the admission to community hospitals of high acuity cases."
>
> TOM MARTIN, CEO
> LINCOLN HOSPITAL

are communicated to the patient on a small screen below the larger live interaction screen.

Hawkeye has a battery life of four to five hours. Its homeport is a docking unit at the nurses' station. When "asleep," the robot's head, or monitor, bows down as if in slumber. When physician-activated, an uploaded schematic of the hospital directs the robot to the correct room for consultation. "You can usually tell when a new doctor's utilizing Hawkeye," says Martin with a chuckle. "The robot careens from one side of the hall to the other until the doctor gets the hang of it." IPad navigation allows those without precise "gaming skills" to safely operate the robot with relative ease at a top forward speed of 3.36 m.p.h.

Equipped with detection avoidance sensors that include laser range finders, Hawkeye can maneuver around obstacles in its path and safely navigate busy hospital hallways. It creates a digital map of an environment that it can access for future use, labeling rooms, controlling navigation speeds for certain areas, and marking zones where the robot should not travel.

Hawkeye Convinces Skeptics

Fred Reed, MD, chief of staff at Lincoln, says that patients like the novelty of the robot and quickly overcome any awkwardness once the interaction begins. "No one has refused to talk to the robot," says the family practitioner and veteran Navy physician. "One provider, who was skeptical of the robot at first and quite sure he wouldn't use it, embraced it rather quickly. All of our physicians make use of it. It reassures you that you're doing things right and gives both patient and family confidence that they're receiving the highest level of care."

As for Udahl, she will tell you Hawkeye improved her care experience and that she was reassured to have a stroke specialist show up at her emergency room bedside just minutes into the greatest health scare of her life. He could have been teleported to her side Star Trek-style for all she cared. He was there during her crisis and knew what she needed.

"I'd go for it again," says Udahl, who still lives on her own and is a great-grandmother and one-time star softball pitcher enshrined in the Spokane Metro Softball Association Hall of Fame. "I play to win."

Martin foresees a day when "the virtual hospital" will care for patients where they are. It holds particular promise for seniors, he says, by allowing them to "age in place" in the familiar surroundings of home, their health monitored remotely by doctors comfortable with the full spectrum of technology-assisted care. PR

House Calls to Virtual Care

How Telemedicine Serves the New Health Care Consumer

It's seven thirty in the evening, and Stacy, a working mother of four-year-old twins, is finishing bath time. She notices that one of her children has a large, bright red, and raised rash on the back of her thigh. There's no fever and no other symptoms, but this doesn't look good, and Stacy begins to think about trying to get a drop-in appointment at the pediatrician's in the morning.

If her daughter can be squeezed into the doctor's already packed schedule, she'll have a long wait with two active toddlers in the office waiting room, both kids will be late for preschool, and if the appointment takes longer than expected, she may have to take the whole day off work.

Stacy and her kids really like their pediatrician. But unfortunately, their situation is not uncommon. And for others like Stacy, options for getting timely care often seem limited and time consuming. At least, that's the way it used to be.

Today, telemedicine has evolved into a growing and well-received delivery channel of high quality care. Certainly, there are limits to what types of care can be delivered through telemedicine, but for people like Stacy, the value is tremendous.

With roots in the old-fashioned house call, Carena—a Seattle-based company—has evolved the high-quality experience found in the traditional office visit into virtual care. Today, the company provides care to self-insured plans covering more than 500,000 lives and has a hospital-system coverage area in six states (expanding to four more in 2015) with more than six million lives covered.

"We are always focusing on the patient experience," says CEO Ralph Derrickson. "This is part of our core mission. We want to change how customers and consumers access health care, providing medical care on their terms." Those terms are based largely on a growing health care consumer base that wants different things than they have had in recent years.

Ralph Derrickson, CEO, Carena

The evolution of health care, stemming from the Affordable Care Act and the Triple Aim (Berwick's model of care quality, population health, and reducing costs), is changing not just the delivery systems and provider practices but also how patients see themselves. Cost transference in the form of high-deductible plans is changing care-seeking behaviors. "The health care consumer today is now asking if they even need to see a doctor, and if so, what kind of doctor is the right choice both in terms of care and economics. Patients today are looking for buying advice," notes Derrickson.

But these are not the only changes impacting the new health care consumer. With more and more services being investigated, reviewed, and purchased online, these consumers are looking for the Amazon online equivalent to their health care. This goes beyond just offering online appointment scheduling and portals to view a medical record. It has to do with transparency—what does something cost, what are other consumer reviews, what is the refund policy? And it has to do with speed of delivery.

"When someone contacts Carena, we average about twelve minutes to get them connected to a provider. The visit lasts about twenty minutes. So the total time is less than one hour from the time someone decides they need care to the completion of their patient visit," says Derrickson. This is compared to the hours, days, and sometimes even weeks of waiting to see a provider for a ten-minute visit. "Seventy percent of the time, we can take care of your issue in that one virtual visit. Thirty percent of the time, we refer you to other resources."

And it's in those referrals that Carena's model is finding physician and employer support. By contracting with employers and health systems, Carena knows when someone calls who their insurer is and what in-plan resources are available. This keeps patients connected to their primary care provider as well as other in-plan options. "We work hard to ensure that the patient's primary care doctor knows we delivered care. We'll send them a report of our interaction with their patient, describing the care we provided," notes Derrickson. "We approach the virtual visit from the PCP perspective. We want to get you back to your PCP so that everything we are doing is fully integrated and supports the continuity of care." Derrickson believes this model can actually help physicians and their practices stop patient leakage away from clinic panels.

The care that Carena provides follows clinical practice guidelines. In fact, Carena is the only virtual care provider that is certified by Washington State's QAIP Program—a continuous quality improvement program for clinicians that tracks quality measures and is granted to those entities who regularly perform above and beyond the average. This third-party credential is important to the virtual care model, so a focus on quality measurement programs (e.g., HEDIS) is only one tool to choose from. "We have metrics that tell us if care was delivered beyond the complaint, the total amount of care we actually delivered, and what our prescribing rates are (which are below the national average in several categories)," says Derrickson.

Carena's model is working. Companies like Microsoft, Costco, and Boeing are using Carena to supplement their self-insured plans and to help keep costs down. Hospital and health systems like Catholic Health Initiatives (CHI) are using Carena as a way to support their own employee populations and as a means of extending the primary care arm of the system, as well as to market to new patients. "This model works for these types of organizations because we're protecting the sanctity of the office visit. We're not changing who patients see—just how consumers access their care," says Derrickson.

And perhaps that is where virtual care makes medicine better. As Derrickson puts it, "If we combine one-third clinical, one-third technology, and one-third consumer orientation, we can create a total customer experience." For patients, it is easy to see how they will become more savvy buyers of care who are looking for different models of delivery. If this is true, access to clinically appropriate goods and services will not be exclusive to the brick-and-mortar office visit. For providers, teaming with a virtual care provider extends their ability to care for patients without having to take two a.m. calls or pack more patients into an already full day. (PR)

Gossman's Macro-Simulation Offers Caregivers Safe Place to Practice Skills, Improve Quality

Today's health care simulation is rooted in aviation training, computer science, and health care education. While there is much variety in how simulation is executed, all simulations have the same purpose: Improve the safety and quality of health care.

But what is the limit of safe and quality care? Is it quality health care if the patient survives but has a less-than-satisfying experience with her care providers? Is it safe care if the patient gets the correct treatment but the caregivers have to adapt through several "work-arounds" to give the treatment? There are many components that make up safe and quality health care, and all of the components can be improved through simulation.

The word "macro" means "relating to the whole of something, rather than its parts." Gossman Advanced Health care Simulation has been working since 2010 to develop macro-simulation programs that not only allow caregivers to practice specific skills and procedures in the safe environment of simulation but that also incorporate many of the other components of quality care, including safety behaviors, teamwork, communication skills, workflow, system barriers, outdated protocols and policies, patient and family satisfaction, and caregiver job satisfaction. And in some cases, improving the process and workflow has the added benefit of making care more efficient and cost effective.

The Problem

- Postpartum hemorrhage is in the top three causes of maternal mortality in the US.
- Caregivers consistently underestimate visible blood loss by as much as 50 percent.
- Rapid recognition and diagnosis of PPH is essential to successful management.
- Hypovolemic shock is an emergency condition in which severe blood and fluid loss make the heart unable to pump enough blood to the body.
- The major cause of the adverse outcomes associated with severe PPH is delay in initiating appropriate management.

In 2010, Dr. Jane Uhlir, then executive director of women and infants services at Swedish, noticed that the Seattle campuses were experiencing an average of one major postpartum hemorrhage (PPH) a day between the two birth centers. While this number is within the national average, Dr. Uhlir felt more could be done to mitigate the severity of the hemorrhage.

As Dr. Uhlir tells the story, "You will receive the very best care at Swedish, but we are also the best at forming committees and sending out learning modules." So the committees met and the learning modules were distributed, but when Dr. Uhlir reviewed the data, she saw that little had improved regarding the management of PPH. It was just about this time that Dr. Uhlir became the executive director of the Gossman Center for Advanced Health care Simulation at Swedish.

With minimal experience, the simulation team developed a postpartum hemorrhage simulation that included more than 600 caregivers from two campuses, including OB providers, anesthesiologists, nursing, unit secretaries, lab and blood bank employees, and others. The simulation team recognized the importance of having all of the players participate in the simulation, as simulation is not a train-the-trainer activity. The simulation team collected twelve months of PPH data prior to the simulation and twelve months of data once the simulation sessions were complete.

The behavior changes and improvement in care that occurred due to the simulation

(Continued on page 12)

Physicians Insurance OB and Anesthesia Training Focuses on Teamwork, Communication, and Saving Lives

OB Shoulder Dystocia Simulation Training. Shoulder dystocia, postpartum hemorrhage, and eclampsia are examples of obstetrical emergencies physicians and medical staff may encounter during deliveries. Although infrequent, they require the best teamwork for positive outcomes.

Physicians Insurance offers specialized simulation training to enable hospital teams to rise to the challenge and successfully work together when these crises occur. The program is part of an ongoing commitment to help make obstetrical practice safer and improve outcomes.

"It became clear that delivering obstetrical care relies not only on well-meaning people but even more on adequate systems and protocols being in place to deal with emergencies," says Angela Chien, MD, Physicians Insurance's physician instructor, who practices at EvergreenHealth in Kirkland, WA. She adds, "While we had run simulations in the past, these were infrequent events and not mandatory for staff or providers."

Dr. Chien, who is active on the Claims and Risk Management Committees of Physicians Insurance, and her Physicians Insurance colleagues gathered a team, observed simulation training, and, within a few months, were offering shoulder dystocia drills at Evergreen. "The process was seamless for us—we just had to make sure that staff and providers attended. As part of the implementation process, Physicians Insurance also made sure those who participated would receive continuing education credit."

"It was like Christmas morning," says Dr. Chien, adding, "Having the ability to simulate shoulder dystocia and practice maneuvers was truly a gift. For many of our staff, this was their first simulation experience that involved providers and other staff members. In addition, to a staff member serving as a patient. The response was overwhelmingly positive. It was clear that simulation was something worth doing for every obstetrical emergency."

Customization: Program Strength

A unique strength of Physicians Insurance's shoulder dystocia simulation program is the ability to customize training to meet the team's needs. This requires extensive advance planning in collaboration with the participating hospitals.

Key steps include recruiting physician champions, identifying an on-site nurse instructor, clearly assigning team roles, and reviewing and documenting existing processes and protocols, as well as recommended changes.

The training begins with the team reviewing a video demonstrating the technical aspects of shoulder dystocia. It continues with hands-on use of a life-like birth model, as well as a live nurse instructor functioning as a patient to simulate the delivery.

"This brings the whole training to life," says Celia Smith, CCMEP, director of Continuing Medical Education for Physicians Insurance. "Having a real person participating who knows how difficult births happen, along with the birth model, gives team members a realistic sense of what it's like and how to respond."

The birth model includes removable skin so participants can see pelvic bone structure, and the model is hooked to force-monitoring software that measures the distress the infant experiences so a drill can be stopped if the physician is approaching risk of patient injury.

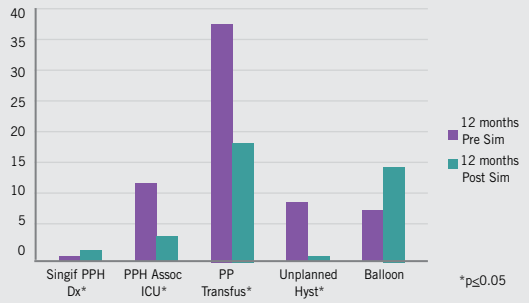
(Continued on page 13)

(Gossman, Continued from page 10)

were quite impressive. Appropriately, the number of PPH increased due to better recognition of the hemorrhage, but the number of major PPH went down, which resulted in the amount of blood used through transfusion to be reduced by 41 percent. Not only did the amount of a precious resource decrease but also fewer women experienced unplanned hysterectomy and there were fewer intensive care unit admissions. Women were receiving better care with fewer interventions. These changes in care also provided significant cost savings.

Improved Outcomes for Complications Associated with Significant Postpartum Hemorrhage

Estimaged Blood Loss of ≥10 0cc Vaginal Delivery and ≥1500cc Cesarean Section



This first simulation program was a precursor to the robust, outcome-driven macro-simulations conducted by the Gossman simulation team at Swedish and more than thirty-six hospitals across the country over the last four years.

The Gossman Simulation team has coined the phrase "macro-simulation," which describes the data-driven, robust process used to plan, implement, and follow-up on multi-disciplinary simulation. It often takes sixty to ninety days of planning by the Gossman team with the physician and nurse leaders of the particular unit to develop a macro-simulation. The planning begins with identifying the objectives, gathering the data, reviewing and revising protocols, and determining the scenario. Implementation of the on-site simulation takes place on the unit where the patient is cared for by the people who do the work. In a macro-simulation, there is no role-play and there is no "If this were real, then I would…" It is imperative that all details of the simulation are accurate to the actual event. (See sidebar.)

Macro-simulations provide a unique opportunity to identify and address many important issues and concerns in one succinct activity. A macro-simulation is planned with objectives to improve specific data points, but also included in the simulation are culture-of-safety behaviors, communication tools, teamwork and leadership, workflow, role clarification, new processes, hierarchy, and patient satisfaction. All simulation sessions are recorded and viewed by the team during a facilitated debriefing process. It is often said that the simulation takes place so that the debriefing can happen. This is where the best work is accomplished. Different disciplines come together to bring down silos and talk about how they work together to care for the patient.

When care providers take the time to slow down, review, and study the process through simulation, many barriers to safe, quality, and efficient practice are identified and corrected. As we hurry through our day, we get very used to "how things are," and we often don't think about "how things should be." Simulation offers the opportunity for teams to come together to imagine their "ideal state" and then simulate to that ideal state. In-situ, team-based, multi-disciplinary, and interprofessional simulation is a powerful tool helping health care teams to work at their highest level not only in the toughest of situations but also in their everyday practice. (PR)

Contributed by: Theresa Demeter, Director, Gossman Advanced Health care Simulation
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Macro-simulation

- Takes place in situ, where the patient is cared for.
- Multi-disciplinary and interprofessional—physicians, nurses, ancillary staff, and other units all participate.
- Ninety percent of all who come in contact with the patient participate.
- Start with the goals and objectives—why do you want to do this simulation?
- Determine the data points and collect twelve months data prior to start and twelve months post-simulation to quantify behavior change and outcome improvement.
- Review and update protocols, policies, workflow, and roles.
- Create the simulation scenario with all components imbedded.
- Each macro-simulation session is usually sixty to ninety minutes, and each person participates in one session.
- Each simulation session is filmed and used in the team debriefing to identify, address, and communicate ways to improve.
- Depending on the size of the unit, there may be two to twenty days of simulation with each session lasting thirty to ninety minutes.

(Physicians Insurance, Continued from page 11)

"We found the shoulder dystocia drills extremely helpful. It gave us confidence to make mistakes in an educational atmosphere," says Amber T. Roberts, RNC, BSN, assistant director of BirthPlace, Pullman Regional Hospital. "We were able to ask questions and practice current and newly acquired skills in an efficient manner," she said, adding that her team has made several changes, including modifications to nursing role assignments in the delivery room. They now have a shoulder dystocia policy defining these roles, as well as having physicians say out loud, "We have a shoulder," which prompts a standardized protocol.

Another integral part of the simulation training is a post-birth bedside debrief, something Smith said staff greatly value as many providers and staff are extremely busy and accustomed to rushing off to their next encounter. She describes the short debrief as a "ripe moment" of not only shared information on what worked and what could have been done better but also as solidifying the team and helping them work together.

A final step in the simulation covers a problem often seen in medical practice liability claims: shared documentation. This ensures the birth is accurately and consistently captured by all team members.

COMMUNICATION IN ANESTHESIA: OPTIMIZING THE PREOPERATIVE INTERVIEW

When anesthesiologists focus on the clinical aspects of a case, they may overlook an essential element—undivided and relaxed attention to the patient.

"As an anesthesiologist, along with my colleagues in emergency medicine and interventional radiology, I face distinct patient communication challenges," says Aparna Ananth, MD, Tacoma. "We're among those medical specialists whose patients are often emotionally wrought when we first meet them. We evaluate their needs, establish trust, relay information, and answer questions—usually in ten minutes or less. Not because we're all communications superheroes but because those are circumstances and expectations of our specialties."

A member of the Risk Management Education Committee at Physicians Insurance, Dr. Ananth reviewed focus group and member survey results of anesthesiologists. It was clear that preoperative interviews were a primary concern, heightened by questions about informed consent and the added weight of patient satisfaction surveys.

In response, Physicians Insurance developed the workshop "Communications in Anesthesiology: Optimizing the Preoperative Interview." The two-hour course simulates real situations and gives participants' constructive feedback from their peers and from patients. And the training is video recorded, so participants can further review themselves after the course.

Three physicians and a patient (a trained actor) sit at a table, and each physician takes turns interviewing the patient and then observing as the other physicians do the same. The participants interview patients with real-life scenarios, such as an individual who is anxious about being intubated while conscious, another who will have been required to arrive with an empty stomach but has been kept waiting for hours without explanation, and another patient who is in active labor and accompanied by an overly helpful family member who is clearly causing additional stress.

PROVIDING BOTH PEER AND PATIENT FEEDBACK IS A STRENGTH OF THE PROGRAM

"Providing patient as well as peer feedback sets the Physicians Insurance workshop apart from other programs," says Smith, adding that the detailed critiques are far beyond what most physicians get in medical school.

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>
> AMBER T. ROBERTS, RNC, BSN, ASSISTANT DIRECTOR, BIRTHPLACE, PULLMAN REGIONAL HOSPITAL

Vita Pliskow, MD, an anesthesiologist in Tacoma, agrees. "I can't tell you when I've had so much fun yet learned so much with a CME class. The entire format—presentation, mock interviews with REAL actors, valuable feedback on performance, and subsequent viewing of the video—resulted in a great experience." She adds that the fact that it was specific to anesthesiologists made it particularly helpful. PR

To learn more about these simulation training courses and how your team can participate in them, along with the many other CME opportunities offered by Physicians Insurance, please contact Risk Management at risk@phyins.com or contact Celia Smith at celia@phyins.com.

Project Access Northwest

Evolving to Ensure Patients Get the Care They Need

A patient in Edmonds needs life-saving oncology care, a patient in Silverdale needs complex hand surgery, and a patient in Seattle needs significant dental work to gain control of her diabetes. Thanks to Project Access Northwest, all of these uninsured patients with limited access and means will receive the care they need.

Project Access Northwest is a nonprofit group that makes medicine better by collaborating with providers in the health care community to open doors to medical and dental care for people with limited access. Building and leveraging relationships with clinicians enables team staff to case manage in a way that helps uninsured and Medicaid patients blend seamlessly into a clinician's practice.

"For me, the easy part is doing the surgery and taking care of the patient. The hard part is doing all the preoperative medical clearance and getting everything lined up before the surgery," says James Crutcher, MD, Orthopedic Physician Associates, Swedish Orthopedic Institute. "Project Access Northwest does all the upfront work for you, which makes it very easy for me to include a patient in my regular surgery day. It's seamless."

Dr. Crutcher, who has been involved with Project Access Northwest for a number of years, adds, "If we were tasked with doing all the preoperative testing, it would be formidable for us to take care of these patients. The beauty of Project Access Northwest is that all that work is done by the time the patient comes to us. The patient is ready to go."

Crutcher is an orthopedic surgeon specializing in hip- and knee-joint replacement and was instrumental in bringing to Seattle the national program Operation Walk USA, which provides joint replacement surgery for uninsured patients.

Last year, eleven Seattle-area patients received life-changing surgeries as a result of the partnership of multiple specialty providers in orthopedics and anesthesiology and Project Access NW.

INCREASED NEED FOR CARE COORDINATION

While many thought the need for a community care coordination program like Project Access Northwest would go away with the implementation of the Affordable Care Act, the opposite appears to be true. In fact, Project Access NW continues to evolve to meet patients' needs.

"Project Access provides access to people who don't have any insurance. Helping people who are underinsured may be an expanded role for the organization," says Crutcher.

With that in mind, Project Access NW is working with specialists to provide the same kind of care coordination for the Medicaid patient population as they have done for more than eight years for the uninsured patient population.

The organization also provides the added benefit of building individual patient's health literacy by helping each understand his or her responsibility for engaging with the physician. This lowers no-show rate (less than 5 percent, compared to 30 percent in typical uninsured or underinsured populations) and reduces cancelled appointments, providing better follow-through and a better understanding of and respect for the valuable services being provided to the patient.

CHANGE IN EVERY CORNER

"We are seeing more ripples as these changes continue to unfold. The challenges are significant, the pace of change huge! There will continue to be change, improvements, and challenges for many years to come. While it is sometimes difficult, there is good news in all this change," Crutcher says.

The ACA has created changes in almost every aspect of our health care systems. It has enabled 423,000 Washington State residents to enroll in Medicaid for the first time, an important program of subsidized insurance for low-income US citizens and legal residents who have lived in the country five years or more. An additional 416,000 Medicaid enrollees completed their annual redetermination on the Exchange. While it's well known the Medicaid payment rate isn't sufficient, coverage is an important step.

The ACA provides access and federal subsidies to low-income people purchasing commercial insurance in the Exchange as well—over 164,000 Washington residents took advantage of this during open enrollment. Using Washington State's Exchange, a total of over one million Washington State residents purchased commercial coverage, enrolled in Medicaid, or completed their Medicaid redetermination. While these numbers are impressive and significant, there are an estimated 450,000 people in the state who don't have insurance.

FIXING HEALTH CARE IN FLIGHT

The changes wrought by health care reform are very much a work in progress. "This [health care reform] is an evolutionary thing," according to Brian Wicks, MD, The Doctors Clinic and an orthopedist specializing in foot, hand, and ankle surgery.

"Fixing health care is like trying to repair an airplane while it's flying. If we are going to be fixing health care on the run, we're going to have to be able to take care of those folks who can't yet get access to the system. Project Access Northwest is a great way to make that happen."

QUALITY CARE FOR ALL

"Project Access Northwest thinks the physicians we work with are the best… They are not only top notch in their specialty; they are dedicated to making sure everyone gets access to the very best care," says Sallie Neillie, executive director.

"Physicians went into health care to help patients. The care coordination that Project Access Northwest provides makes it easier for the physician to include the low-income, uninsured, and Medicaid patients in their practice by seeing a reasonable number of them who prepare well, show up, and are engaged in their own care."

Without a crystal ball, none of us know what health care delivery will look like in five years. But with the commitment of local physicians and organizations like Project Access Northwest, Neillie adds, "We can be sure that patients will be well cared for by some of the best specialists in the community. And in a manner that works for the health care practice, as well as the patient." (PR)

"Fixing health care is like trying to repair an airplane while it's flying. If we are going to be fixing health care on the run, we're going to have to be able to take care of those folks who can't yet get access to the system. Project Access Northwest is a great way to make that happen."

Brian Wicks, MD, Orthopedist, The Doctors Clinic

Expertise, Compassion, Impartial Support: Key Benefits of Rural Health Quality Network

Peer Review

In 2002, six hospitals in the northeast corner of Washington State combined efforts for the specific purpose of maintaining their critical access hospital status. They formed the Rural Health care Quality Network (RHQN), an entity created to meet their external peer review needs in order to meet the conditions of participation as a critical access hospital. Over the years, review by the RHQN has expanded to include all but two of the state's critical access hospitals, earning national awards along the way.

Not all response to peer review is positive. Some physicians are concerned the deck is stacked in favor of physicians employed by hospitals, that peer review committees can be motivated by financial interests to limit competition, and that the process can be subjective. However, in a recent Washington State Medical Association survey, many respondents indicated they knew very little about how the system works.

WHY IS THIS SERVICE VALUABLE?

Peer review physicians bring to RHQN member facilities a level of expertise, compassion, collegiality, impartiality, teaching credentials, and rural hospital appreciation that makes them highly sought after. CMS regulations require that peer review physicians not be a member of the facility's medical staff and not live in the community. They are objective, outside voices of support and assistance to physicians who often have no one else to turn to.

SUPPORT TO RURAL HOSPITAL STAFF

The RHQN's peer review service supports rural hospital medical staff by offering assistance and support in assessment and rewriting of facility medical staff bylaws and credentialing and privileging policies. Outside input into facility bylaws and privileging policies are vital to provision of safe patient care and objective assessment of physician competency. Peer review physicians are often asked to provide subject-specific continuing medical education in support of the medical staff and targeted at the needs of the facility. Many rural hospital physicians form a close working relationship with their peer review physician.

An example demonstrating the valuable support peer review offers occurred three years ago when a family practice physician at a critical access hospital was performing colonoscopies. While a valuable early colon cancer detection tool, the procedures weren't being done as efficiently as possible.

"They were taking longer than usual—an hour or more—and there were patient safety issues," says Randy Benson, RHQN Executive Director. "They were requiring extra x-rays and increased patient sedation time." As a result, he says, patient and staff satisfaction were low.

The family practice physician wanted to continue to offer the procedure so his patients could receive them close to home rather than have to drive to a large city many miles away. So the RHQN was contacted, and a peer reviewer arranged for a gastroenterologist to consult with the physician both on site at the rural hospital and at the Spokane hospital where the specialist practiced. The consult also included chart review and ongoing mentoring.

PATIENT, STAFF SATISFACTION INCREASE DUE TO PEER REVIEW SUPPORT

What were the results? The colonoscopies went from taking more than an hour to half that time, says Benson. This greatly improved patient satisfaction due to reduced sedation time, and staff satisfaction improved as well due to the more efficient processes and improved patient safety. Plus, the family practice physician was able to continue offering the needed service in the rural community.

HOW IT WORKS

As part of their dues, RHQN members receive four external peer review site visits per year. For an additional fee, member facilities may avail themselves to additional site visits (up to ten per year). Approximately a third of RHQN's membership have contracted for site visits over and above the four included in their dues. Each two-day site visit includes review of open and closed charts in specific areas defined by CMS, the RHQN, and the facility. After the completion of chart review, the peer review physician writes a summary and presents their findings to the medical staff, facility quality improvement committee, and CEO. Included in this meeting is continuing medical education designed to share clinical best practices and provide tools for the medical staff to use in improving patient care quality.

The RHQN employs seven external peer review physicians. All are board certified in either emergency medicine or family practice. Six of the seven are also actively practicing. They have been selected for their expertise, appreciation for rural hospital care quality, communication skills, and teaching ability.

In 2013, the RHQN external peer review physicians reviewed more than 5,700 charts. An average visit results in review of thirty-five to fifty charts. In addition to inpatient chart review for each facility, the external peer review physicians provide clinic chart review, as requested; medical staff consultation and assistance with developing and maintaining hospital medical staff bylaws; and support and assistance with privileging and credentialing issues.

SUPPORTING STATE-WIDE QUALITY IMPROVEMENT

The most valuable tool in the scope of the RHQN's external peer review service is the opportunity to create and support statewide clinical quality improvement strategic initiatives. These strategies are based on collective findings from individual critical access hospital chart reviews. The RHQN peer review physicians meet quarterly to discuss their collective findings, review progress of ongoing clinical quality improvement strategies, and suggest new or modified strategies. Clinical quality improvement strategy work is a major scope of work for the RHQN.

Washington is the only state in the nation to provide on-site external peer review with a follow-up statewide clinical QI plan. The RHQN's external peer review physicians review ten to twenty times as many charts as any other state. All peer review is in full compliance with the HIPAA confidentiality standards. Member facilities look to their external peer review physician as a mentor, teacher, peer, subject matter expert, and sometimes even a referee to help handle specific physician-related issues.

> "This program has provided this facility direction, information, and tools to make huge strides to improve quality and safety practices to the patients and community that we serve."
>
> BETTE BARLOND, RN, BSN, MBA, QUALITY AND SAFETY DIRECTOR, PEACEHEALTH UNITED GENERAL MEDICAL CENTER

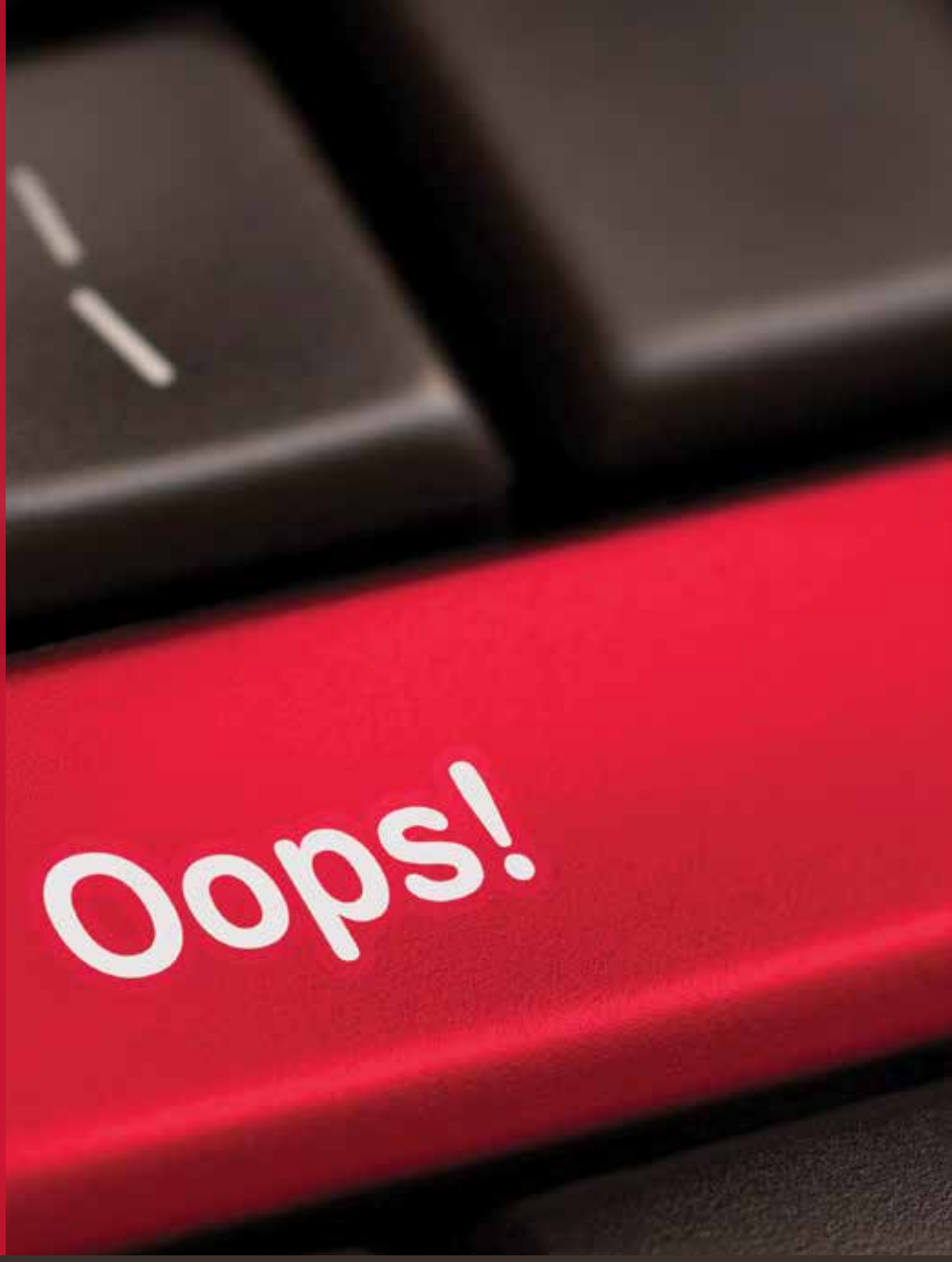
SUBSPECIALTY REVIEW INCREASINGLY IMPORTANT

In addition to on-site external peer review, the RHQN provides subspecialty peer review services. When one of the physicians reviews a chart that they feel needs evaluation by a physician with expertise in the given clinical area, they have the option of referring

(Continued on page 20)

NAVIGATING E-COMMUNICATIONS

How to Manage Privacy & Security Risks



Patients increasingly prefer electronic communication with their health care providers. It is an essential component to demonstrating meaningful use, and some health IT analysts predict that electronic communication will soon become standard operating procedure in health care.

There are many positive aspects of this technology as new platforms offer patients improved access to their health information, as well as streamline communication with their providers.

But with these new communication tools — including web-based technologies such as patient portals and e-mail — come increased privacy and security risks as well as the potential for unintended consequences.

ELECTRONIC BREACHES SURPASS PAPER

As technology evolves, mobile devices (cell phones, laptops, tablets, etc.) are now the leading source of breaches, overtaking paper records. Theft of laptop and desktop computers now

accounts for more than sixty percent of breaches of protected health information according to Health Information Privacy/Security Alert Analysis of HHS Office for Civil Rights Data (See "Cyber Liability" article page 24). That is why HIPAA requirements emphasize that providers must identify vulnerabilities in electronic device use and implement appropriate physical, technical, and administrative safeguards.

PATIENT PORTALS

HealthIT.gov defines a patient portal as a secure, online Web site that gives patients convenient twenty-four-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view and receive health information, including:

- Appointment scheduling
- Recall/reminder notices and follow-up care instructions
- Prescription refills
- Lab results
- Billing inquiries
- General medical information

With patient portal implementation, organizations can enhance patient-provider communication, empower patients, and support care between visits. Portals provide opportunities for patients to become more engaged in their health, potentially resulting in improved outcomes.

Recent media coverage of large protected health care information breaches has understandably heightened patient concern for privacy and security.

Key to successful patient engagement with portals is understanding what the patient experience will be and taking action to address their needs or concerns.

The following are some helpful patient portal suggestions offered by Kathy Ferris, Physicians Insurance risk management consultant:

- Provide patient education before offering sign on. This should include informed consent on the use, security policy, and measures taken to keep PHI secure. A key component in patient training must be clear information on the time frame in which electronically messaged questions or requests are responded to. Doing so enables patients to know what to expect and reduces potential patient frustration or anxiety when they don't receive an immediate response.

- Be clear on the appropriate uses of the portal messaging function versus phone calls to the provider's office. Explain how urgent needs or requests should go to the provider office or to call 911. It's helpful to provide examples of correct uses and common examples of those that are not. For example, reporting new symptoms through portal e-mail is probably not a good practice due to the limitations of the tool.

- Use drop downs rather than free type when possible to prevent patients from circumventing the appropriate uses. When patients use free type inappropriately, use the opportunity to reinforce the best way to contact the practice for particular issues.

- Develop appropriate uses and stick with them. Frequently physicians may want to accommodate patients and will address more in an e-mail than they prefer or should. "Be sure to always redirect in a positive way as these electronic modalities are new territory for many patients," says Ferris.

- Clearly describe what to expect regarding lab results or other diagnostic reports. For example, it is common for routine blood test results to post on the portal simultaneously with physician notification. It may be appropriate for complex results requiring clinical interpretation to be posted differently so that patients will be able to understand and use the information more effectively.

- Make sure technical security is up to HIPAA standards and encryption requirements. Use the following link as a resource for relevant security topics and for technical guidance: www.healthit.gov/providers-professionals/ehr-privacy-security/resources.

E-MAIL

E-mail has become a vital means of communication for many of us. It provides opportunities for users to reach out and respond to others easily at whatever time or location is most convenient. Convenience sometimes comes with risk, however, and when e-mail communications contain PHI, several risks need to be considered and accounted for.

Misdirection, interception, or unsafe forwarding may lead to reportable breaches. Utilization of professional e-mail addresses could expose personal information in ways unintended or unanticipated by patients. Additionally, communications with patients outside of the medical record or portal may introduce the possibility

(Continued on page 21)

(Peer Review, Continued from page 17)

it to a subspecialist under contract to the RHQN. The network's subspecialty peer review panel includes internal medicine, general surgery, orthopedic surgery, ophthalmology, sleep studies, trauma surgery, gastroenterology, radiology/mammography, nephrology, pediatrics, ENT, and anesthesia/CRNA subspecialists. So far in 2014, the RHQN has provided subspecialty peer review for 107 charts from fifteen of their thirty-seven members.

Subspecialty peer review has grown exponentially in recent years due to increased activity in the merger/affiliation arena. When rural hospitals engage in merger or affiliation negotiations with a larger hospital or hospital system, the larger entity quite often requests a full chart review of subspecialty physicians who may become employees of the merged organization. In 2013, the RHQN carried out a subspecialty review of 123 patient charts associated with an orthopedic surgeon included in affiliation discussions.

In addition to remote review of subspecialty charts, the RHQN provides on-site visits by subspecialists to rural hospitals. They provide chart review, support, assistance, and mentoring, as needed. Recent activity in this area includes OB, general surgery, and gastroenterology.

Clinic chart review has been a natural addition to the RHQN's portfolio of peer review services. Clinic peer review can be done when the peer review physician is on-site doing inpatient charts or is offered as an additional on-site visit. Clinic chart peer review is becoming a highly requested service as hospitals and clinics see more focus placed on documentation of patient care quality as a means of receiving payment for care.

NATIONAL RECOGNITION

The RHQN's external peer review system has received national recognition for its effective and professional processes for meeting the CMS conditions of participation related to external chart review. Benson notes that he has received inquiries about the RHQN and its work from Alaska, Oregon, Idaho, Wyoming, and Montana. (PR)

If you have questions about the external peer review services offered to Washington State's critical access hospitals that are members of the Rural Health care Quality Network, please contact Randy Benson at 206-577-1821 or randyb@wsha.org.

A Participant's Perspective

"The RHQN External Physician Peer Review is an exceptional program,"says Bette Barlond, RN, BSN, MBA, quality and safety Director for PeaceHealth United General Medical Center, Sedro Wooley, WA. It provides an objective review using best-practice standards in Critical Access Hospitals. "The number of physicians working in a Critical Access Hospital is small, so when a quality review is necessary, there can be a conflict of interest as to who can objectively, within the specialty expertise, review the case."

Barlond adds, "The medical staff values the input and direction from the RHQN Medical Director site visits along with the quarterly recommendations for improvement following the chart reviews. The RHQN's Clinical Newsletter is reviewed and eagerly anticipated by our medical staff, with several physicians requesting a copy be mailed to their practice."

"This program has provided this facility direction, information, and tools to make huge strides to improve quality and safety practices to the patients and community that we serve."

NEW PHYSICIANS INSURANCE MEMBERS: WELCOME!

PROFESSIONAL LIABILITY COVERAGE

Hot Springs County Memorial Hospital, Thermopolis,WY
Portland Dermatology Clinic, LLP, Portland, OR
Santiam Memorial Hospital, Stayton, OR
Puget Sound Psychiatric Center, Bothell, WA
Wallowa Memorial Hospital, Enterprise, OR
Emerald Valley Emergency Physicians, Eugene, OR
Mid-Valley Hospital, Omak, WA
Ocean Beach Hospital and Medical Clinics, Ilwaco, WA
Washington Poison Center, Seattle, WA
Sound Sleep Health, Kirkland, WA
Summit Pacific Medical Center, Elma, WA
Cascade Emergency Physicians, Inc. PC, Auburn, WA

MEDICAL STOP-LOSS

Spokane Eye Clinic, Spokane, WA
Yakima Valley Farm Workers Clinic, Toppenish, WA

(Navigating E-Communications, Continued from page 19)

of undocumented patient care, which can be troublesome for other providers, future treatment planning, or the defense of a claim. Maximize the potential value of e-mail while reducing your risk by following safe practices:

- Address security issues (i.e. e-mail with encryption software, which converts the message to unreadable text for unauthorized recipients).
- Develop policies for use.
- Educate staff and patients on appropriate use.
- Obtain written consent from patient or guardian.
- Treat e-mail as medical record information and save and store it accordingly.

Secure e-mail may be appropriate for:

- Scheduling appointments
- Billing inquiries
- Recall/reminder notices for follow-up care
- Prescriptions refills
- General medical information

E-mail is not:

- A substitute for an in-person visit
- Appropriate for urgent or emergent situations
- For highly sensitive issues, such as HIV/AIDS, STDs, or mental health

GO MOBILE, GET SAFE

Personally owned mobile devices are subject to the same privacy and security regulations as organization devices with regards to the storage and transmission of e-PHI.

According to an article in Physicians Practice (12/2/13) by Ann Whitehead, RN, JD, a vice president of risk management and patient safety for The Cooperative of American Physicians, HIPAA security rules require a covered entity to implement three types of safeguards for e-PHI:

- Administrative (policies and procedures to protect e-PHI)
- Physical (typically measures to protect electronic information and the equipment it resides on)
- Technical (specific technology to protect PHI)

Some of the administrative safeguards include:

- Risk assessments of your mobile device
- Missing device policies for when your device is lost or stolen
- e-PHI plans regarding retention and/or destruction of electronic communications
- Training of staff on the need to protect e-PHI
- Security policies to protect e-PHI through use of encryption or other measures

Some technical safeguards include:

- **Encryption**: Many mobile devices can be encryption enabled. Doing so creates an exemption from HIPAA fines.
- **Auto-lock**: Configure the auto-lock screen to appear after a brief time of inactivity.
- **Wi-Fi network security: Enable Wi-Fi** network security for mobile devices that use public Wi-Fi or unsecured cellular networks to prevent compromise.
- **Passwords**: Create complex passwords on the device.
- **Storage**: Only store e-PHI on these devices when absolutely necessary for business purposes, delete as soon as possible, and set a policy to save e-PHI for no more than a month.

Some physical safeguards include:

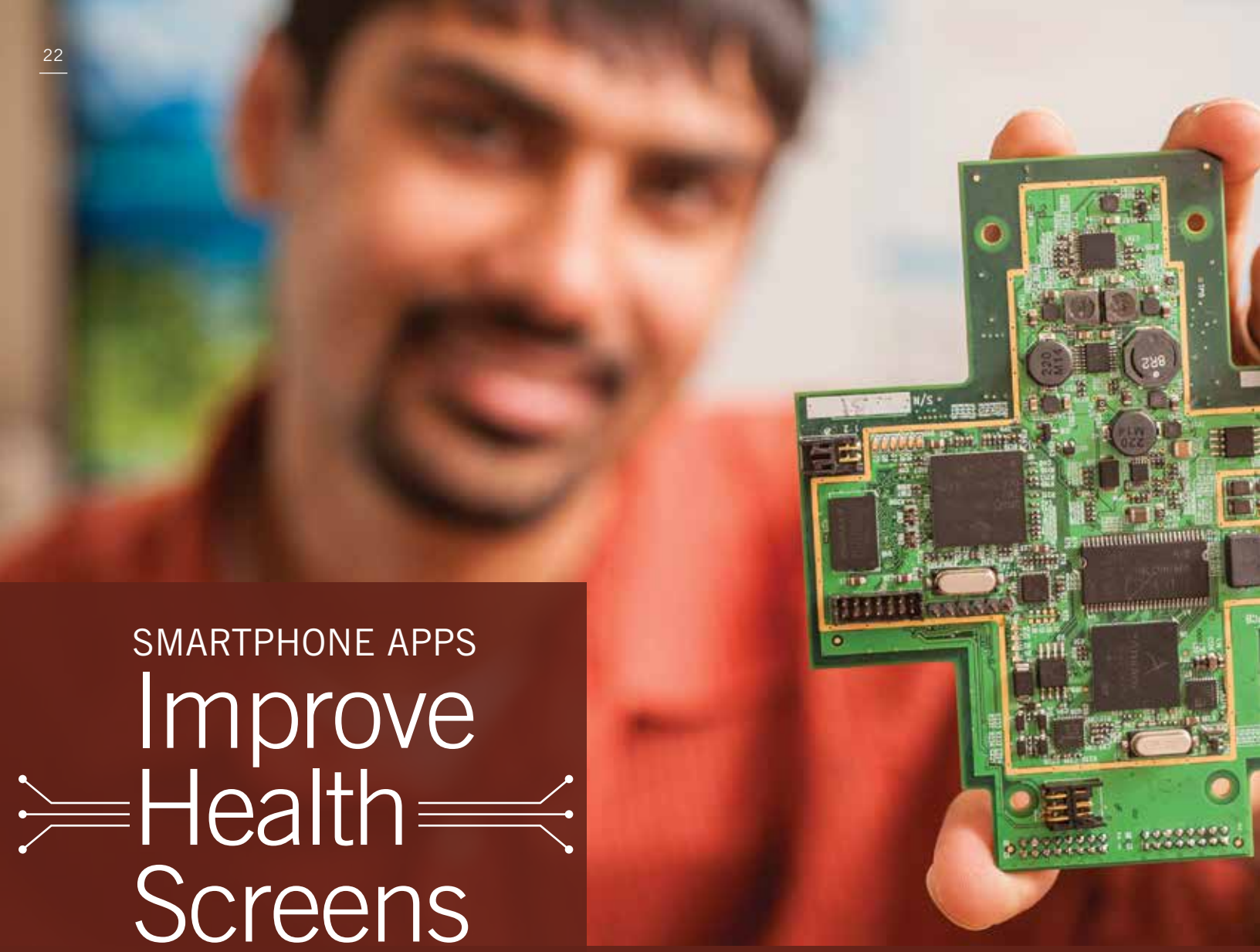
- **Remote wipe**: Set up so wipe feature can be activated remotely if device is lost.
- **Inventory**: Keep a current list of personal devices used by health care providers who send or receive PHI.
- **Radio frequency identification (RFID)**: Use this to identify lost or stolen mobile devices.

Learn more about electronic security guidelines and precautions:

- Your Mobile Device and Health Information Privacy and Security www.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security
- HealthIT.gov Security Risk Assessment Tool: www.healthit.gov/providers-professionals/security-risk-assessment
- National Institute of Standards and Technology HIPAA Security Rule Toolkit http://scap.nist.gov/hipaa/ (PR)

Develop appropriate uses and stick with them. Frequently physicians may want to accommodate patients and will address more in an e-mail than they prefer or should.

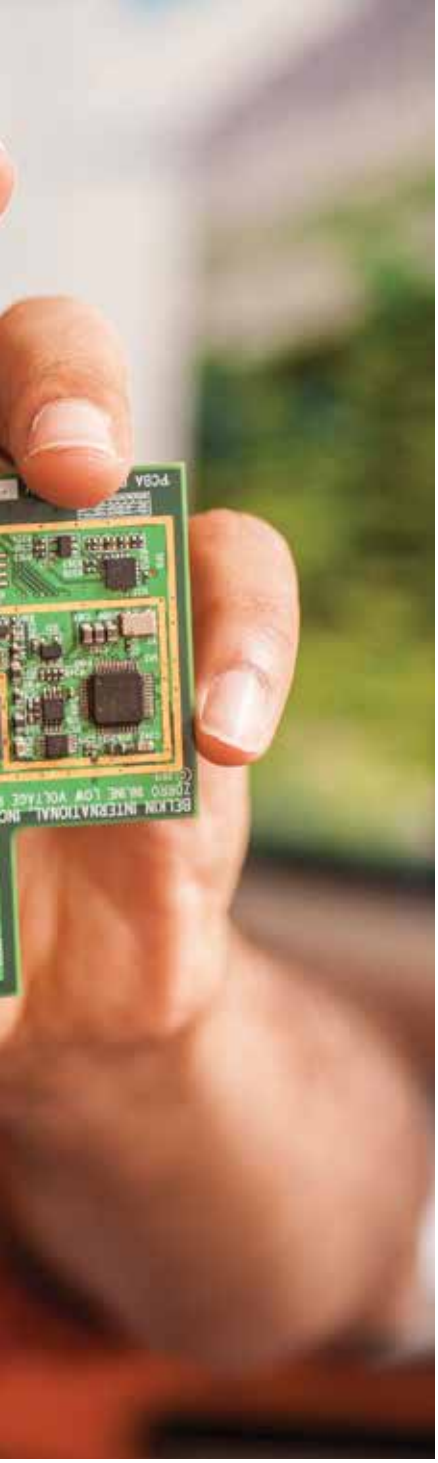
KATHY FERRIS, PHYSICIANS INSURANCE RISK MANAGEMENT CONSULTANT



SMARTPHONE APPS

Improve Health Screens

The next innovation in health care may just be found in someone's pocket or purse if Dr. Shwetak Patel, an associate professor at the University of Washington, has anything to do with it. From the Computer Science & Engineering and the Electrical Engineering departments at the university, Dr. Patel runs his research group focusing, in part, on human-computer interaction.



And, with two new apps that both improve quality of screens and lower costs, he is well on the way to making medicine better for physicians and patients.

Dr. Patel has created apps for two projects—BiliCam, which uses a smartphone's embedded camera to assess the risk of hyperbilirubinemia in newborns, and SpiroSmart, which uses a smartphone's microphone to measure pulmonary functions.

"These may be futuristic concepts, but they have the capability of making a significant impact in the near term," notes Patel. "What's interesting is that today's mobile phone has the computational power and network connectivity of the desktop of just a couple years ago, but they reside with us all the time." In other words, whenever and wherever the scan needs to be done, it can be.

SpiroSmart is a mobile application where the user exhales at a smartphone's microphone. According to data coming from testing, the results are comparable to a clinical spirometer. "We didn't set out to build a better machine," says Patel. "Rather, as engineers, we focused on solving a problem without any preconceived notions of how it is currently done." And by moving away from making existing tools better or cheaper, they built a different tool using ubiquitous technology (it is estimated that there are now one billion smartphones in use and that this figure will double by 2015). "We came at this from a different perspective—use sensors in new ways—and that helped to foster innovation."

The same thing happened with BiliCam, an innovative way to conduct a jaundice assessment on newborns. The traditional bilirubinometer (priced at more than $6,000) uses an algorithm that is more than fifteen years old and cannot accurately assess the many different skin tones presented in today's multicultural world. Notes Patel, "Our app uses a smartphone camera matched with machine-learning logic and constantly updates itself to the region you're in." Unfortunately, regulations have contributed to keeping devices in place that are becoming obsolete.

Today, Patel collaborates with physicians to build better tools and reinvent how sensing technologies can improve health screening and monitoring and, ultimately, create healthier people. And though that's hard to argue with, critics still highlight the adoption and integration of these tools, which, perhaps, is his greatest challenge. Active monitoring of patients could easily transform a patient's medical file from having ten scans to ten thousand. EMRs may not yet be ready to receive all this data, and the challenge of how to aggregate the data into a meaningful analysis is real.

Patel, however, believes this isn't too big of a deal. "The technology exists today to solve many of the data-processing challenges in health care, and we've already solved some of the problems associated with collecting and analyzing big data. Plus, we are already seeing a number of patients who want access to self-management apps." He notes that patients with chronic diseases or those who live in rural areas with limited access to care are likely going to be early users of this type of technology.

At the end of the day, whether it be an app to monitor your heart rate, blood pressure, insulin levels, or even brain activity, Patel's vision of better health through sensing technology is probably just around the corner. And, if his vision comes to fruition, these simple apps could be just one more way to make medicine better. PR

YOU'VE LIKELY BEEN HACKED

Now What?

Breach Costs Add Up Fast

Costs to respond to a data breach are directly proportional to the amount of records that are compromised. Based on industry research, average data breach response costs for health care can range from $188 to $233 per compromised record. This includes the cost for lawsuits, IT security experts, regulatory fines/penalties, or lost revenue due to a damaged reputation and the cost to respond, e.g., communications, call center for escalated inquiries, or credit monitoring for potentially affected victims. When you multiply even the low end of that range by the number of medical records in your practice, the exposure adds up quickly.

The following are actual cases. They demonstrate the sort of threats facing medical practices today.

A physician suffered a burglary at his residence, and his work laptop was stolen. The laptop had his entire fifteen-doctor medical group's patient database on it, comprising 57,000 records. Unfortunately, the laptop was not encrypted.

In another practice, an employee of a doctor stole the identities of multiple patients and made credit card purchases with the stolen information. The doctor first became aware of the breach when the employee was arrested. Local and federal law enforcement later advised the doctor that the identities of five patients, and approximately $10,000, had been stolen by this employee.

Both types of cases are pretty well-accepted forms of threats facing a medical practice today. And unfortunately, they happen more often than you would think and are not inexpensive to fix.

The physician who had his laptop stolen had to hire legal counsel to determine notification requirements and manage the response process—they determined that 37,000 unique identities were on the laptop. This level of breach required the medical group to publish a notice of the breach on their website and in the local media. Additionally, the group was required to notify the Office of Civil Rights of the breach, which led to a Department of Health and Human Services investigation. Total expense was $44,000.

The practice that had the employee illegally using patient information endured two lawsuits. The total defense costs were $25,000, and a combined settlement was reached for $20,000.

Unfortunately, those are less expensive examples. In another true case:

A plastic surgeon posted unauthorized "before and after" photos of several patients on her website who were identifiable by name. There are fifteen invasion-of-privacy actions against the plastic surgeon to date, with several settling in the range of $150,000 per plaintiff. Additional legal expenses incurred were $50,000.

Today, however, the more common risks from rogue employees, theft, and business mistakes are taking a backseat to new threats coming from cyberspace. Hackers and malware are regularly trying to find their ways into poorly protected practice networks—and it's working.

Medical data breaches affect millions of patients each year. Reports show an alarming trend of frequent and large-scale health

(Continued on next page)

**CSID from Javelin Strategy and Research*
**"Electronic health records ripe for theft," Politico, accessed July13, 2014, http://dyn.politico.com

(You've Likely Been Hacked, Continued from page 25)

care records breaches. According to a report published by CSID, a leading provider of global, enterprise-level identity protection and fraud detection solutions and technologies, some 43 percent of data breaches in 2013 occurred in the health care industry.

Data breaches are defined as an event in which an individual's name, social security number, driver's license number, medical record, or personal financial record (credit card, debit card, etc.) is potentially put at risk either in electronic or paper format. In some states, this definition is being expanded to include username, passwords, and e-mail addresses.

EMRs Ripe for Theft

"Frankly, health care organizations are struggling to keep up with this," says information security expert Ernie Hood of The Advisory Board Company in an article published in Politico. Significant breaches are already occurring. Over the course of three days, hackers using a Chinese IP address infiltrated the St. Joseph Health System in Bryan, Texas, and exposed the information of 405,000 individuals, gaining names, addresses, Social Security numbers, dates of birth, and other information. It was the third-largest health data breach tracked by the federal government until it was announced this summer that Community Health Systems, based in Tennessee but with 206 hospitals in twenty-nine states, had been hacked in 2014. The result was 4.5 million individuals' nonmedical patient data stolen.

Some further startling numbers:

1.84 million

—Estimated people affected by medical identity theft in 2012

$12 billion

—Out-of-pocket costs incurred by medical identity theft victims

$3.7 million

—Average cost of a data breach in 2012

$233 per record

—Health care breaches are the most costly to remedy

"What I think it's going to lead to, if it hasn't already, is an arms race between the criminal element and the people trying to protect health data," says Robert Wah, president of the American Medical Association, in a *Politico* article. "I think the health data stewards are probably a little behind in the race. The criminal elements are incredibly sophisticated."

> "What I think it's going to lead to, if it hasn't already, is an arms race between the criminal element and the people trying to protect health data."
>
> ROBERT WAH, PRESIDENT, AMERICAN MEDICAL ASSOCIATION

The Office of Civil Rights, which is part of HHS and responsible for tracking PHI breaches, reported there were 221 breaches in 2013 involving almost 8.5 million patients. Through August of 2014, the OCR indicates 107 breaches were reported involving more than 6.2 million patients. And these are just the breaches that exceeded the 500-patient record threshold. Countless more breaches occur below 500 and are never reported but still incur remediation costs.

Health care is the least prepared for cyber attack, according to security ratings firm BitSight Technologies. The industry had the highest volume of threats and the slowest response time, leading the FBI in April to issue a warning to health care providers.

Some high-profile cases have included:

- Target—110 million records compromised
- Nieman Marcus—1.1 million records compromised
- Saint Joseph Health System—405,000 records compromised
- Sutherland Health care Solutions—168,500 records compromised
- Archdiocese of Seattle—90,000 records compromised

Other instances of data breach occurred in regional health systems, community clinics, and small groups alike.

Tacoma's Franciscan Health System notified some 8,300 patients that their personal information—medical records and Social Security numbers—may have been shared with computer scammers who accessed staff e-mail accounts through phishing e-mails.

Skagit County, in Northwest Washington, agreed to a $215,000

settlement for potential violations of HIPAA and Breach Notification Rules and agreed to work closely with HHS to correct deficiencies in its HIPAA compliance program.

What to Look for When Considering Cyber Liability Insurance

Not all insurance programs are created equal, so it is important to compare policies. Physicians Insurance recently compared its cyber liability coverage with the new and increasing threats to practices and made some changes and increased coverage.

You are at risk from simple negligence, rogue employees, unencrypted data, and outsourced information technology. And that means you need to protect your billing information such as credit card numbers, addresses, bank information, insurance information, Social Security numbers, employee information, and basically everything in your medical records.

Physicians Insurance includes a basic level of coverage as part of its standard physician and clinic policies and higher limits for increased protection are also available. See the tables below for a summary of what is included in this new, expanded program. (PR)

If you have questions about cyber threats or this new coverage program, call Physicians Insurance at 800-962-1399.

First Party Insured Events	Description of Coverage
Security Breach and/or Privacy Breach	Mitigation costs, including legal expenses, forensic investigation fees, public relations and advertising expenses, notification costs, and the costs to provide a maximum of twelve (12) months of credit monitoring and identity restoration services to affected individuals.
Network Security Incident	Income loss, business interruption expenses, and costs to restore, replace, or recreate electronic data that is damaged, corrupted, or destroyed as a direct result of a network security incident.
Cyber Extortion Threat	Funds paid by the insured to persons reasonably believed to be responsible for a cyber extortion threat made against the insured.
Cyberterrorism	Income loss, business interruption expenses, and costs to restore, replace, or re-create electronic data that is damaged, corrupted, or destroyed as a direct result of an act of cyberterrorism.

Third Party Claims	Description of Coverage
Regulatory Fines and Penalties	Coverage for administrative fines/penalties resulting from federal, state, or local governmental investigations of violations of privacy regulations, including but not limited to HIPAA and the new HITECH Act.
Multimedia Liability	Coverage for copyright/trademark infringement, libel/slander, plagiarism, invasion/right of privacy claims resulting from the written or electronic dissemination of media material.
Security and Privacy Liability	Coverage for claims resulting from the insured's failure to prevent or hinder a security breach or privacy breach and/or unauthorized disclosure or use of personal or confidential information that violates the insured's privacy policy or any federal, state, or local law.

VBAC REVISITED
Risks and Considerations

COURSE DESCRIPTION: The risks and benefits of VBAC present a complex challenge. Pressures to lower cesarean rates run headlong into the question of whether prompt operative intervention can be guaranteed in an emergency. The reconsideration of previously established guidelines and appeals from natural childbirth advocates add to the complexity, especially as acceptable risk differs from patient to patient.

How should you counsel women about trial of labor after cesarean? How should you manage their labor?

In this one-hour seminar, obstetrical leader Dr. Steven L. Clark will address these questions through a reasoned approach to VBAC based on careful patient selection and a focus on patient safety.

WHO SHOULD TAKE THIS COURSE: Obstetrical practitioners and anesthesiologists

FACULTY *Steven L. Clark, MD, is a maternal-fetal medicine specialist and professor of Obstetrics and Gynecology at Baylor College of Medicine in Houston. He was formerly medical director of Women's and Children's Clinical Services for the Hospital Corporation of America. He has served as president of the Society for Maternal Fetal Medicine, Chair of the ACOG Technical Bulletin Committee, and as a board examiner. He has served on several ACOG task forces and committees and as patient safety consultant to the US Air Force Surgeon General. He currently serves on the Scientific Advisory Board for United Health Care and on the Joint Commission Perinatal Advisory Panel. He has published more than 200 scientific articles and chapters and edited several textbooks, including Critical Care Obstetrics. He serves as a peer reviewer for twenty-three national and international scientific journals.*

SPORTS CONCUSSIONS:
Where Are We Now?

COURSE DESCRIPTION: Sports-related concussions remain a serious health condition, with as many as 3.8 million being reported in the United States each year, according to the Centers for Disease Control and Prevention. Immediate recognition and management is critical. In this one-hour webinar, Dr. Stanley Herring, medical director of the Seattle Sports Concussion Program, will help bridge the gap in recognizing and managing traumatic brain injuries and help health care providers establish appropriate return-to-play guidelines for injured athletes.

WHO SHOULD TAKE THIS COURSE: Physicians of all specialties and affiliated providers who treat injured athletes of all ages

HIPAA MAINTENANCE:
Daily Habits for the Health Care Team

COURSE DESCRIPTION: This course is best suited for physicians and allied health staff of all specialties, as well as clinic administrators, managers, HIPAA privacy and security officers, and general office staff involved in the care of patients and handling of protected health information.

WHO SHOULD TAKE THIS COURSE: Physicians and allied health staff of all specialties, as well as clinic administrators, managers, HIPAA privacy and security officers, and general office staff involved in the care of patients and handling of protected health information.

SELF-STUDY ON RISK MANAGEMENT FUNDAMENTALS:
Strategies for Reducing Risk in Your Practice

COURSE DESCRIPTION: Claims data, supported by national trends, reveals increasing liability associated with basic risk management issues in medical practice: pain management, electronic medical records, communication among providers, physician-patient communication, incomplete documentation, medical-legal issues relating to the informed-consent process, HIPAA compliance, medical identity theft, and the impact of social media. This two-hour printed self-study course is intended to close the gap between best practice and common practice.

This self-study course consists of a pre-course survey, required reading of the information included in the booklet, and a self-assessment quiz, as well as a course evaluation. You will find ordering information and course instructions here: www.phyins.com/RMfundamentals.

WHO SHOULD TAKE THIS COURSE: Physicians and affiliated providers of all specialties and their staff involved in direct patient care and practice management. While specific references are made to Washington State laws, participants are encouraged to verify the pertinent laws in their own states.

SEPTIC STONE MANAGEMENT:
A True Urologic Emergency

COURSE DESCRIPTION: The incidence of sepsis is dramatically increasing, with infection a major source of mortality in stone disease. In this one-hour webinar course, Dr. Glenn Preminger, chief of urology at Duke University, gives you a short checklist to keep "hot stones" on your radar, introduces a treatment algorithm, and demonstrates efficient multi-disciplinary communication.

WHO SHOULD TAKE THIS COURSE: Urologists, emergency physicians, primary care physicians

DANGERS OF THE EMR FOR UROLOGISTS:
Increasing Patient Safety and Lowering Liability

COURSE DESCRIPTION: The electronic medical record can be a great ally in patient safety and care coordination—or it can expose lapses in critical communication and overwhelm you with conflicting data. This one-hour module gives you practical guidelines for using the EMR to your best advantage. It includes urology-specific case examples of how to manage alerts and macros, how to steer around pitfalls, and how to ensure agreement between different parts of the record.

Part I is presented by a national authority in urology, Carl Olsson, MD. Part II expands upon Dr. Olsson's case examples with an interview between board-certified urologist Kathleen Latino, MD, and top trial lawyer Elizabeth Leedom. Both components show you how to improve patient care and bolster your defense in the event of a malpractice claim.

WHO SHOULD TAKE THIS COURSE: Urologists and ancillary personnel who use electronic medical records managers, HIPAA privacy and security officers, and general office staff involved in the care of patients and handling of protected health information.

TEAMSTEPPS®:
Tools & Strategies for the Emergency Department

COURSE DESCRIPTION: From 1995 through 2005, the Joint Commission identified ineffective communication as the root cause for nearly 66 percent of all reported sentinel events, and from 2010 through 2013, it remained in the top three root causes of all sentinel events reported. Communication problems and information gaps among physicians, nurses, and other hospital departments are a primary cause of diagnostic errors in the emergency department and can result in disorganized care, delayed treatment, and role confusion, as well as staff and patient dissatisfaction. All of these factors combine to create an unhealthy work environment and the potential for unsafe patient care.

In this one-hour webinar, Dr. Hurley discusses the concepts of team training with a shared mental model culminating in enhanced physician and staff performance and patient safety.

WHO SHOULD TAKE THIS COURSE: Emergency physicians and other affiliated health care staff in the emergency department

Sign up for a course today:
www.phyins.com/cme

Through Technological Advancements and Practice Evolution,

Passion for Brain Science and Patient Care Remain

In a world full of technologically related progress, few people get to take advantage of this progress as much as Barry J. Landau, MD has for nineteen years as a neurosurgeon.

In neurosurgery, he says, "We see some terrible tragedies, but we also see dramatic saves. People in our specialty must like that. I feel privileged to be involved with patients and their families during these critical life events."

Dr. Landau was an early adopter of minimally invasive spinal surgery techniques, and in 1999, he began to use small incisions, tubular retractors, and other technological improvements whenever possible. Since then, he has continued to use them and has even taught others the techniques.

Over the years, his practice has evolved to focus on spinal care, and he sees patients with common neck and back conditions, such as spinal stenosis, degenerative disc disease, herniated discs, and many others. He also provides care for brain trauma, tumors, and vascular abnormalities. The procedures he performs range from craniotomy to remove tumors and blood clots to disc replacements and spinal fusions, along with many other spinal cord procedures. Landau's practice also provides non-surgical treatment, including pain management procedures such as epidural and facet blocks.

"Neurosurgery is the most challenging, frustrating, and rewarding profession I can imagine," says Dr. Landau. "I get to do a job where I can use my brain and my hands, and I get to interact with all different kinds of people."

Landau's fascination with brain science began as a biology student at MIT in the 1980s. Although an immature area of study by today's standards, he was hooked on the complex, interconnected web of the human brain. Now the field has evolved with new technology and less invasive approaches to care, but that fascination has never wavered.

Dr. Landau was trained in general neurosurgery, and in 1995, began his practice doing a bit of everything. His quest to understand the interworkings of the brain continued as he and others in his field have learned how technology can enhance patient care and improve outcomes.

Still, there are many aspects of neurosurgery beyond keeping up with—and utilizing—technological advancements. Along with focusing on neck and spine care, he now works to educate and prepare patients for surgery and to help them understand other, nonsurgical treatments and why they are often more appropriate. This need to educate, says Landau, is a result of the over-availability of advanced imaging.

"It's a common misconception that any time spinal abnormalities appear in an MRI, they must be addressed with surgery," Dr. Landau says, adding, "I frequently have to explain [to patients and primary care physicians] that most abnormalities are a normal part of aging and that these aren't necessarily the source of pain."

> "I feel privileged to be involved with patients and their families during these critical life events."
>
> BARRY J. LANDAU, MD, FOURTH CORNER NEUROSURGICAL ASSOCIATES, BELLINGHAM

This understanding is key when he advocates and implements nonsurgical treatments, such as physical therapy and pain management medications.

FAST FACTS

PRACTICE LOCATION: FOURTH CORNER NEUROSURGICAL ASSOCIATES, INC., P.S., CASCADE BRAIN AND SPINE CENTER, BELLINGHAM, WA

- Graduated MIT in 1982 with a BS in Biology
- Graduated University of Connecticut Medical School, 1988
- Completed residency in neurosurgery at Northwestern University, 1995
- Private practice at Genesys Regional Medical Center, Grand Blanc, MI, 1995–2001
- On medical staff at St. Joseph Hospital, Bellingham, since 2001

LESS INVASIVE MEANS MORE OUTPATIENT CARE

The use of minimally invasive spinal surgery techniques has transformed the patient care experience in neurosurgery, as well as many other specialties. Landau says the most notable change is the ability to do many procedures on an outpatient basis. This often reduces recovery time, gets patients back to full function faster, and can mean cost savings.

An avid recreational mountain biker, Dr. Landau's professional impact extends to the many athletes he counts as his patients. These cyclists are among his favorite cases due to their commitment to retain active lifestyles. "I just did lumbar surgery on a sixty-seven-year-old mountain biker, and I practically had to hold him down after surgery. . . . He really wanted to get right back out there!" he said, adding, "It's really gratifying to help get them back to high-performance athletics."

An increasingly challenging aspect of his practice has nothing to do with treating spine or neurological conditions, but it does have a huge impact on a patient's ability to heal.

(Continued on page 33)

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 participants when reporting these results.

Improper Performance

SPECIALTY: Neurosurgery

ALLEGATION: A 40-year-old male underwent an L5-S1 arthroplasty utilizing a Charité total artificial intervertebral disc. The plaintiff alleged he had several contraindications, based on FDA guidelines, and that as a result of this surgery, his back condition worsened resulting in disability, wage loss, medical expenses, and pain and suffering.

PLAINTIFF ATTORNEY: John Doubek, Doubek, Pyfer & Fox, Helena, MT

PLAINTIFF EXPERTS: Brian Holmes, MD, Neurosurgery, Hagerstown, MD; Charity Rowsey, CPA, Helena, MT

DEFENSE ATTORNEYS: Gary Kalkstein, Kalkstein Law Office, Missoula, MT

DEFENSE EXPERTS: Dan Keefe, Edward Bruya, Keefe, King & Bruya, Spokane, WA

DEFENSE EXPERTS: Michael Levy, MD, Neurosurgery, San Francisco, CA

RESULT: Defense verdict. Silver Bow County District Court, Judge Newman.

COST TO DEFEND: $286,841

Improper Performance

SPECIALTY: Radiology

ALLEGATION: Improper interpretation of obstetrical ultrasounds resulting in fetal demise of a female twin. Early ultrasounds were appropriately interpreted as a dichorionic diamniotic twin pregnancy but the plaintiffs alleged that this was a monochorionic pregnancy—and had the patient been monitored as such, the fetal demise would not have occurred. The parents claimed emotional distress, physical suffering, and loss of the parent-child relationship. The estate of the decedent claimed loss of net future earnings and earning potential.

PLAINTIFF ATTORNEY: Michael Riccelli, Spokane, WA

PLAINTIFF EXPERTS: Harris Finberg, MD, Radiology, Phoenix, AZ; Randall Patten, MD, Radiology, Olympia, WA

DEFENSE ATTORNEY: John Hart, Hart Wagner, Portland, OR; Jennifer Moore, Bennett, Bigelow & Leedom, Seattle, WA

DEFENSE EXPERTS: Peter Callen, MD, Radiology, San Francisco, CA; Roy Filly, MD, Radiology, San Francisco, CA; Mary D'Alton, MD, Maternal Fetal Medicine, New York, NY; Mark Tomlinson, MD, Maternal Fetal Medicine, Portland, OR

RESULT: Defense verdict on appeal. Spokane County Superior Court, Judge O'Connor.

COST TO DEFEND: $733,358

Failure to Diagnose

SPECIALTY: Radiology

ALLEGATION: Failure to properly identify a poorly positioned lap band in a 30-year-old female and failure to recommend follow-up with a bariatric surgery consult resulting in delay in treatment. The patient elected to be admitted at another facility for insurance reasons and alleged the delay in diagnosis and treatment led to a necrotic stomach and a gastrectomy. The patient claimed physical and emotional suffering, permanent disability, medical expenses, and wage loss.

PLAINTIFF ATTORNEY: Lincoln Beauregard, Connelly Law Office, Tacoma, WA

PLAINTIFF EXPERTS: Randall Patten, MD, Radiology, Olympia, WA; David

The cost to defend varies across states. For example, because very little discovery is allowed in Oregon, defense expenses are lower in Oregon than in other western states. Other factors that also impact defense expenses include state law, the complexity of a case, and the number of experts and attorneys used.

Oliak, MD, Bariatric Surgery, Brea, CA; Cloie Johnson, MEd, Life Care Planning, Seattle, WA

DEFENSE ATTORNEY: Christopher Anderson, Fain, Anderson & VanDerhoef, Seattle, WA

DEFENSE EXPERTS: Jonathan Berlin, MD, Radiology, Chicago, IL; Brian Fennerty, MD, Gastroenterology, Portland, OR; William Skilling, MA, Life Care Planning/Vocational Rehabilitation, Seattle, WA

RESULT: Defense verdict. King County Superior Court, Judge Rogoff.

COST TO DEFEND: $593,413

Improper Treatment

SPECIALTY: Anesthesiology

ALLEGATION: The estate of a 63-year-old female alleged negligence in proceeding with a mastectomy without a cardiology exam, given the patient's risk factors for myocardial infarction that included obesity, hypertension, hyperlipemia, diabetes, and EKG findings of a previously undiagnosed myocardial infarction. The plaintiffs allege the patient was not an appropriate surgical candidate and that a cardiology consultation should have occurred prior to surgery. The patient underwent an unremarkable surgery and appeared stable postoperatively but died six hours later of an acute myocardial infarction. The estate claimed funeral expenses, pain and suffering, and loss of companionship to the surviving spouse and children. Under Oregon law, the maximum amount of damages permitted for wrongful death claims is $500,000.

PLAINTIFF ATTORNEY: Doug Schaller, Johnson, Johnson & Schaller, Eugene, OR

PLAINTIFF EXPERTS: Bruce Halperin, MD, Anesthesiology, Palo Alto, CA; John Olsen, MD, Seattle, WA; Irene Wapnir, MD, Oncological Surgery, Stanford, CA; Nancy McGushin, RN, Perianesthesia Nurse Educator, Lancaster, OH

DEFENSE ATTORNEY: Jeff Street, Hodgkinson Street, LLC, Portland, OR

DEFENSE EXPERTS: James Hicks, MD, Anesthesiology, Portland, OR; Jeffrey Kirsch, MD, Anesthesiology, Portland, OR; Bradley Evans, MD, Cardiology, Portland, OR

RESULT: Defense verdict. Jackson County Superior Court, Judge Gerking

COST TO DEFEND: $173,977 (PR)

"You can't always fix patients' issues, but making the effort to help them get screenings and the mental health care they need will hopefully prevent surgeons from making the mistake of operating on someone who won't get better."

Dr. Barry J. Landau

(Member Spotlight, Continued from page 31)

"I had no idea when I went into practice that I'd be spending so much time working with patients addressing the psychological components of their illnesses," he says.

That's why learning to identify when patients may have mental health issues, such as depression, anxiety, or other disorders, and to advise that they seek a formal screening and counseling or work with their primary care provider to do so, has become an invaluable skill.

"I often see patients who need this help, and research shows it directly correlates with their ability to recover," he says, adding, "You can't always fix patients' issues, but making the effort to help them get screenings and the mental health care they need will hopefully prevent surgeons from making the mistake of operating on someone who won't get better."

Compassion, Communication Key to Good Care

Along with helping patients access mental health care, another part of his practice that requires sensitivity and good communication skills is talking with patients and their families after a bad outcome. "In neurosurgery, we know we have a high-risk specialty. Most of the time, there's no one to blame… Things just happen," he says.

"I have learned we must be especially compassionate and direct and stay with people through the ups and downs."

The ups and downs happen in any busy practice, but what drives Dr. Landau is hearing of patients who need him to regain their quality of life. When that happens, he says, "I feel an obligation to serve them and try to meet their needs." (PR)

MAKING SURE OUR MEMBERS' CONCERNS ARE HEARD

Government Relations Update

"There are risks and costs to a program of action. But they are far less than the long-range risks of comfortable inaction."

JOHN F. KENNEDY

The upcoming elections will most certainly determine the future direction of our government. To create a political environment that responds and promotes negotiated results with a balanced, fair approach to our members' medical professional liability exposure and engage in strategic efforts to develop effective legislative agendas, Physicians Insurance regularly seeks opportunities to engage and collaborate with our elected officials.

We believe advocacy is crucial to ensuring that the concerns of our members and their patients are heard by lawmakers at both a state and national level. We also work to promote civil justice issues from a defense perspective. As the only medical professional liability carrier based in the Northwest with an in-house lobbyist registered in Oregon and Washington, this equips us to work in close cooperation with organizations that pursue similar goals in the Northwest region and the nation's capital.

WASHINGTON'S NEW CIVIL DEFENSE PAC

Physicians Insurance recently supported the formation of a new political action committee called the Civil Defense PAC. The Civil Defense PAC was created by lawyers defending businesses and individuals in civil courts for damage.

The Civil Defense PAC provides a structure for corporate counsel, defense attorneys, insurers, professionals, businesses, individuals, and others who care about civil justice issues from a defense perspective and provides financial support for identified campaigns and candidates in Washington State. Physicians Insurance's vision for working with the Civil Defense PAC is to create the only PAC in Washington State dedicated to supporting elected officials and candidates for office who are committed, sympathetic, and willing to stand up and fight for civil defense issues. While other interest groups discuss defense issues, the Civil Defense PAC is focused only on issues important to civil defense lawyers.

> "The health of a democratic society may be measured by the quality of functions performed by private citizens."
>
> ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA*

OREGON AND EARLY DISCLOSURE

Physicians Insurance continues to expand the government relations and community outreach efforts in Oregon. We partnered with the Oregon Medical Association, the Oregon Patient Safety Commission, and the Oregon State Bar ADR Section to participate in an Adverse Health Care Incident Mediation Training panel held at the Oregon Medical Association on the nuances of mediating adverse health care incidents from Physicians Insurance's claims perspective.

We also regularly collaborate with the Oregon Patient Safety Commission on the implementation of the state's early discussion and resolution law (SB 483) passed in 2013. The most recent development is that the U.S. Department of Health and Human Services clarified the National Practitioner Data Bank reporting requirement in response to inquiries about payments made via "early disclosure" programs. The HHS determined that payments made did require reporting, provided the elements for requiring such a report already existed, thus maintaining status quo for entities reporting to the NPDB. We've set up a Web page containing information and resources for our Oregon members at www.phyins.com/edr.

Physicians Insurance continues to sit on the Board of Directors of the Oregon Liability Reform Coalition and will participate in its newly created effort to support candidates for office, regardless of their political affiliation, who actively promote meaningful liability reform measures. This new role is critical in advancing the priorities of the Oregon Liability Reform Coalition agenda and will focus solely on issues important to improving Oregon's tort system.

IDAHO UPDATE

Physicians Insurance met with the Idaho Medical Association to partner and assist in legislative strategic planning and prepare for Idaho session matters, such as supporting certain telemedicine initiatives and protecting physician standard-of-care statutes. We are committed to the efforts and will continue to seek opportunities to expand the company's government relations and community outreach effort into Idaho.

FEDERAL UPDATE

Physicians Insurance continues to support the Physicians Insurance Association of America (PIAA), a national member association for medical professional liability insurers. Our focused support is on PIAA's push for national legislation to prevent health care regulations from being used as a standard of care in medical professional liability lawsuits, along with other meaningful initiatives.

Recently, the PIAA hosted a Capitol Hill Day to make a grassroots push for federal policies to meet the needs of PIAA members. Companies throughout the nation sent representatives to Washington, D.C., to meet with their federal legislators to promote the medical professional liability community's legislative agenda. We are working with the PIAA to develop other successful grassroots efforts to promote federal action.

These are just a few of the ways Physicians Insurance acts on its promise and commitment to you—to provide insurance coverage to health care providers, anticipate and respond to changing needs and trends, and improve the quality of medical care and patient safety. Our quest for medical justice for health care providers and their patients has not wavered; it continues to grow and strengthen. PR

For more information on Physicians Insurance's Government Relations and Community Outreach Program, contact

Anne E. Bryant,
Senior Director of Government Relations
Anne@phyins.com

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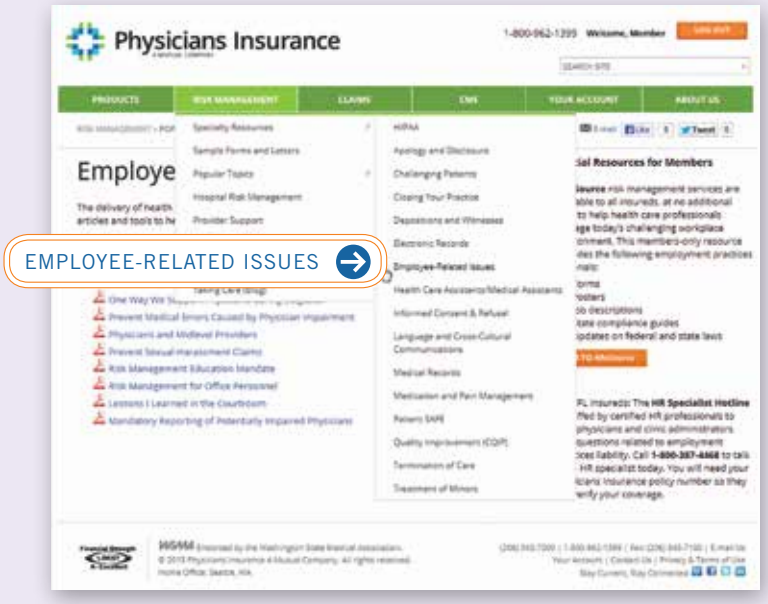
HOW TO ACCESS EMPLOYEE-RELATED TOOLS AND RESOURCES

Log in to www.phyins.com

After you sign in to the Physicians Insurance site, you can access more than a dozen resources that specifically relate to employee issues. Click on the RISK MANAGEMENT TAB, select POPULAR TOPICS (which will expand the menu options), and then select EMPLOYEE-RELATED ISSUES.



Select the Materials You Need

From articles on preventing sexual harassment to risk management tips for office personnel, our tools and documents are relevant and useful for your practice. Be sure to check out the CME tab, which lists several options for staff education and training.

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