

THE Physicians Report

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FOCUS ON EMERGING SOCIETAL ISSUES IMPACTING HEALTHCARE

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Considerations
in Healthcare

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Care for Refugees and
Immigrants**

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How Healthcare Can Help

PREPARATION IS KEY

In the 2002 blockbuster film *Spider-Man*, Peter Parker (a.k.a. Spider-Man) is cautioned by his Uncle Ben: “Remember, with great power comes great responsibility.” While Spider-Man’s uncle is credited with popularizing this cautionary statement, he is not alone in expressing the sentiment. Variations can be found in the New Testament, numerous political speeches worldwide, and even a 2015 Supreme Court opinion.

Managing the delicate balance between power and responsibility is nothing new to medical professionals. The concept is embedded within the Hippocratic Oath, by which physicians swear to use their knowledge of the healing arts for good and not abuse their patients. The relationship between provider and patient holds a special status in modern society. In addition to special legal protections created by statute, there are also ethical and professional medical standards designed to preserve the sanctity of the provider-patient relationship. Indeed, responsibly exercising the power entrusted to providers by their patients is intrinsic to the ethos of the profession.

Over the past few decades, this special relationship has also been recognized as a resource in combating certain social problems, including abuse and human trafficking. More recently, providers have been recruited to help confront other complicated social issues, including illegal immigration and reproductive rights. This societal encroachment on the individual provider-patient relationship results in healthcare providers increasingly being asked—and even compelled—to use their position and authority to serve a purpose beyond simply providing “good care” to their

patients. In doing so, healthcare providers are being asked to act not only for the well-being of their individual patients, but also for the perceived well-being of the broader community. Consequently, providers increasingly find themselves in difficult predicaments, pitting their personal and professional duty to their patients against broader legal obligations to the community.

How can medical providers responsibly balance their different powers, especially given the frequent shifts of political and social currents that are often the catalysts for these powers being vested in them in the first place?

In short, preparation is key. A provider must be familiar with both legal and ethical parameters in order to make a decision that best satisfies their obligations to the patient and the community. It is empowering for providers and their staff to have policies in place to help guide those decisions. Moreover, providers benefit from prospectively identifying and having available resources on hand to consult—not only for themselves, but also for their patients. Providers will always owe a duty to their patients. Being armed with resources and guidance before being confronted with a difficult situation will help them responsibly exercise their power under any circumstance—no superpowers required.



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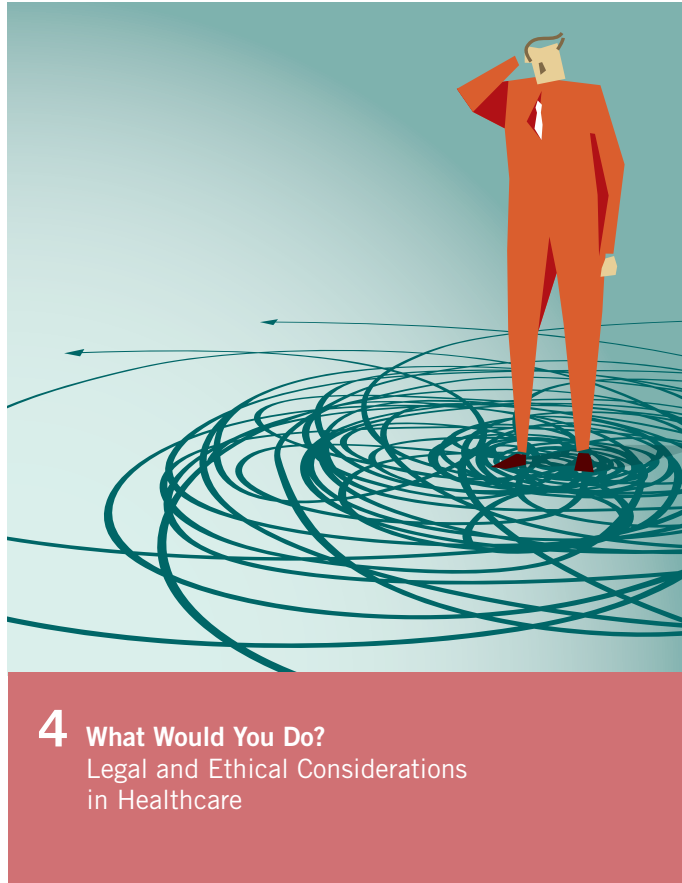
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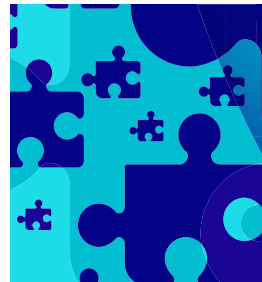
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What would you do?

Legal and ethical considerations in healthcare



Imagine yourself in the role of Dr. Connelly, a primary-care physician in a well-established private practice. One day, a new patient checks in with identification that a staff member deems suspicious.

Dr. Connelly's nurse, Kim, concludes that the patient is not a legal resident, based on the ethnicity and language preference the patient selected on her check-in forms. Kim feels strongly about illegal immigration and asks Dr. Connelly to have someone from the office report the patient to federal immigration authorities.

Amid a busy workday, Dr. Connelly asks Kim to wait to discuss the matter later. When the patient checks in, Dr.

Connelly learns that Kim has already mobilized other staff members, who agree that the patient should be reported. Dr. Connelly hesitates, unsure of whether she does in fact have a duty to report a patient who is possibly an undocumented citizen. She also wonders whether she'll be able to effectively care for a patient who may not be telling the truth.

This was the case explored by Jeff Sconyers, JD, a senior lecturer

in the University of Washington's graduate program in Health Services Administration, and Tyler Tate, MD, assistant professor of pediatrics and associate director of The Center for Ethics in Health Care at Oregon Health and Science University, in a recent paper for the American Medical Association's Journal of Ethics.

The case was fictional, but these types of ethical dilemmas are common in healthcare settings, says Sconyers.



These types of ethical dilemmas are common in healthcare settings. When they arise, providers may be caught in a struggle between their presumed legal responsibilities and their ethical or moral obligations.

When they arise, providers may be caught in a struggle between their presumed legal responsibilities and their ethical or moral obligations.

Increasingly polarized views around immigration and other emerging social issues make these quandaries especially divisive and emotionally charged. Without thoughtful deliberation, it's easy to make decisions based on fear instead of clear reasoning. "In my own experience, I have not had an increase or decrease in undocumented patients," says Tate. "I've had a steady rate since 2012. That being said, I do think there is more fear among undocumented patients around getting discovered and reported."

When healthcare providers face ethical questions—from what to do when a patient presents a false insurance card, to how to end a relationship with a problematic patient—there are a number of legal and ethical factors to consider. Weighing each one can help guide providers toward decisions that are morally, ethically, and legally sound.

CONSIDERATION 1: WHAT DOES THE LAW SAY?

All healthcare providers need to know what they're required to do under both federal and state law, says Sconyers. While federal law requires the reporting of child abuse, certain states also mandate reporting of human trafficking of adults and the presence of infectious diseases. Under federal law, elder abuse must be reported in facilities that meet certain conditions, but state laws on elder abuse may vary. Regulations

differ by state, so healthcare providers need to be familiar with the laws in states where they practice.

Just as important as knowing what the law requires of providers is knowing what it does not require. A common misconception, highlighted in Dr. Connelly's case, is that healthcare providers are required to report patients' criminal activity. In fact, they are not required to report illegal activity that does not relate to a mandatory reporting requirement.

"Some people think that their primary duty is to report conduct that they think is illegal," says Sconyers. "It comes up all the time in healthcare settings. For example, somebody presenting an insurance card that's forged—that's illegal and may be a crime, but while the provider would have an obligation not to

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Ethical Conflict

When Should the State Intervene?

How should a physician proceed when a child's medical treatment is opposed by his or her parents? This complex ethical problem is the topic of *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, by Douglas S. Diekema, MD, professor of bioethics and emergency medicine at the University of Washington. He presents eight conditions that must be met in order to justify seeking treatment for a child against a parent's wishes.

HARM PRINCIPLES

1. By refusing to consent, are the parents placing their child at significant risk of serious harm?
2. Is the harm imminent, requiring immediate action to prevent it?
3. Is the intervention that has been refused necessary to prevent the serious harm?
4. Is the intervention that has been refused of proven efficacy, and therefore likely to prevent the harm?
5. Does the intervention that has been refused by the parents also not place the child at significant risk of serious harm, and do its projected benefits outweigh its projected burdens significantly more favorably than the option chosen by the parents?
6. Would any other option prevent serious harm to the child in a way that is less intrusive to parental autonomy and more acceptable to the parents?
7. Can the state intervention be generalized to all other similar situations?
8. Would most parents agree that the state intervention was reasonable?



If you have questions around a reporting or privacy situation, please contact Physicians Insurance.

(What Would You Do, continued from page 5)

submit a claim based on an illegitimate insurance card, they don't have an obligation to report the illegal activity."

With a firm understanding of their legal obligations, providers can devote more of their energy to considering the moral and ethical underpinnings of each situation. "As a healthcare provider, you have a responsibility to learn the rules," notes Tate. "But we do have ethical duties that are not dependent on what the law might say. The law is codified to secure what we should and shouldn't do; I'm more interested in thinking about the moral underpinnings of the law."

CONSIDERATION 2: WHAT ABOUT PATIENT PRIVACY?

When do a physician's legal or ethical responsibilities outweigh a patient's right to privacy? Most of the time, when conflicts arise between a patient's right to privacy and a physician's responsibility to report illegal conduct, patient privacy wins, says Sconyers. "If, during a physician visit, a finance director says, 'I've been stealing from my employer, can you give me something for the stress?' the physician would be required to honor the patient's privacy, not to report the conduct," he says.

Important exceptions include situations involving mandatory reporting



requirements, which vary by state. “In general, when there’s a conflict between reporting a patient’s conduct and patient privacy, patient privacy wins,” notes Sconyers. “Except when there are specific rules requiring disclosure, like with child-abuse reporting—in that situation, child-abuse reporting takes priority over patient privacy. Same thing with infectious diseases. Each state has its own set of exceptions for what needs to be reported.”

“There is something sacred and binding in a physician-patient relationship that must be respected, but there are times when you have obligations to other people as well,” says Tate. “But it’s case by case. If you find out a patient is a drug user, but isn’t going to die or harm themselves or others, often the right thing to do is to respect the confidentiality of the patient, even though you know the activity is harmful. However, if you discover your patient is hurting someone other than themselves, as with child abuse or elder abuse, you do have a responsibility to talk to law enforcement or notify the appropriate people.”

CONSIDERATION 3: WHAT IS YOUR DUTY TO THE PATIENT?

Must a physician continue treating a patient who supplies false information, reveals illegal activity, or persists in

“In my opinion, if you’re acting because you care about the patient—rather than about profit or out of fear, for example—that’s a morally sound approach.”

TYLER TATE, MD, ASSOCIATE
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unethical behavior? Possibly, but not indefinitely, says Sconyers. “If you become aware of a patient’s unethical or illegal conduct and you can’t tolerate it, there are specific procedures for ending that relationship,” he says. “You can’t abandon a patient in the course of chemotherapy treatment, but at the end of their treatment, you can end the relationship.”

In the AMA case, Dr. Connelly wonders whether she’ll be able to treat a patient who may be hesitant to tell the truth. When trust between a patient and a

provider is damaged beyond repair, or can’t be established at the outset of a relationship, allowing the patient to find another doctor may be the most caring course of action.

“In my opinion, if you’re acting because you care about the patient—rather than about profit or out of fear, for example—that’s a morally sound approach,” says Tate.

CONSIDERATION 4: DOES YOUR SCHEDULE SUPPORT SOUND DECISION-MAKING?

A factor complicating Dr. Connelly’s case is one that’s familiar to many physicians: Without enough time for thoughtful reflection, important ethical, moral, and legal decisions may be rushed. “In his book *Thinking, Fast and Slow*, Daniel Kahneman has a thesis that we have two ways of thinking: one that’s more rudimentary from an evolutionary perspective, and a second mode that’s more rational,” says Tate. “It’s the second mode that allows us to slow down and assess. I think when it comes to thinking about an emotionally charged situation like this one, you have to try and access the second mode of thinking and be more deliberative.”

That’s easier said than done. Burgeoning patient panels, brief

(Continued on page 39)

Bridging Barriers to Care for Refugees and Immigrants

The world's population is increasingly on the move, a trend that has implications for healthcare providers in the U.S. and abroad. Globally, nearly one in seven people is a migrant. According to the World Health Organization (WHO), around one-quarter of the world's one billion migrants move across international borders.

Some 68 million people are refugees, forcibly displaced from their homes and communities. With some 46 million immigrants (as of spring 2019), the U.S. is home to just under one-fifth of the world's migrant population, more than any other country.

The shifting nature of international immigration poses complex challenges to healthcare providers in the U.S., who may care for patients from diverse backgrounds with complex, rapidly changing healthcare needs. Refugees are often in general good health, according to the WHO, but experience higher rates of diabetes, work-related injuries, post-traumatic stress disorder, depression, and anxiety than the general population.

Children and those who have experienced torture are particularly vulnerable to PTSD and depression. The Center for Victims of Torture reports that 44 percent of refugees living in the U.S. have experienced torture, making them 2.5 times more likely to experience depression.

By bridging common barriers to healthcare, providers can better serve newly arrived patients and help build stronger, healthier communities.

BARRIER—LANGUAGE

Effective communication between patients and providers is foundational to quality healthcare. When patients and providers don't speak the same language, important details may be missed or misinterpreted. "The biggest barrier

[for refugees accessing healthcare] is language and communication," says Annette Holland, Refugee Health Program Manager, Seattle and King County Public Health.

When friends or family members are used as interpreters in a healthcare setting, patient privacy may be compromised and complex medical terminology may be easily misunderstood. "In Public Health, we work with qualified, certified interpreters who are experienced and have a good working knowledge of medical terminology," Holland says. Newly arrived refugees may not know that they can request an interpreter during a medical visit and may not be in a position to advocate for one, she notes.

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“Physicians may not all know how easy it is to access an interpreter. For instance, Washington state will pay for an interpreter involved in a Medicaid-covered visit, and signing up to access the interpreters is just a little hurdle for the physician or clinic on the administrative side.”

ANNETTE HOLLAND,
REFUGEE HEALTH PROGRAM MANAGER,
SEATTLE AND KING COUNTY
PUBLIC HEALTH





Expanding Access to Transportation

“Transportation can be a huge barrier to healthcare, and learning to navigate public transportation in a new country takes time. In King and Snohomish counties, we have a contract with HopeLink to provide transportation to health screenings for all newly arriving refugees. A public-transportation orientation program provides free guided tours that can help refugees and immigrants learn how to use public transportation and grow their confidence.”

ANNETTE HOLLAND, REFUGEE HEALTH PROGRAM MANAGER,
SEATTLE AND KING COUNTY PUBLIC HEALTH

*(Bridging Barriers, continued
from page 9)*

High-quality interpretation is becoming more common in hospital and primary-care settings but is less common in smaller clinics, Holland says. “Physicians may not all know how easy it is to access an interpreter,” she says. “If you receive Medicaid funding, you are obligated by law to provide equal access to your medical services, and interpretation is part of that access. For instance, Washington State will pay for an interpreter involved in a Medicaid-covered visit, and signing up to access the interpreters is just a little hurdle for the physician or clinic on the administrative side.”

Digital tools, like Martti’s video-based interpretation platform and call-in interpretation services, can help make interpretation more accessible for providers and patients. “I would urge all providers who deal with patients with a language barrier to offer the opportunity for language interpretation, because even when patients say they understand, they may not understand the impact of the deep discussion that needs to take place,” says Roda Scego, CNM, ARNP, certified nurse midwife at CHI Franciscan’s Highline Medical Center in Burien, Washington.

BARRIER—CULTURAL DIFFERENCES

Healthcare providers who serve refugee and immigrant populations must navigate varying beliefs and preferences around nearly every aspect of care, from vaccinations and preventative care to end-of-life decisions. “A lot of people come from countries where you only go to the doctor when you’re sick, so one of the challenges is the idea of preventative care,” says Holland.

Often, providers can mitigate these challenges by simply taking time to ask patients about their background, she notes. “Sometimes, for example, a physician will suggest a dietary regimen that isn’t a good fit culturally,” she says.



Physicians need to think outside the box when caring for refugees and immigrants; thankfully, Holland points out, many providers already do, but there are always exceptions. “Someone from another country may be susceptible to different illnesses or diseases,” she says. “The average physician here might not think to screen for malaria, parasites, or certain vitamin deficiencies.”

“I wish providers would take a little more time with these types of patients,” says Scego. “Remember, these patients are in a unique situation and need a little more time and support.”

Group medical appointments for refugee families can help providers navigate cultural differences and language barriers, says Holland. “If a physician sees a family of four or six together, as we do during refugee health-screening appointments, there are multiple benefits, including being able to spend more time with the family learning about their history and culture, and possibly using one interpreter instead of having to schedule all of these appointments separately,” she says.

BARRIER—SOCIAL SUPPORT
Refugees and immigrants may be

experiencing prolonged separations from loved ones that strain their physical and emotional health, says Scego. As a certified nurse midwife, she cares for many such patients through pregnancy and early parenthood. “I have multiple pregnant patients under my care who are separated from their spouses or partners and family members,” she says. “We’re talking about a woman who is forced to go through pregnancy and childbirth without the support of her loved ones.”

This ongoing strain can lead to physical symptoms and trigger an emergency-department visit, “I see them coming into the emergency departments with psychosomatic symptoms, because the emotional symptoms have become physical problems,” she says. “We know from research that constant stress during pregnancy negatively impacts the health of the pregnant mother, as well as of the unborn baby. We also worry about the emotional connection between the mother and the child when the mother is so worried about her husband or partner in another country.”

Connecting newly-arrived patients to services such as community groups, post-partum support, care navigators,

and doulas can help create a network of support for these patients, Scego says.

And physicians who aren’t familiar with resources for refugees and immigrants can seek out a local resettlement agency, says Holland. “I would advocate for anyone who works with refugees to be familiar with the different local resettlement agencies,” she says. “They can be a lifeline for refugees when they arrive, and they can also be a resource for physicians.” 

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Healing Human Trafficking


HOW HEALTHCARE CAN HELP

As a healthcare provider in the U.S., you have likely cared for a victim of human trafficking. But if you're like many healthcare providers, you likely weren't aware that your patient was experiencing abuse.

If you did spot signs of human trafficking, you may not have had the opportunity to speak privately with your patient, or known how to connect them with the right support.

Human trafficking, a \$150 billion global industry affecting 25 million victims around the world each year, traps people in a form of modern slavery through fraud and coercion. According

to a 2018 report by Polaris, a nonprofit organization that runs the national human-trafficking hotline, and Freedom Network USA, the country's largest anti-trafficking coalition, healthcare is one of the industries most accessed by people experiencing human trafficking, along with financial services, transportation, and short-term housing.



Polaris reports that up to 88 percent of those experiencing human trafficking interact with a healthcare provider, but only 6 percent of healthcare providers recall treating a victim of human trafficking. There are several reasons for this awareness gap, says Hanni Stoklosa, MD, executive director of HEAL (Health Education Advocacy Linkage) Trafficking, a group working to end human trafficking by impacting public policy and increasing awareness of human trafficking as a public-health issue.

“I think that gap between the percentage of trafficking victims who are accessing healthcare and healthcare providers reporting trafficking or knowing what to do can be attributed to three things: awareness, behavior, and structure,” Stoklosa says.

SEPARATING MYTH FROM FACT

First, like the general public, many healthcare providers aren't aware of the forms human trafficking can take, or the signs that a patient might be experiencing coercion or abuse. “Trafficking is not integrated systematically into our medical education, so there are providers who have never heard of trafficking,” says Stoklosa.

Misconceptions about human trafficking are widespread, says Abigail English, JD, of the Center for Adolescent Health & the Law. English, who chairs the HEAL Trafficking Advocacy Committee, says these pervasive trafficking myths can prevent healthcare providers from recognizing victims in their care.

The term “human trafficking” is generally associated with young women born outside the U.S. being transported across borders and coerced into sexual slavery. According to research published in *Obstetrics & Gynecology*, fewer than half of trafficking victims are forced into sexual labor. The rest are involved in labor trafficking, in which victims are forced to perform labor in a wide range of industries including food service, carnivals, hospitality, and even healthcare.

“I think that gap between the percentage of trafficking victims who are accessing healthcare and healthcare providers reporting trafficking or knowing what to do can be attributed to three things: awareness, behavior, and structure.”

HANNI STOKLOSA, MD, EXECUTIVE DIRECTOR OF HEAL TRAFFICKING

Because reports about human trafficking tend to focus on sex-trafficking cases, labor trafficking is often underrecognized. “We need to communicate that both sex and labor trafficking are important parts of the problem, both globally and here in the U.S.,” says English.

Trafficking affects people of all ages, genders, and nationalities. Although the term “trafficking” implies movement, trafficked individuals are not necessarily being transported. “People have often thought about human trafficking as something that happened somewhere else, and that trafficking victims were foreign-born,” says English. “There’s also a misperception that in order to be considered a victim of human trafficking, one had to be transported from one place to another. In fact, under the law, trafficking is not dependent on a change of location.”

The coercion tactics employed by traffickers can make victims particularly hard to recognize, because these victims may not realize that they are involved in human trafficking. “The trafficked person themselves may not realize that they’re being exploited; all of their information is being controlled by the trafficker,” Stoklosa notes. “So they may not identify with being a victim of trafficking, and they may not present in a way that the healthcare provider identifies with trafficking.”

The second factor preventing healthcare providers from recognizing victims in their care relates to human behavior. “On the behavioral side, as a physician, I am human,” Stoklosa says. “I have an unconscious bias about what a trafficking victim might look like, which is shaped by how I grew up, my age, and my race. There’s an image of a victim that comes to my mind when I hear the word trafficking. A real victim may not fit that image; in fact, because of prior trauma, they may be angry or be perceived as an aggressor, not a victim.”

Finally, the patient-flow procedures in place at many hospitals and clinics leave little time or opportunity for victimized patients to ask for help. “When a provider is in the emergency department, even if a patient fits some

(Continued on page 20)



Does Your Office Have a Plan to Avoid Employment Practices Liability Claims?

IN THE WAKE OF #METOO, YOU CAN TAKE STEPS TO MITIGATE YOUR RISK

Last December, United Airlines agreed to pay \$321,000 to settle a harassment suit after one of their pilots allegedly posted explicit photos on social media of a flight attendant, repeatedly and without her consent, for years.

The case alleged that the airline was made aware of the pilot's behavior but did not take action to prevent or correct the conduct.

“Employers must not ignore harassment complaints simply because the harasser holds a position of authority,” says U.S. Equal Employment Opportunity Commission supervisory trial attorney Eduardo Juarez, in a release announcing the settlement.

United is not alone. In recent months, Uber has agreed to pay \$4.4 million to resolve a sexual-harassment and retaliation charge, and Dollar General accepted a \$6 million settlement when faced with charges that it denied employment to African Americans at a higher rate than to white applicants.

EMPLOYMENT PRACTICES LIABILITY INSURANCE: NO LONGER A LUXURY

Employment Practices Liability Insurance (EPLI) offers employers coverage against claims of discrimination (based on race, sex, age, or disability), wrongful termination, sexual harassment, retaliation, and other employment-related issues, including failure to promote.

While once considered a niche product, EPLI policies are now offered by most major insurance companies.

**“Tolerance for inappropriate behavior
has gone down with #MeToo. There is much
more awareness. In the litigation realm,
juries are handing out bigger awards.”**

REID EKBERG, PRESIDENT, PILKEY HOPPING & EKBERG INC., TACOMA, WASHINGTON

These examples are just a few of the big-name, big-dollar discrimination, retaliation, and sexual-harassment cases currently being handled by the U.S. Equal Employment Opportunity Commission (eeoc.gov), the federal agency charged with enforcing laws that prohibit discrimination on the job. And in the wake of the #MeToo movement, claims against harassment specifically are on the rise.

“The biggest trend right now is a social trend,” says Reid Ekberg, president of Pilkey Hopping & Ekberg Inc., a Tacoma, Washington-based insurance brokerage. “Tolerance for inappropriate behavior has gone down with #MeToo. There is much more awareness. In the litigation realm, juries are handing out bigger awards.”

Here, we offer a few steps to help your office steer clear of potential missteps in order to lessen the chance of employment practices litigation.

“I would really encourage every business, even small businesses, to have a stand-alone EPLI or management liability policy,” says Ekberg. “If it’s a small business, you might be okay with \$500,000, though usually we start with \$1 million in coverage.”

Some insurance companies offer free EPLI claims-assistance services, with some even providing channels such as a 1-800 or email hotline to field questions. “If you have a scenario you have a question about, you can make contact and ask a question,” Ekberg says. “Those resources are very valuable for policyholders.”

EMPLOYEE TRAINING REDUCES RISK

As vital as EPLI coverage is, though, it’s only one step in any employer’s risk-mitigation plan. The real key is to take steps within your office to reduce the chance of potential wrongful-act claims.

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RESPONSIBLE
FOR HR?

Meet Your Hero



For companies of any size in any industry, human resources is one of the most complicated and fast-changing areas of business management—and one that’s fraught with liability.

Layer in the challenges of running a medical practice and addressing emerging social issues, and human-resources managers in this field certainly have their work cut out for them.

Enter HR Hero—a collection of online state-specific and federal employment-law resources for HR professionals, created to help them find quick answers to their employment-law and management questions, maintain a positive and productive workplace, and avoid devastating lawsuits. Users

of HR Hero can rely on the expertise of employment-law attorneys in all 50 states and Washington, D.C., for assistance with human-resources compliance and strategic planning, via tools that can be customized to each organization.

“A resource like HR Hero is preventative care for those with HR responsibilities,” says Susan Brodeur, a representative from BLR who provides and maintains content on HR Hero. “Any HR mistake can potentially become a claim, so HR Hero is a crucial support resource to

access for guidance on HR issues and documentation.”

While HR Hero offers an array of features to access, the two most popular are the Employee Handbook Builder and the Fair Labor Standards Act (FLSA) Audit and Classification tool.

“The employee handbook is the most important HR document,” Brodeur says. “If a problem arises, it is likely that an employee’s attorney will request a copy of it.” Even if there’s already one

in place, she urges all organizations to make sure their handbooks are updated and not missing essential elements. “If it’s out of date, it doesn’t reflect well on the organization,” she says. HR Hero’s handbook builder generates an employee handbook with updates specific to the user’s needs—including state addendums—that can be downloaded. Policies regarding discrimination, sexual harassment, and substance use are part of a handbook and should also be part of a training program, which the resource can also support.

The FLSA Audit and Classification tool is a step-by-step assessment of an individual job that helps determine whether the position should be paid on an hourly basis or if it can be salaried (exempt). The Fair Labor Standards Act (FLSA) establishes minimum wage, overtime pay, record-keeping, and youth-employment standards affecting full-time and part-time employees in the private sector and in federal, state, and local governments. The rules for salaried and hourly pay have changed effective January, 2020, so businesses should use the tool to make sure they’re compliant, Brodeur says.

HR Hero also includes access to:

- **Regulatory informational analysis** that not only summarizes the detail of the regulations but also helps to make it understandable.
- **Self-audit checklists** to determine whether you are compliant.
- **A state law chart builder** that allows you to pick your state(s) and topics to create a compliance chart.
- **A job description builder** that includes relevant tasks, behaviors, and physical requirements for that job; the ability to add, edit, delete, or reorganize easily and quickly; the ability to create

“If you aren’t sure about something, ask before you act. It’s easier to prevent a mistake than to resolve one.”

SUSAN BRODEUR,
REPRESENTATIVE, BUSINESS
& LEGAL RESOURCES (BLR)

a personal job-description library; and the ability to produce printable PDFs with the click of a mouse.

- **A salary finder for benchmark competitive salary data** that can be set according to demographics by industry, state, and city, and that can access data for more than 2,500 job titles.
- **Email-based support** where users can email questions to employment law experts for guidance. With a typical turnaround time of 24 hours, responses come with details to save for your files.

Users of HR Hero can also receive alerts with time-sensitive information such as upcoming compliance dates, minimum-wage increases by state and when they take effect, changes to drug-screening policies or sick leave, and the like. The alerts also feature insightful articles on best practices.


Further, HR Hero offers customizable instructor-led training resources that include training documents for group trainings on more than 165 HR topics, in the form of 10-minute trainers and customizable slides with supporting

documents such as exercises, handouts, quizzes, and speaker notes.

“Unconscious-bias training is new and popular,” Brodeur says. “Everyone has some unconscious bias, and it’s very worthwhile to explore this topic with both supervisors and employees in order to get at the root of recognizing and overcoming potential discrimination issues.” Sexual-harassment training resources are also available.

“If you aren’t sure about something, ask before you act,” Brodeur says. “It’s easier to prevent a mistake than to resolve one.”

You can find HR Hero in the Resource Library at phyins.com/resource-library—or call your account manager to learn more.

NOTE: If you have an imminent issue that requires immediate legal attention, contact Physicians Insurance and ask for a claims representative. 

Finding Additional Resources

Physicians Insurance provides its clients with excellent legal defense, should they need it—but in addition, it offers services and resources to help protect clients from needing it in the first place. Many of these are found online in the password-protected Physicians Insurance portal (phyins.com).

Look for HR Hero in the Additional Resources section of the Resource Library, under the Risk Management tab at phyins.com.

CARE MANAGEMENT

2020 Medicare Physician Fee Schedule Final Rule



The Centers for Medicare & Medicaid Services (CMS) released its 2,475-page 2020 Medicare Physician Fee Schedule Final Rule (Final Rule) on November 1, 2019. Noting that only 9% of Medicare fee-for-service beneficiaries presently receive ambulatory-care management services, CMS is making several important changes to expand access to these services.



See the full document
of the 2020 Medicare
Physician Fee
Schedule Final Rule:
[go.aws/2GZBBXa](https://www.fda.gov/2GZBBXa).

The following insight summarizes new Medicare reimbursement rules for transitional care management, chronic care management, principal care management, and remote patient monitoring.

TRANSITIONAL CARE MANAGEMENT (TCM)

According to CMS, a recent analysis of TCM claims data determined that “beneficiaries who receive TCM services

demonstrated reduced readmission rates, lower mortality, and decreased healthcare costs.” The same analysis, however, “found that use of TCM services is low when compared to the number of Medicare beneficiaries with eligible discharges.” In fact, providers submitted only 1.3 million claims for TCM in 2018, compared to approximately 9.5 million Medicare hospital discharges that year.

To increase TCM utilization, CMS is reducing the administrative burden associated with billing TCM services. Specifically, CMS is eliminating the prohibition on a practitioner billing for certain services furnished during the 30-day period covered by TCM. Most importantly, a practitioner will be able to bill for chronic care management (CPT® codes 99490, 99491, 99487, and 99489) and care-plan oversight (HCPCS G0181 and G0182) furnished during the same time period as TCM.

Also, CMS is improving payment for TCM by increasing the work relative value units (RVUs) for the two TCM CPT codes. For CPT 99495, payment is increasing from \$166.50 to \$175.76. For CPT 99596, it will increase from \$234.97 to \$237.11. (Please note, we use the non-facility national payment rate calculated with the 2020 conversion factor of \$36.09 throughout this article, unless noted otherwise.)

For detailed information on TCM reimbursement rules, view PYA's white paper, *Providing and Billing Medicare for Transitional Care Management*, at <https://bit.ly/39tYONt>.

CHRONIC CARE MANAGEMENT (CCM)

As with TCM, CMS notes that CCM is “increasing patient and practitioner satisfaction, saving costs and enabling solo practitioners to remain in independent practice.” Like TCM, however, CCM “continue[s] to be underutilized.”

To address this, CMS is creating an add-on code for non-complex CCM, HCPCS code G2058. Effective January 1, 2020, a practitioner can bill CPT 99490 for the first 20 minutes of clinical staff time spent performing CCM activities in a given calendar month, and can bill G2058 for the second and third 20-minute increments. Payment for CPT 99490

(Continued on page 34)



Human Trafficking Red Flags

Recognizing potential indicators of human trafficking can help healthcare providers connect victims with resources and assistance.

The individual in question:

- Is not free to leave or come and go at will
- Is unpaid, paid very little, or paid only through tips
- Owes a large debt and is unable to pay it off
- Was recruited through false promises concerning the nature and conditions of his/her work
- Is living and working at the same site
- Experiences verbal or physical abuse by their supervisor
- Is not given proper safety equipment
- Is fearful, anxious, depressed, submissive, tense, or nervous/paranoid
- Shows signs of substance use or addiction
- Shows signs of poor hygiene, malnourishment, and/or fatigue
- Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture
- Is not in control of their own money or identification documents
- Is not allowed or able to speak for themselves
- Appears to have lost the sense of time and location
- Shares scripted, confusing, or inconsistent stories
- Protects the person who may be hurting them, or minimizes abuse

Source: Polaris



(Healing Human Trafficking, continued from page 13)

of the red flags for sex trafficking or labor trafficking, the provider may not feel they have a moment of time to inquire more,” says Stoklosa. “If we don’t allow providers to have a private moment with each patient, we’re doing patients a disservice, and it’s rare that an ED has that in their flow.”

WHAT HEALTHCARE PROVIDERS NEED TO KNOW

Thanks to the efforts of groups like Polaris and HEAL Trafficking, human trafficking is increasingly being recognized as a public-health issue. “In general, there has been a growing awareness among policymakers as well as healthcare providers that human trafficking is a public-health issue, not just a criminal-justice and law-enforcement issue,” says English. “This is really a welcome development, and I hope this trend will continue.”

This means that more healthcare providers will have access to training that can help them identify and support survivors of human trafficking. The SOAR Training from the US Department of Health and Human Services equips healthcare and social-service professionals to identify and treat victims of human trafficking.

“There’s an intrinsic power in being able to tell someone, ‘You’re seen and heard’ Opening the door to that conversation adds to somebody’s resilience.”

AHANNI STOKLOSA, MD,
EXECUTIVE DIRECTOR, HEAL TRAFFICKING

Healthcare providers also need to be aware of their state’s laws related to reporting suspected abuse, notes English. “A number of states have now incorporated human trafficking into their child-abuse reporting laws, so it’s important for healthcare providers to know what the law requires them to do,” she says. “They also need to understand what services are and are not available for trafficking survivors, and what protections are available to them if they’re reported to child welfare or law enforcement under child-abuse laws.”

HEALTHCARE AND HEALING


Without the right protocols in place, even well-trained, caring healthcare providers will struggle to help trafficking victims in their care. Key changes—like updating patient-flow protocols to allow clinicians time alone with patients, routinely using interpretation services, and employing new screening tools to improve patient-provider communication—can help those experiencing human trafficking better connect with trauma-informed support.

New screening tools can increase the chances that a victim will disclose abuse to their healthcare provider, says Stoklosa. “When a person is experiencing violence or exploitation, there needs to be a framework for them

to disclose if and when they’re ready,” she says. “Evidence from domestic violence shows that when you do a disclosure-based screening with a checklist, you get less disclosure than when you take a universal educational approach. People can tell when you’re ‘checkboxing’ them.”

HEAL Trafficking, in collaboration with Dignity Health, is creating that framework with the PEARR (Provide privacy, Educate, Ask, Respect and Respond) tool, a screening framework that prioritizes human connection over checkboxes. By combining privacy, education, and simple questions, PEARR empowers patients to ask for help if they choose.

Getting comfortable with certain phrases and questions helps providers make use of limited time alone with patients. “What I say is, ‘As your doctor I care about your health, and I see your health is related to your relationships and the work that you do,’” says Stoklosa. “‘A lot of my patients exchange sex for drugs and then they meet the wrong drug dealer, who starts controlling every inch of their lives. The reason I’m asking is, we have resources to help people to who get stuck in those situations.’”

Not every victim will take the opportunity to ask for help, of course. But creating pathways to safety allows more people to find their way to freedom. “There’s an intrinsic power in being able to tell someone, ‘You’re seen and heard,’” says Stoklosa. “Opening the door to that conversation adds to somebody’s resilience.” 

National Human Trafficking Hotline:
(888) 373-7888

Sources:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5699814/>

<https://polarisproject.org/human-trafficking-and-the-health-care-industry/>

<https://journals.lww.com/greenjournal/pages/results.aspx?txtKeywords=trafficking>



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Executive Director,
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*Abigail English, JD,
Chair, HEAL Trafficking
Advocacy Committee
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Director, Center for
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Law (www.cahl.org)*

“Good training is important for all incoming employees for the full range of staff, even up through the physicians.”

JENNIFER SMITROVICH, ATTORNEY,
FAVROS LAW, SEATTLE



Does Your Office Have a Plan, continued from page 15)

First, take time to re-evaluate your employee-training protocols at least annually. Be sure your office has an employee handbook, and check that it's up to date and in compliance with the latest employment laws in your state.

Laws surrounding the wording of employee-training materials can change from year to year. Case in point: Oregon recently passed a Workplace Fairness Act requiring precise written policies to prevent unlawful employment practices. The legislation mandates that specific details be included in all employee handbooks.

If your office doesn't already have a designated HR manager, it's a good idea to task a staff member to stay abreast of changes to HR policies and employment legislation affecting your state. Websites for your state legislature, state labor department, or statewide Chamber of Commerce are good portals to check for updates.

Also, you should set aside time for employee training with new on-boarding staff, once as they're hired and again for your full team at least once a year—or more often, if possible.

“Good training is important for all incoming employees for the full range of staff, even up through the physicians,” says Jennifer Smitrovich, an attorney with FAVROS Law in Seattle. “Educate employees about various situations—what a hostile work environment means, what is appropriate, what is inappropriate. In light of the #MeToo

movement and what's happening in terms of the visibility of sexual harassment in the workplace, many states are moving toward making these trainings mandatory.”

Beyond issues of harassment, it's also important that your employee handbook outline clear guidelines for proper or expected standards of employee behavior at work—as well as the precise administrative steps that will be taken to address situations in which they're not being met. Having everyone on the same page helps avoid the risk for claims of discrimination or retaliation down the line.

“Especially in smaller group practices, there's often not a lot of guidance in place,” Smitrovich says. “In some cases, there are no written policies or procedures in place. But if you have an employee who is improperly using the internet at work, who is really tardy



HR HERO

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to HR Hero through
phyins.com. Learn more
on page 16.

(Continued on page 26)

Sexual Harassment in the #MeToo Era



Since the Harvey Weinstein story broke in October 2017, and in the midst of the #MeToo movement that has arisen in its wake, there's been a shift in society's awareness of and tolerance for harassment—a shift which is, in turn, playing out in the court system.

The U.S. Equal Employment Opportunity Commission (eoc.gov), the federal agency charged with enforcing laws that prohibit discrimination on the job, reported a 13.6 percent increase in the number of charges of sexual harassment it received in Fiscal Year 2018 over Fiscal Year 2017.

Over the same period of time, the EEOC reported a 23.6 percent increase in charges of harassment with reasonable cause, and a 43 percent increase in cases that were successfully conciliated on behalf of the plaintiff making the harassment charge. Examples of harassment that are not sexual in nature could include offensive jokes, slurs, or name-calling, as well as physical threats or ridicule.

Just as striking, settlements and awards for claims of harassment tended to be higher in Fiscal Year 2018. The EEOC recovered nearly \$70 million for victims of sexual harassment through administrative enforcement and litigation in FY 2018, up from \$47.5 million in FY 2017.

The rising tide of awareness surrounding sexual harassment has brought a shift in how physical contact—of any type—may be perceived.

SMALL CHANGES MAY HELP AVOID MISUNDERSTANDINGS

"I've been seeing more that it's not just employees making claims against other people that they work with—say, medical assistant versus physician—but it's now also patient versus doctor or patient versus provider," says Jennifer Smitrovich, an attorney with FAVROS Law, a medical-malpractice defense law firm in Seattle. "People are stating that a physician touched them inappropriately during an examination or spent too long examining an area, for example."


To mitigate the risk that a patient may feel a procedure has crossed the lines of propriety, Smitrovich suggests that physicians invite a second staff member into the room during exams when possible. She also recommends that physicians work to become acutely aware of their personal space and the personal space of their patients, and allow enough clearance that physical contact doesn't happen unless necessary for an exam.

Smitrovich has seen claims stem from unintentional body contact when no ill-intent was meant—simply as the result of a tight examination room.

"I've seen complaints made where patients believed that they were improperly touched by a physician who was just trying to get to the other side of the room," she says.

In another case Smitrovich recalls, a claim was made against a provider that alleged improper touching of a patient's leg after completing an orthopedic exam of her elbow. "It goes back to training, and awareness that how you touch people matters, even if it's inadvertent," she says.

For times when physical touch between providers and patients is necessary—as in the case of an exam—Smitrovich recommends that physicians take the time to fully explain the process to their patient beforehand to lessen the possibility of a complaint.

"It's important to explain exactly what you're doing and why," she says. "Part of it is being mindful of your body and its relation to how you're conducting the exam, especially when others may have a different perception of the situation." 



RESOURCE

Read the whitepaper: *Search Effective Interpersonal Communication with Patients* at phyins.com/resources.

CASE STUDY

Hidden in Plain View

A Case of Delayed Diagnosis of Stroke

When it comes to stroke, you've got **one chance to get it right. Your patient's outcome depends on near-instant assimilation of countless components gathered from different sources, including the patient themselves and their family.**

In the following case, modified for privacy protection, consider how each component affected the diagnostic process.

AN UNLIKELY CANDIDATE

Lisa Ingram's 15-year-old son called 911 one morning when she dropped a jar of jam and slumped to the kitchen floor unconscious. She'd been making breakfast for him and her 6-year-old daughter when the dizzy spell overtook her. Lisa had no risk factors for a stroke.

The emergency-medicine resident was given a medical history of altered mental status and syncope. He wasn't concerned about a stroke in an otherwise-healthy 37-year-old. Lisa could

not answer questions but opened her eyes to her name, bit down on a tongue depressor when her gag reflex was tested, and moved her arms and legs. Her sister arrived and reported that Lisa had been upset over marital problems and an impending divorce.

The resident ordered a non-contrast CT of the head, as well as a chest X-ray. He thought about the possibility of trauma, encephalopathy, intoxication/overdose or medication reaction. The workup found no evidence toward causation. He suspected that the trouble at home had caused acute psychiatric stress that had brought about the dizziness and fainting. The attending physician agreed, and Lisa was admitted to the hospital.



Lisa believes that her legal team advocated for her more strongly than her medical team. Her attorney pointed out several stages in her care that, if recognized, might have led to a full recovery.

The radiologist reported to the attending physician that the head CT was normal, with symmetrical anatomy and no hemorrhages, gross lesions, fractures, infarcts or edema. The hospitalist agreed with a diagnosis of conversion disorder.

When Lisa developed right-sided weakness throughout the late afternoon, a neurologist ordered an urgent MRI that revealed areas of acute ischemic injury in the left-middle cerebral artery—a stroke. By then, Lisa was clearly past the time window for thrombolytics or endovascular clot retrieval. She was transferred to the ICU for close neurologic monitoring, and was discharged a week later with speech impairment and mild right-side weakness.

Now, nearly two years later, Lisa can do everything she did before her stroke, just not as well or as quickly. Her case was settled soon after trial began: on the face of it, the atypical presentation could have fooled anyone. However, Lisa believes that her legal team advocated for her more strongly than her medical team. Her attorney pointed out several stages in her care that, if recognized, might have led to a full recovery.

LOST OPPORTUNITIES

- EMTs listed stroke as a possible diagnosis, which was downplayed by the nurse who presented the case to the emergency-medicine providers.

(Continued on page 36)

*Does Your Office Have a Plan,
continued from page 22)*

all the time—whatever the issue is, having a policy that says, ‘Here’s what the expectation is’ helps, if you want to take disciplinary action later.”

KEEP RECORDS UP TO DATE

Because claims against wrongful termination, failure to promote, or discrimination can sometimes come down to one person’s word against another’s, carefully keeping employment records for all staff—including information about hiring, firing, employee job evaluations, and staff interactions—is essential.

“Record-keeping is paramount, especially in cases where you’ve got a wrongful-termination claim, or if you place an employee on a performance-improvement plan on a path toward termination,” says Smitrovich. “It’s one thing to say something to an employee, as in, ‘You need to improve,’ or, ‘You’re not meeting expectations’—but if it’s not in writing, it almost doesn’t count. If an employee is fired or offered a resignation in lieu of firing and a claim comes later, juries are less likely to see the dismissal as some sort of retaliation or perceived discrimination if you have documentation in place. Having written evaluations—documentation in a personnel file or anything about efforts to improve performance—could help defend your case.”

Ekberg agrees. “Was the issue really that they were missing things and missing procedures? Did you document that? That’s the really important piece,” he says. “All of these claims involve a level of ‘my word against yours,’ which is why documentation is critical in defending yourself.”

Additionally, be aware that many states have begun extending their statute of limitations for harassment or

If an alleged instance of improper conduct is brought to your attention, take it seriously and investigate it fully.

discrimination claims, so it’s important to enact a record-keeping policy that extends beyond the statute of limitations for your area.

“The statute of limitations for discrimination and sexual-harassment claims in Oregon is going up, from one year to five years,” says Michael Estok, an attorney with Lindsay Hart LLP in Portland, Oregon. “You want to make sure you don’t delete anything until the statute of limitations fully runs its course. That material—especially if there was helpful information in there—if it’s gone, makes your case harder to defend.”

Destroying personnel records before the statute of limitations runs out, even if by mistake or without nefarious intent, can be viewed, legally, as “spoliation of evidence, which has negative consequences in the courts,” Smitrovich says.


ACT QUICKLY ON COMPLAINTS

Finally, if an alleged instance of improper conduct—say, an incident of harassment between two employees

at your office—is brought to your attention, take it seriously and investigate it fully. Ignoring it or trying to dismiss it via an internal investigation that lacks thoroughness can, in the long run, lead to a stronger case in court for the plaintiff.

“If there’s a lack of adequate fact-gathering or documentation, or if there are things in the report that seem biased, or if the employer is inclined to find things unsubstantiated without due process, it can become a big problem for the clinic facing the case,” says Estok.

In cases such as these, Estok recommends bringing in an independent investigator to address the situation when possible.

“That’s when the company can show that they went above and beyond in trying to investigate the incident and take it seriously,” he says. “Then they can explain what they did or didn’t do in good faith.” 

Sources:



Reid Ekberg, President,
Pilkey Hopping &
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Michael Estok, JD,
Lindsay Hart LLP



Jennifer Smitrovich, JD,
Principal/Owner,
FAVROS Law


COVID-19 RESOURCES

ON PHYINS.COM

The Risk Management Resource Library on phyins.com offers flyers, links, and other resources for use with patients and staff at your facility. Visit phyins.com/resources and filter for COVID-19, or click on the COVID-19 information button.

CORONAVIRUS FEARS AT WORK: WHAT EMPLOYERS NEED TO KNOW

Source: BLR/HR Hero




Coronavirus Fears at Work: What Employers Need to Know

By Tammy Blanford, Contributing Editor

News reports of deaths and illnesses from the rapidly spreading coronavirus get scarier every day. Millions of people are being quarantined. Foreign companies and governments are evacuating their people from hard-hit areas of China where the virus got its start. And even employees who don't travel for work are getting anxious about traveling coworkers who may have been exposed.

With the virus continuing to spread, employers need to plan how to respond and comply with the law's worker safety requirements. The U.S. Department of Labor (DOL) has posted [information](#) on the 2019 Novel Coronavirus (2019-nCoV), its background and reminding employers of worker protection standards from the Occupational Safety and Health Administration (OSHA) and the need to consult [guidance](#) from the Centers for Disease Control and Prevention (CDC).




What Employers Can Do

One way you can protect employees is to send sick or exposed workers home. Jo Ellen Whitney, an attorney with the [Baker, Berman & Lee](#) in Des Moines, Iowa, says, "If an employer knows an employee may have been exposed, the employer is within its rights to send the employee home even if the doctor's test is flat."


"We do that for the flu and other types of exposures as well," Whitney says. "Common indicators are fevers or vomiting, as to when someone should be sent home."

[Lori R. Bahr](#), an attorney with [Tiffany & Bess, P.A.](#), in Phoenix, Arizona, says that sending employees home can be advisable, but laws such as the Americans with Disabilities Act (ADA) must be kept in mind.



SPECIAL DROPLET CONTACT PRECAUTIONS

Source: WA Dept. of Health



SPECIAL DROPLET/CONTACT PRECAUTIONS

In addition to Standard Precautions

Only essential personnel should enter this room

If you have questions ask nursing staff

Everyone Must: Including visitors, doctors & staff


- Clean hands when entering and leaving room
- Wear face mask
- Wear eye protection (face shield or goggles)
- Gown and glove at door

When doing aerosolizing procedures fit tested N-95 with eye protection or higher required

KEEP DOOR CLOSED

Use patient dedicated or disposable equipment
Clean and disinfect shared equipment

Contact Infection Control prior to discontinuing Precautions



WHAT HEALTHCARE PERSONNEL SHOULD KNOW ABOUT CARING FOR PATIENTS WITH POSSIBLE OR CONFIRMED COVID-19

Source: CDC



What healthcare personnel should know about caring for patients with confirmed or possible coronavirus disease 2019 (COVID-19)

Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible infection with coronavirus disease 2019 (COVID-19) and have an increased risk of exposure to the virus that causes it, now identified as SARS-CoV-2. HCPs can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control guidelines, including use of recommended personal protective equipment (PPE).

How COVID-19 Spreads

There is much to learn about COVID-19, including how and how easily it spreads. Based on what is currently known about COVID-19 and what is known about other coronaviruses, spread is thought to occur mostly from person to person via respiratory droplets during close contact.

Close contact can occur while caring for a patient, including:

- being within approximately 6 feet (2 meters) of a patient with COVID-19 for a prolonged period of time.
- having direct contact with infectious secretions from a patient with COVID-19. Infectious secretions may include spit, tears, blood, and respiratory droplets.

If close contact occurs while not wearing all recommended PPE, healthcare personnel may be at risk of infection.

How You Can Protect Yourself

Healthcare personnel caring for patients with confirmed or possible COVID-19 should adhere to CDC recommendations for [infection control and control](#) (PPE).

- Assess and triage these patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure, including placing a screen on the patient and isolating them in an airborne infection isolation room (AIIR), if available.
- Use Standard Precautions, Contact Precautions, and Infection Control and Control (PPE) when caring for patients with confirmed or possible COVID-19.
- Perform hand hygiene with alcohol-based hand rub before and after all patient contact, contact with potentially infectious material, and before putting on and after removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
- Practice how to properly put on and take off PPE in a manner to prevent self-contamination.
- Perform several gowning procedures, including collection of diagnostic respiratory specimens, in an AIIR, while following appropriate PPE practices, including use of appropriate PPE.

Environmental Cleaning and Disinfection

Routine cleaning and disinfection procedures are appropriate for COVID-19 in healthcare settings, including those patient care areas in which several gowning procedures are performed. Products with [EPA-registered](#) emerging viral pathogen claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19. Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.

When to Contact Occupational Health Services

If you have an suspected exposure (i.e., not wearing recommended PPE) to a confirmed or possible COVID-19 patient, contact your supervisor or occupational health immediately.

If you develop symptoms consistent with COVID-19 (fever, cough, or difficulty breathing), do not report to work. Contact your occupational health services.

For more information for healthcare personnel, visit: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>



For more information: www.cdc.gov/COVID19



FEDERAL RESOURCES

Center for Disease Control and Prevention (CDC)

Information for Healthcare Providers
<https://bit.ly/2W2Hg7S>

US Dept. of Labor Occupational Safety and Health Administration (OSHA)

Information that may apply to worker exposure to novel coronavirus, COVID-19.
<https://bit.ly/2INZCBL>

STATE INFORMATION

Most state health departments are providing ongoing updates and resources for the novel coronavirus (COVID-19) in their area, including prevention and preparedness guidelines for patients, answers to frequently asked questions, and resources for healthcare providers.

Alaska Dept. of Health and Social Services
<https://bit.ly/336oSwH>

Idaho Official Government website
<https://coronavirus.idaho.gov/>

Oregon Health Authority
<https://bit.ly/2vMnZgh>

Washington State Dept. of Health
<https://bit.ly/2lFeOAI>

Wyoming Dept. of Health
<https://bit.ly/3a07ZJr>

Living in the Postcard

on Kachemak Bay:
Homer, Alaska

Small, independent hospitals in rural areas are few and far between these days.

As the healthcare industry continues to consolidate and large health systems become the norm across the country, what's gained are greater resources, economies of scale, and concentrations of expertise—but what's lost are proximity, community ties, and personalized, locally coordinated care.

There doesn't always have to be a trade-off, though. Under the right circumstances, hospitals can stay small and strong. Case in point: South Peninsula Hospital in Homer, Alaska.

PICTURE-PERFECT

Homer is a small city of about 6,000 residents on Kachemak Bay, on Alaska's Kenai Peninsula. The city sits on a long strip of beaches lined with shops, art galleries, and seafood restaurants, and fishing boats dock at its harbor. The new CEO of South Peninsula Hospital, Ryan Smith, describes it as a “postcard community”—a nature lovers' paradise that an outdoorsman such as himself can't resist. In fact, this is the third time Smith has moved to the area—this time for good, he says, as he hopes to





eventually spend his retirement there. “For those who don’t like big population centers and who love to hunt and fish, this is the place to be,” he says. As such, Homer is becoming a destination location for many retirees—mostly in the summer, but more and more are now staying year-round.

As this trend has grown, so has South Peninsula Hospital. Its annual net revenue has increased from \$30 million to \$80 million in the last decade. “We’re increasingly busier with Medicare

patients,” Smith says, “and our future plans will revolve around that. We’ll grow to meet that need with more facilities.”

COMMUNITY PILLAR

South Peninsula Hospital is a full-service, nonprofit hospital that was founded in 1956 with three beds. Today, it’s a state-of-the-art facility licensed for 22 medical beds and 28 nursing-home beds. It employs 70 physicians who provide general, acute, post-acute, and specialty care. Services include emergency care, a birthing center, cancer care, a functional-medicine clinic, home-health services, imaging and laboratory services, long-term care, rehabilitation services, a sleep center, orthopedics, surgery, and more.

The hospital is the result of a partnership between the Kenai Peninsula Borough (providing service-area tax support for the facility and capital investments), the City of Homer (for the land), and SPH, Inc. (the nonprofit organization that provides the healthcare). The hospital is governed by a nine-member board of directors, and an elected Service Area Board provides public recommendations on capital spending with tax dollars and scope of services.

The hospital employs more than 400 local residents, making it the area’s largest employer, and contributes over \$20,000,000 annually to the local economy in payroll alone. That, combined with service contracts, materials acquisitions, and leases, creates a significant positive impact on the area’s economic health.

CRITICAL ACCESS

South Peninsula Hospital has a service area of about 15,000 residents. (The next nearest hospital is 75 miles away.) South Peninsula is a “critical access hospital,” a designation by the Centers for Medicare and Medicaid Services that is intended to keep essential healthcare in rural areas. Among the benefits of critical access

“We’re increasingly busier with Medicare patients and our future plans will revolve around that. We’ll grow to meet that need with more facilities.”

RYAN SMITH, CEO,
SOUTH PENINSULA
HOSPITAL



(Continued on page 38)

EDUCATION

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Six-part Series Social Determinants of Health

Certain external conditions, often beyond an individual's direct control, are referred to as the social determinants of health, and they have the potential of affecting the health of your patients. These conditions, contributing to individuals' health inequity and inequalities at all levels, encompass where a patient lives and works; socioeconomic policies, systems, and norms; and more. This course discusses how the five pillars of the social determinants of health impact the daily delivery, accessibility, and engagement of health-improvement efforts. It also presents strategies for assessing the social determinants of health that may be affecting your patient population, how to increase awareness and interest in these determinants, and ways to engage patients, stakeholders, and other providers in addressing social determinants of health. (1.00)



VISIT [PHYINS.COM/EDUCATION](https://phyins.com/education)
and search "Social Determinants of Health" to view the full series.

Workplace Harassment

Ensuring that employees are free from harassment in a safe and healthy work environment is key to achieving your company's goals. This course examines various types of workplace harassment, the basic skills needed to understand and deal with such situations, and information concerning your role in ensuring a harassment-free work environment. (1.25)

Sexual Harassment for Employees

Sexual harassment makes it hard for workers to feel comfortable and perform their jobs. It also creates problems for employers. This course discusses what sexual harassment is, how to recognize it in the workplace, how it affects individuals and organizations, and what actions to take in response to it. This information will help employees in any industry be better equipped to deal with sexual harassment. (.50)

Sexual Harassment for Supervisors

This course is designed to provide greater awareness of sexual harassment in the workplace, steps to take to prevent it, and methods to deal with it if it does occur. The course will focus on federal laws, liability issues, harassment policies, employee rights, supervisor responsibilities, and investigation procedures. The content in this course is applicable to supervisors in all settings. (1.00)



VISIT [PHYINS.COM/EDUCATION](https://phyins.com/education)
and search "harassment" to view the full series.

Human Trafficking: Identification and Assessment of Victims

Human trafficking is widespread, even within the United States. Victims come in all sexes, genders, nationalities, and ethnicities. This form of modern slavery includes domestic, industrial, and farm labor, but the majority of U.S. victims are unwilling participants in the sex trade. This module covers the information, tools, and resources your healthcare team needs to identify, assess, and treat victims of human trafficking. It also provides referral resources for legal and social services. (1.00)

Human Trafficking: Forced Labor

Human trafficking has been reported in countless industries, including construction, agriculture, hotels, restaurants, nail salons, and domestic servitude. Studies show that while they are still being victimized, many victims interact with medical professionals. This course discusses how to spot red flags, what to do if you suspect that someone is being trafficked, and how to better understand the complexities of human trafficking. By recognizing the signs and gently working with potential victims, you may be able to help get them to freedom. (1.00)



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to learn about the CME that is included with your Physicians Insurance policy at no additional cost.

Employee Wellness: Stress Management

Stress is part of everyone's life. While a certain level of stress can motivate one's productivity, too much stress can leave a person feeling drained and irritable. Stress can't be avoided, but it's possible to learn to respond differently to it. This course discusses assessing your own stress levels, recognizing the difference between good and bad stress, identifying stress triggers, and developing a personal stress-management plan. (.25)

Employee Wellness: Side Effects of Care-giving

Caregiving demands a tremendous amount of compassion and empathy. While this can be incredibly rewarding, it can also cause some adverse side effects. This course discusses compassion fatigue—its signs and symptoms, how it can affect you and others, and practical methods of dealing with it. (.25)

Healthcare Worker Fatigue: Too Tired to Care?

Healthcare workers live with the reality that people need care beyond standard business hours. This course presents statistics and research concerning healthcare-worker fatigue, overnight work, and safety. Included is a discussion of how Boomers' retirement rates and the increase of Millennials in nursing might affect the workforce, how much or little fatigue it takes to impair one's thinking, and whether consistent nighttime hours affect workers the same as consistent daytime hours. This course will prepare you to support, equip, and protect night-shift and on-call heroes who work while others rest. (1.00)

Federation of State Physician Health Programs

fsphp.org

This national nonprofit exists to support physician health programs in improving the overall wellbeing of medical professionals. Visit their website to learn more about your state program, or contact your state's program directly:

ALASKA:

Physician Health Committee of Alaska
907-561-9644 | phcak@alaska.net

IDAHO:

Physician Recovery Network
(208) 323-9555 | tina@southworthassociates.net

OREGON:

Integrated Behavioral Health-Oregon
(888) 802-2843 | monitoring@ibhsolutions.com

WASHINGTON:

Washington Physicians Health Program
(800) 552-7236 | admin@wphp.org

Building a Multicultural Care Environment

This course examines factors that may contribute to the underutilization of healthcare services, as well as ways to improve cultural understanding and competency in healthcare treatment. More specifically, the course covers the significance of cultural diversity, demographics, and individual and cultural diversity factors. The information in this training proposes some helpful conceptual frameworks for embracing cultural considerations in healthcare. (1.25)

Individual and Organizational Approaches to Multicultural Care

This course presents an overview of multicultural care and service delivery. You will be guided through the national standards in the United States for working with individuals from diverse backgrounds and cultures, along with key concepts that relate to your role in the alleviation of health disparities. Examples of individual and organizational applications of multicultural care will help you apply these concepts in your own setting. You will learn about ways that you and your organization can improve quality of care by considering health literacy, cultural responsiveness, and structural disparities. (1.25)

Cultural Responsiveness in Clinical Practice

This training introduces you to several models to enhance your communication with individuals from a range of diverse backgrounds. You will also learn about cultural barriers to treatment, several health-belief systems, and factors to consider in a culturally responsive assessment. It is worth noting that culture is always at play, regardless of the healthcare provider's capacity to recognize and/or respond to it appropriately. (1.50)

Cultural Competence

This introductory overview of cultural diversity will help enable you to interact with others of diverse cultures and effectively perform your job responsibilities. (.50)

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 healthcare professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.

UNNECESSARY HERNIA SURGERY

SPECIALTY: General Surgery

ALLEGATION: A male patient had been diagnosed with a hernia and underwent surgery in 2014. The surgery itself was uneventful, and the surgeon noted, "No obvious hernia defect" but significant weakness to the inguinal floor, which the surgeon addressed with placement of a mesh patch.

The patient developed significant pain from what turned out to be an entrapped nerve. After several months of conservative treatment, the patient underwent a right-groin exploration with neurolysis of the ilioinguinal and iliohypogastric nerves, as well as mesh removal. This provided some, but not complete, relief of the patient's debilitating pain. By the time of trial, the patient was again able to work; but he claimed he still had constant pain that affected his ability to work at peak capacity.

Plaintiff argued that the surgery was unnecessary and that a diagnostic ultrasound should have been performed before deciding to go to surgery.

PLAINTIFF ATTORNEY: David Williams (Bellevue, WA)

PLAINTIFF EXPERT: Daniel Tseng, MD, General Surgery (Portland, OR)

DEFENSE ATTORNEY: Colin Kearns (Seattle, WA)

DEFENSE EXPERT: Kelly Clinch, MD, General Surgery (Kirkland, WA)

RESULT: Defense Verdict, King County

FAILURE TO TIMELY DIAGNOSE PULMONARY EMBOLISM, RESULTING IN DEATH

SPECIALTY: Internal Medicine

ALLEGATION: It was alleged that the provider had negligently prescribed narcotics, benzodiazepines, and methadone for chronic pain and fibromyalgia, after the patient had transferred care from another provider who had initiated these prescriptions. The provider obtained prior records, adjusted the medications, referred the patient to a pain-management specialist, noted that the patient was seeing a psychiatrist, and referred the patient for imaging. The plaintiff alleged that the medications made the patient less ambulatory and this inactivity caused the DVT/PE, resulting in the patient's death.

PLAINTIFF ATTORNEY: Carl Lopez, Lopez & Fantel (Seattle, WA)

PLAINTIFF EXPERT: Paul Brown, MD, Internal Medicine (New Hope, PA)

DEFENSE ATTORNEYS: Steve Lamberson and Jeff Galloway, Etter McMahon (Spokane, WA)

DEFENSE EXPERTS: Greg Ledgerwood, MD, Family Practice (Brewster, WA), Dermot Fitzgibbon, MD, Pain Management (Seattle, WA), Tim Chestnutt, MD, Pulmonology (Spokane, WA)

RESULT: Defense Verdict, Private Trial

FAILURE TO DIAGNOSE EPIDURAL ABSCESS, RESULTING IN PARALYSIS

SPECIALTY: Emergency Medicine

ALLEGATION: In August 2015, a 46-year-old single female with a history of homelessness and chronic intravenous drug use presented to the Emergency Department with right flank/back pain that she reported had been ongoing for three days and was atraumatic. The patient had previously been seen at, and promptly discharged from, another facility for back pain six days prior.

On this date the patient denied use of drugs, although she later admitted she had used heroin shortly before presenting to the hospital. The emergency physician



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performed a physical exam, a neurologic exam, and lab work. There were no motor or sensory deficits noted. The lab results were effectively normal, with a somewhat elevated white-blood-cell count. In an effort to identify a cause of the patient's back pain, a CT scan was ordered. The patient had been given morphine to address her pain. She then told a nurse that she required additional medication in order to complete a CT scan, and additional morphine was ordered. When the nurse returned to administer the additional morphine, the patient appeared to be sleeping. The nurse opted not to give the additional morphine to an already sedate patient and updated the provider. The emergency physician looked in on the patient and also saw her sleeping or resting quietly. When the patient was taken to Radiology, she refused the CT exam, stating that her pain was muscular. She was taken back to the Emergency Department, where the provider talked with her about the fact that he was unable to reach a diagnosis for her pain and it could be a very serious, life-threatening condition. He indicated that he wanted her to get a CT scan. She again refused. She left the Emergency Department, ambulating on her own.

The patient returned to her apartment, where she obtained additional intravenous drugs. The next morning she was found on the ground at a bus stop and a passerby called paramedics. When they arrived, the patient refused their assistance. She got up and sat on a bench on her own power, then apparently returned to her apartment. Later that afternoon, she was taken to a hospital by ambulance with significant motor dysfunction of both lower extremities. A CT scan was obtained but did not reveal any concerning findings. An MRI showed an epidural abscess from T7 to T11, and the patient underwent urgent surgery.

PLAINTIFF ATTORNEY: Carl Lopez, Lopez & Fantel (Seattle, WA)

PLAINTIFF EXPERT: Patrick Tibbles, MD, Emergency Medicine (Las Vegas, NV)

DEFENSE ATTORNEYS: Chris Anderson and Rachel Bench, Fain Anderson VanDerhoef (Seattle, WA)

DEFENSE EXPERT: Fred Abrahamian, MD, Emergency Medicine/Infectious Disease (Los Angeles, CA)

RESULT: Defense Verdict, King County

(Medicare Fee Schedule, continued from page 19)

is \$42.23, while each add-on code (up to two) pays \$37.89. Thus, total reimbursement for an hour or more of non-complex CCM services is \$118.01.

CMS is making one minor revision to the list of items typically included in the required comprehensive care plan, replacing “community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/ coordinated, identify the individuals responsible for each intervention” with this language: “interaction and coordination with outside resources and practitioners and providers.”

CMS is also revising the care-planning element for complex CCM (CPT 99487 and 99489). CMS will now interpret the code descriptor “establishment or substantial revision of a comprehensive care plan” to mean that a comprehensive care plan is established, implemented, revised, or monitored.

For detailed information on CCM reimbursement rules, view PYA’s white paper, *Providing and Billing Medicare for Chronic Care Management*, at phyins.com/pya-ccm.

PRINCIPAL CARE MANAGEMENT (PCM)

Effective January 1, CMS will reimburse for PCM furnished to beneficiaries with a single chronic condition. The following table identifies the key differences between CCM and PCM services.

Concerned about paying for duplicative services, CMS includes two additional requirements for PCM: (1) the practitioner billing for PCM must document in the patient’s record ongoing communication and care coordination between all practitioners furnishing care to the beneficiary; and (2) the practitioner cannot bill for interprofessional consultations or other care-management services (excluding remote patient monitoring for the same beneficiary for the same time period as PCM).

As with CCM, CMS will reimburse for PCM services furnished directly by a physician or non-physician practitioner (as opposed to clinical staff under general supervision) under HCPCS code G2064. Payment will be \$78.68 for 30 minutes, or more for care-management services.

Finally, CMS declined to create an add-on code to reimburse for time spent beyond 30 minutes per month providing PCM. The agency noted that it will monitor PCM utilization to determine whether such additional reimbursement is warranted.

REMOTE PATIENT MONITORING (RPM)

Similar to non-complex CCM billed under CPT 99490, RPM billed under CPT 99457 requires 20 minutes of clinical staff time per calendar month reviewing and taking action based on data reported through RPM, including interactive communication with the patient or caregiver. CMS has previously required the billing practitioner to provide direct

	Chronic Care Management	Principal Care Management
Base CPT/HCPCS Code	99490	G2065
Total RVU/Payment	1.17/\$42.22	1.10/\$39.70
Time Requirement (services furnished by clinical staff under general supervision)	20 minutes/month	30 minutes/month
Number of Chronic Conditions	2 or more	1
Billing Practitioner (most cases)	Primary-care provider	Specialist
Scope of Service	Manage total patient care	Manage disease-specific care
Likely Trigger	General need for care coordination, communication	Exacerbation of condition or hospitalization
Intended Length of Time	Longer-term, as needed	Shorter-term, until condition is stabilized

Note: These summaries are not strict service requirements, but rather provide a brief synopsis of the intended use of the codes based on various readings of CMS regulatory guidance and other materials.




supervision (i.e., in-person) for clinical staff furnishing RPM services. Effective January 1, CMS will permit these services to be performed under general supervision.

Also, CMS has created an RPM add-on code, CPT 99458, similar to the non-complex CCM add-on code. Effective January 1, 2020, a practitioner can bill CPT 99457 for the first 20 minutes of clinical staff time spent performing RPM activities, and CPT 99458 for the second and third 20-minute increments. Payment for CPT 99457 is \$51.63, while each add-on code (up to two) pays \$42.23. Thus, total reimbursement for an hour or more of RPM services is \$136.09. (Unlike non-complex CCM, CMS did not explicitly state only two units of CPT 99458 can be billed each calendar month. This limitation, however, is implicit in CMS's discussion regarding the RPM codes.)

CMS noted that “[s]everal commenters expressed concerns about the ambiguity of the code descriptors for the RPM codes.” The agency responded that it “appreciate[s] the many questions raised by commenters about the set of RPM codes and understand[s] the frustration commenters expressed with the current code descriptors. Therefore, given the numerous questions raised by commenters, [CMS] plan[s] to consider these and other questions related to RPM in future rulemaking.”

For detailed information on RPM reimbursement rules, view PYA's white paper, *Providing and Billing Medicare for Remote Patient Monitoring*, at <https://bit.ly/2uuTs5X>.

If you would like more information about the Final Rule and reimbursement for care management, or would like assistance with any matter involving strategy and integration,

compliance, or valuation, contact one of our PYA executives, Martie Ross or Lori Foley, at (800) 270-9629. 

PYA helps clients navigate the complex challenges related to regulatory compliance, mergers and acquisitions, governance, business valuations and fair-market-value assessments, and more. For more information, please visit www.pyapc.com.

Sources:



Martie Ross, Office Managing Principal, Kansas City, PYA



Lori Foley, Office Managing Principal, Atlanta, Managing Principal of Compliance Services, PYA



(Hidden in Plain View, continued from page 25)

- The emergency-medicine physician nonetheless could have put stroke on the differential, given the patient's altered mental status and syncope. Had he done so, it would have led to more testing by the hospitalist. The radiologist, too, might have made a different interpretation or recommended further imaging.
- The radiologist might have identified what the neurologist saw when he took another look at the head CT—a left hyperdense middle cerebral artery (MCA), which is an early sign of stroke.
- The hospitalist might have conducted an independent assessment of the patient separate and apart from the emergency physician, and begun tPA as a result.

COULD HAVE, SHOULD HAVE, WOULD HAVE

- Everyone involved in this case agrees that the stroke team should

have been called in to rule out the biggest risk first.

- The emergency physician wishes he had ordered a CT with contrast, a better choice when stroke is a possibility.
- The emergency physician is still smarting from the allegation that he didn't take the patient's symptoms seriously because she is female. A simulated jury contended that he wouldn't have so quickly made a diagnosis of conversion disorder, had the patient been male.
- Rear-view reads are the bane of radiology, and even a neuro-radiologist acknowledged that the left hyperdense MCA would have been easy to overlook. Still, the miss was recognized when pointed out to members of the simulated jury.

UPGRADE YOUR STROKE GAME

Of the nearly 800,000 new stroke diagnoses each year in the U.S.,

nearly 10% are misdiagnosed at first presentation.¹ Not only is acute stroke being missed, but diagnosis of transient ischemic attack (TIA) is frequently overlooked. Patients who have had a TIA are at greatest risk of going on to have a more serious stroke, even if the symptoms disappear. Commit to brushing up on your stroke education, beginning with the basics:

- Stroke comes in camouflage. The classic symptom of one-sided weakness that physicians associate with stroke can lead them to discount stroke in the absence of hemiparesis. The misdiagnosis rate can be as high as 35% when symptoms are ambiguous. To highlight the ambiguity, dizziness and vertigo are the symptoms most tightly linked to missed stroke. Whereas not many things cause weakness on one side of the body, the causes of dizziness or vertigo are numerous enough to warrant moving stroke to the top of your differential.²

- The three main stroke syndromes that present without lateralizing weakness are isolated symptoms of dizziness, headache, and difficulty speaking. Blurry vision, eye-movement abnormalities, and confusion may also present.
- Diagnostic imaging of stroke includes multimodal techniques such as noninvasive angiography and perfusion imaging. In the early stages, both CT and MRI imaging can be inconclusive.³ Can you choose the appropriate imaging study to order for suspected intracranial hemorrhage and suspected ischemic stroke? Can you conduct the appropriate examination for suspected TIA?

DON'T BE THROWN BY DEMOGRAPHIC FACTORS

- Not surprisingly, delayed diagnosis disproportionately affects those under age 50, women, and minorities.
- Risks rise as patients age, but when young patients get strokes, they are more likely to have complications.

UPGRADE YOUR HANDOFF PROTOCOL

- Handoff communication is especially critical when you have no prior relationship with the patient. Imagine how subsequent care might have improved in this case if the concern about stroke had been clearly communicated to the emergency-medicine team. Imagine how the radiologist would have viewed the case if suspicion of stroke had been relayed with the imaging order.
- Simulation is an ideal way to raise competence and confidence in your hospital or clinic. No high-tech equipment is required to simulate communication among the providers involved in emergency care. Use a department meeting to advocate for cross-department simulation training.

Of the nearly 800,000 new stroke diagnoses each year in the U.S., nearly 10% are misdiagnosed at first presentation.


- With simulation, you can practice SBAR communication (Situation, Background info, Assessment, Recommendation) to get everyone on the same page.
- The I-PASS system may be better suited to the time-critical ED setting, because it encourages shared reasoning that could expedite care. The steps involved are:
 - Illness severity
 - Patient summary
 - Action list
 - Situation awareness and contingency planning
 - Synthesis by the receiver
- In several studies, handoff-related errors decreased after I-PASS implementation.⁴ Here, too, simulation drills can strengthen the team by giving them the opportunity to work through weak points in the system.
- Regardless of the communication system, make sure it allows for each treating provider to ask questions.

DON'T BE THROWN BY ANOTHER PROVIDER'S INITIAL ASSESSMENT

- High-functioning systems allow for independent judgment. A questioning attitude can benefit your patient when you're reviewing prior assessments presented during handoffs.
- Consider the hospitalist in this case who accepted the diagnosis of conversion disorder. The patient's history of altered mental status and syncope could have triggered a request for further testing.

SHARPEN YOUR DIAGNOSTIC THINKING

Improving diagnosis is recognized by the National Academy of Medicine as a public-health priority. Diagnostic and communication skills can be bolstered through case-specific live or online courses, by reviewing root-cause analyses of adverse events, and by studying the cognitive process involved in optimal medical decision-making. Your immersion in medicine can provide you with constant practice.

While the pressure to get it right every time is unrelenting, the people and systems that support getting it right also support you, so take advantage of those resources. Even in those cases when your one chance to get it right ends up being wrong, your patients will be more likely to see you as their strongest advocate. 

References

- ¹ <https://www.cdc.gov/stroke/facts.htm>
- ² Tehrani, A., Kattah, J., Kerber, K. et al. "Diagnosing Stroke in Acute Dizziness and Vertigo." *Stroke*. 2018; 49:788–795.
- ³ Sanossian, N. "Utilization of Emergent Neuroimaging for Thrombolysis-eligible Stroke Patients." June 14, 2016. Retrieved from <https://doi.org/10.1111/jon.12369>
- ⁴ Ransom, B. and Winters, K. "The I-PASS Mnemonic and the Occurrence of Handoff-related Errors in Adult Acute Care Hospitals: A Systematic Review Protocol." *JBI Database of Systematic Reviews and Implementation Reports*. 2018; 16 1:20–26.

"It's so important to the community, the patients, and the staff that healthcare decisions be made by the people who live here. Someone outside shouldn't dictate that to us."

RYAN SMITH, CEO,
SOUTH PENINSULA HOSPITAL



FAST FACTS

CARE PROVIDERS: 23 active medical staff; 50+ ancillary

TOTAL STAFF: 465

BENEFICIARIES: 14,000

FOUNDED: 1956

MEMBER SINCE: 2017

(Member Spotlight, continued from page 29)

status is favorable reimbursement rates for Medicare services.

The program's requirements have been amended over the years and are always up for debate, so there is some risk to its future. "With the political nature of healthcare now, and dialogue at the national level about reimbursement cuts, there is some instability surrounding critical access status," Smith says, "but our geographic isolation is an advantage in this respect."

South Peninsula has the distinction of being one of the best critical access hospitals in the country. Over the last seven years, it has three times been named a Top 100 Critical Access Hospital, out of more than 1,300 critical access hospitals nationwide. These top 100 scored best on the iVantage Health Analytics' Hospital Strength Index, which incorporates 56


different performance metrics, including quality, outcomes, patient perspective, affordability, and efficiency. (iVantage Health Analytics recognizes exceptional performance among all eligible U.S. general acute-care hospitals, including all rural hospitals and the more than 1,300 designated critical access hospitals.) "This evaluation all goes back to us learning to provide better personalized healthcare," Smith says.

HOME BASE

Smith joined the hospital as its new CEO in August 2019. Originally from Ohio, he later lived in Oregon, Utah, and Wyoming, but Alaska kept calling him back, and has since become his home. Smith was previously CFO of South Peninsula from 1996 to 1998, and from 2006 to 2011 he served as CEO of Central Peninsula Hospital in Soldotna, Alaska, where he oversaw a \$50 million expansion. His most recent position

was as CEO of Memorial Hospital of Converse County in Douglas, Wyoming.

Smith is the third CEO of South Peninsula in less than two years, and one of his goals there is to create stability and consistency in leadership as the hospital confronts reimbursement challenges and capitalizes on growth opportunities in its primary-care and specialty surgical services.

For Smith, the draw to South Peninsula is not just the beautiful area, but also the chance to work at a locally controlled hospital. "There are fewer and fewer opportunities like this," he says. "And it's so important to the community, the patients, and the staff that healthcare decisions be made by the people who live here. Someone outside shouldn't dictate that to us." 

*(What Would You Do,
continued from page 7)*

appointments, language barriers, and the increasing demands of electronic medical records can get in the way of sound decision-making, leading to potential moral and ethical blunders. “Those are not the kind of conditions that thoughtful interactions and facilitate getting into that second mode of thinking,” says Tate. “This contributes to physician burnout, which in my mind is an ethical problem. All of the extra things physicians are being asked to do detract from their ability to think clearly about these issues, which is a moral problem.”

“From a moral perspective, not acting is acting.”

TYLER TATE, MD, ASSOCIATE
DIRECTOR OF THE CENTER FOR
ETHICS IN HEALTH CARE AT OREGON
HEALTH AND SCIENCE UNIVERSITY

When faced with a moral, ethical, or legal question, taking time for reflection is vital—and healthcare providers shouldn’t confuse thinking and deliberation with inaction, notes Tate. “From a moral perspective, not acting is acting,” he says. “Thinking is action, deliberation is action. It’s a movement, a stance, and a way of approaching a situation.”

CONSIDERATION 5: ARE YOUR POLICIES AND PROCEDURES IN ORDER?

Medical offices with clearly outlined policies and procedures will probably face fewer ethical and legal crises, notes Sconyers. “The most important thing providers can do is set up policies and procedures ahead of time and review them periodically, instead of responding to crises in the moment,” he says.



Without clear legal and ethical guidance outlined in writing, costly mistakes can consume precious time and resources. “There’s a lot of harm that could come to your patient or your practice, whether you breach HIPAA and get sued, or bill Medicare with false information,” says Tate. Consulting the office manual about how to handle patient misconduct, falsified insurance information, and other problems gives physicians and staff time to pause and reflect instead of acting immediately.

“When an ethical issue comes up, physicians can make things a lot easier for themselves if they can point to policies and procedures already in place,” says Sconyers. “There are good sample policies from the AMA or state medical associations on how to handle things like patient privacy, security of files, office records, and termination of employees.”

But even the most thorough set of procedures needs to be updated regularly, as laws and policies change. “With ethics, as with anything else, it’s hard to keep up,” notes Sconyers. “Almost all providers have access to ongoing education, and many organizations include ethical issues in their CME. The AMA produces a short article on an ethics topic every week.”

As for the question posed by Dr. Connelly’s dilemma, don’t be too quick to assign blame. “While nurse Kim was more suspicious and

inflammatory in her response to the patient, it’s difficult to assign moral wrongdoing in a case like this,” says Tate. “Everyone in the clinic was probably trying to do the best they could on a busy and stressful day. The problems highlighted here are also about the obstacles physicians face, in not having the time and space to think clearly.”

When providers reflect on each situation and access their own internal moral compass, they’ll be better equipped to manage the delicate balance between their legal, ethical, and moral responsibilities. “Of course, rules are important,” says Tate. “Yet we also cannot afford to be a slave to rules, policies, and procedures, as that can totally suffocate compassion.” [PR](#)

Sources:



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2020 PHYSICIANS INSURANCE

Annual Meeting
and Proxy Vote



The annual meeting of the members of Physicians Insurance A Mutual Company will be held on Monday, April 27, 2020, at 1 p.m. Pacific Time at 1301 Second Avenue, Suite 2700, Seattle, Washington. The purposes of this meeting are to amend the bylaws, elect directors, and act on any other matter coming before the meeting. Additional information on the vote is available on the company's website.

Visit www.phyins.com/proxy2020, to download your proxy and place your vote by close of business, Friday, April 24, 2020.

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