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IMPACT OF COVID-19

Lessons Through Uncertainty

While I was reading recently about the impact of COVID-19 on mental health, a quote jumped out at me: "How do you adjust to an ever-changing situation where the 'new normal' is indefinite uncertainty?"

Isn't that the truth? The disorder and confusion of COVID-19 have shaken us all, to be sure. But even in the midst of it, I'm grateful that the healthcare community has responded as it has during other health crises, large and small—by joining together to face the crisis head-on, and by advocating for health first. Throughout our nation, physicians have stepped up in exceptional ways in response to this pandemic, even as their practices suffered financial losses from steps taken to limit clinic capacity, conserve PPE, and stop the spread of a virus we knew little about.

Now, while there are signs of hope for a vaccine, we are not out of the woods as far as economic destruction is concerned. I can assure you, each state's medical association is working hard to secure adequate financial support from state and federal governments. We continue to work at the national and state levels to pass liability protections for physicians, particularly those forced to adapt and limit their practices to align with state proclamations.

Moving forward, we all must work to capitalize on telemedicine. COVID-19 pushed us to embrace this technology, as we joined policymakers in encouraging our patients to stay home and stay healthy. The proliferation of telemedicine has allowed patients during the pandemic to access primary-care services, medication and chronic-condition management, MAT for opioid-use disorders, and critical psychiatric and behavioral healthcare. And by advancing payment parity for virtual and audio-only visits, we have begun to address some of the health inequities that many patients face in accessing care.

At Physicians Insurance, at your state medical association, and within your own medical practice, we all know that a robust professional and practice environment is necessary to ensure that patients and communities have access to quality care when they need it. That's why, along with COVID-19 support, advancing strong physician leadership and advocacy that will shape medicine's future remains our key priority in this difficult time.

Physicians are no strangers to staying strong during times of crisis—or to navigating indefinite uncertainty. If COVID-19 has taught us anything, it's that we need to focus on being nimble, meeting our patients where they are, and ensuring access to care for all. These are lessons that will feel familiar, though more urgent than ever, to physicians everywhere.

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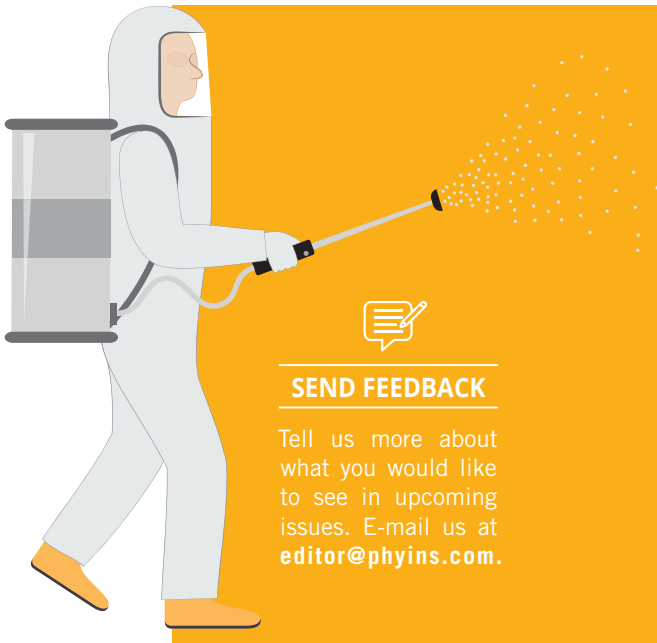

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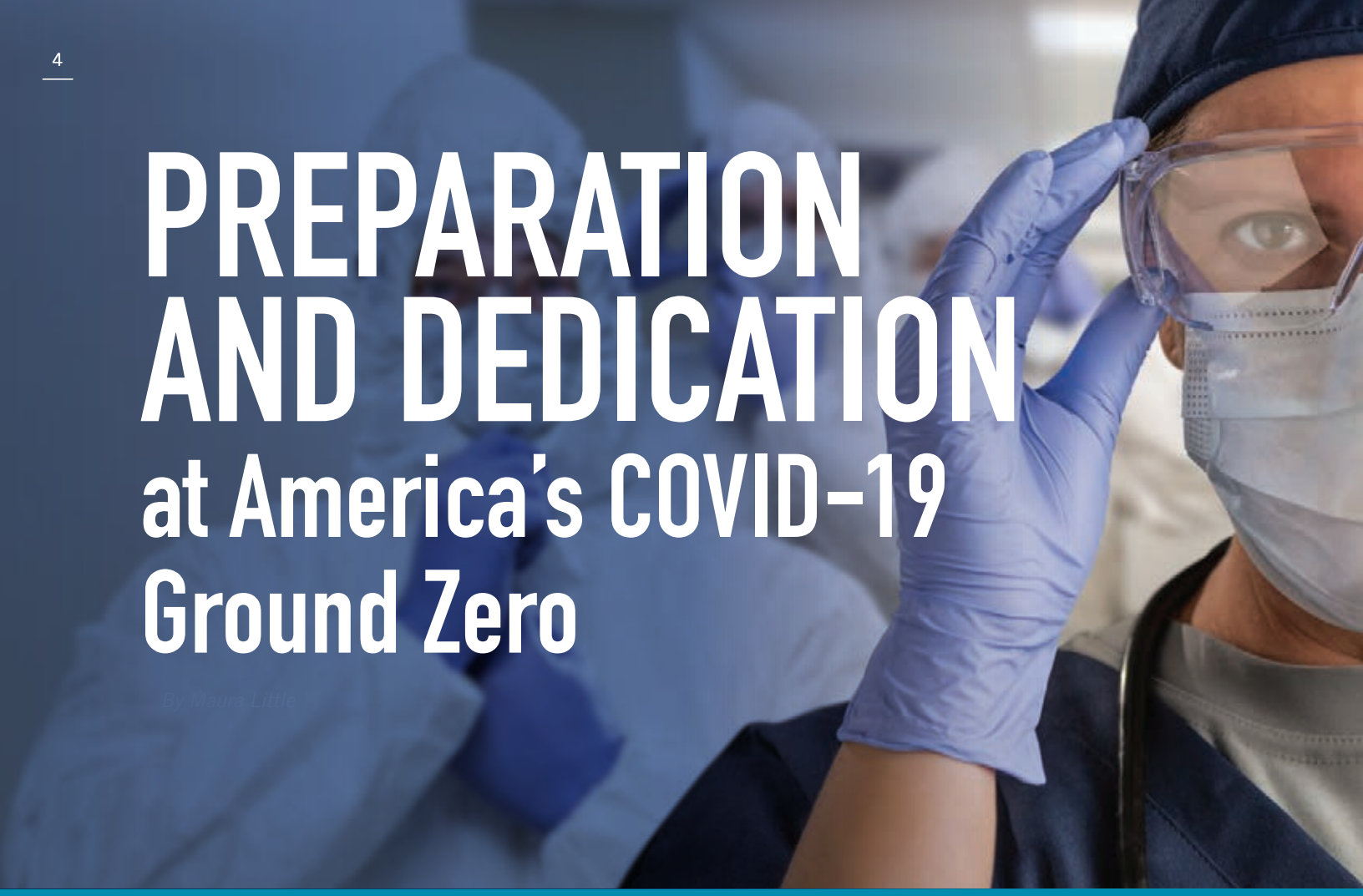


PREPARATION AND DEDICATION at America's COVID-19 Ground Zero

By Maura Little

How EvergreenHealth managed the first known coronavirus outbreak in the U.S.—and what they're doing now.

EvergreenHealth in Kirkland, Washington, found itself under the global spotlight this past February as they reported the first death from COVID-19 in the United States. Located near the Life Care Center of Kirkland long-term-care facility, EvergreenHealth treated dozens of Life Care patients in the first major coronavirus outbreak before the disease rippled across America and the globe.

Leading the EvergreenHealth response, along with his colleagues, was Dr. Ettore Palazzo, MD, Chief Medical and Quality Officer. His responsibilities have included overseeing clinical quality and safety, infection control, risk management, pharmacy and hospital medicine services, and medical staff services. We spoke with Dr. Palazzo to gain insight into how EvergreenHealth was prepared for the outbreak, the steps it took to keep patients, visitors, and staff safe, and ways in which the health system is determined not to be complacent as COVID-19 continues its course.

PREPARED AND PRESCIENT: A TASK FORCE READY TO GO

When the first two COVID-19 tests EvergreenHealth submitted to the Washington State lab came back positive on February 28, the results might have left other healthcare providers surprised and unprepared. But at the time, EvergreenHealth had been reviewing its relevant policies and procedures for several months. The hospital's High-Consequence Infectious Disease (HCID) Pathogen Committee, formed six years earlier during the Ebola outbreak, had revived its regular meetings beginning in the fall of 2019.

"Originally, the HCID Committee was formed to assess the policies and do some revisions, adjustments, and an accounting of what we needed in the organization, both from a PPE and a facilities standpoint," says Dr. Palazzo. "With the threat of Ebola in 2014, we looked at how patients potentially would enter the emergency room, how they would be isolated, what staff would treat them, and what areas of the hospital

"It became very clear, as the case counts rapidly increased and it went beyond just EvergreenHealth, that PPE supply could potentially be an issue."

DR. ETTORE PALAZZO, CHIEF MEDICAL AND QUALITY OFFICER, EVERGREENHEALTH

could be segregated off. The HCID Committee decided to go ahead and bring everyone together again, to start re-looking at those policies and expand beyond just things like Ebola to other respiratory-type pathogens. Just two months later, SARS-CoV-2 was discovered and announced in China in late December."

A QUICK PIVOT TO PREVENT HOSPITAL OUTBREAKS

The first two positive coronavirus test results came back to EvergreenHealth late in the evening on Friday, February 28. Immediately, the hospital activated a command structure outlined by the HCID team, which was based on the National Incident Management System devised by FEMA. Areas of the hospital were designated to move fully into negative airflow. But with more positive cases on the horizon, protecting the staff and patients at EvergreenHealth became a concern of state and federal officials.

"It became very clear, as the case counts rapidly increased and it went beyond just EvergreenHealth, that PPE supply could potentially be an issue," Dr. Palazzo continues. "The CDC were on-site here within the first three days. We also worked with our leaders, both at the state level and in Public Health Seattle King County, our local public health department. We discussed what made sense from a PPE-usage standpoint, with the understanding that we were moving from conventional into contingency phase. At the current burn rate, we could potentially run out of PPE."

During the early periods of the pandemic, scientists were working hard to determine the nature of SARS-CoV-2 transmission—in particular, whether the mode of transmission was airborne or via droplet mechanisms. Based on recommendations from the Washington Department of Health and WSHA (Washington State Hospital Association) in early March, EvergreenHealth adopted a "Special Contact/ Droplet Precautions" protocol for care of COVID-19 patients, with the use of N95 or higher respirators required when caring for any COVID-19 patient undergoing an aerosol-generating procedure.

Also, in the early days, universal masking was not recommended. That, too, soon changed. "We moved to an optional extended-use masking policy early on, because there was evidence that we could mitigate risk and enhance source control for potential employee-to-employee exposures," Dr. Palazzo recalls. This then transitioned

(Continued on page 6)

(Preparation and Dedication, continued from page 5)

to a strict universal-masking policy, requiring all employees, patients, and visitors to wear a mask. A team led by Dr. Francis Riedo, Medical Director of Infection Control and Prevention at EvergreenHealth, was instrumental in guiding all the divisions of the hospital in making these adjustments.

"It was a coordinated effort among all the divisions of the hospital to make sure that we were doing everything as safely as possible, both for our patients and our staff," Dr. Palazzo explains. "The Infection Control team was the hub of the wheel, working with all the departments to ensure that we were following all the surface-cleaning guidelines that were coming out, and implementing the necessary changes as the situation evolved and additional precautions were required."

FOUR KEYS TO PATIENT AND EMPLOYEE SAFETY

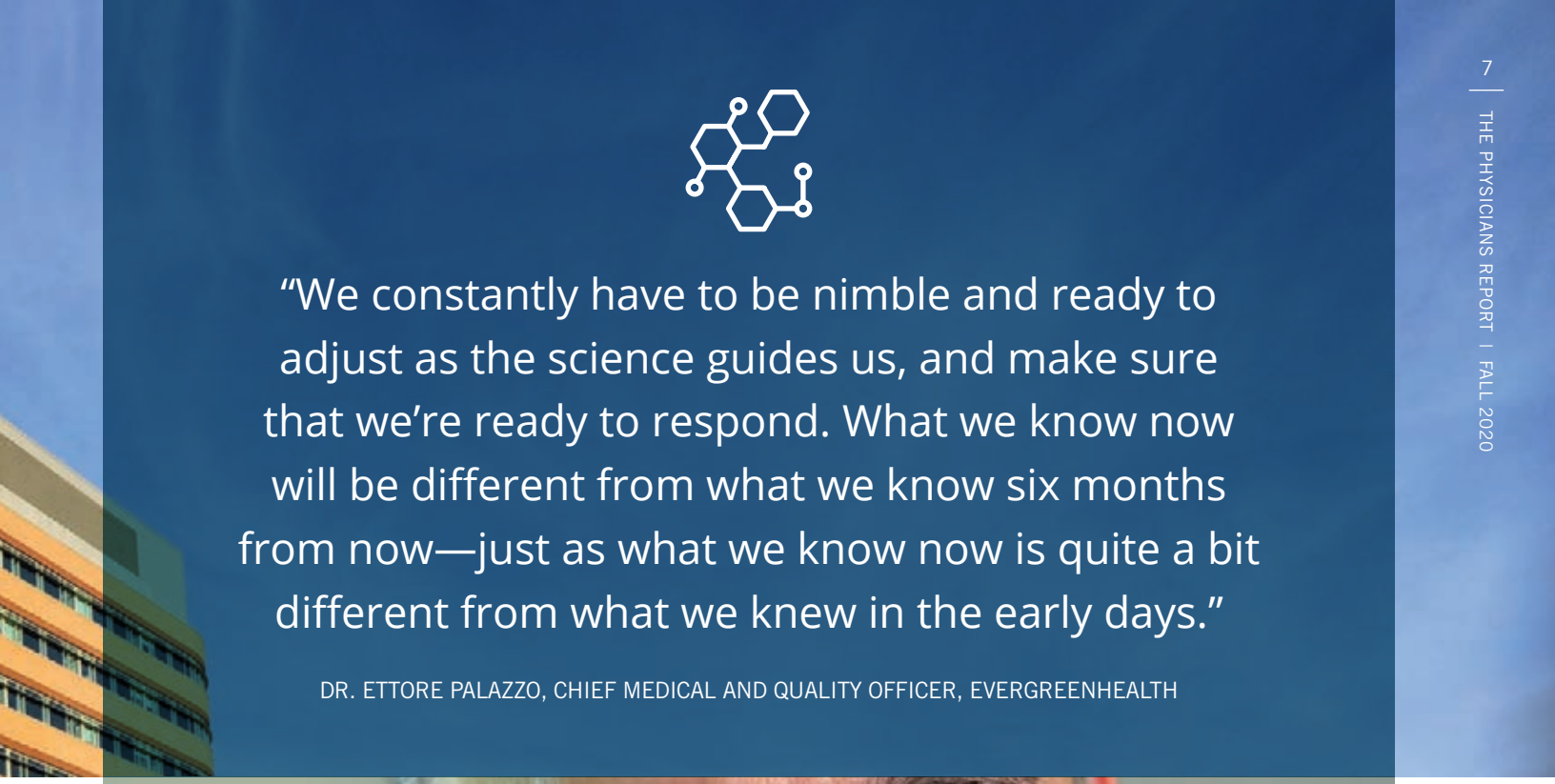
With the COVID-19 pandemic now headed into a second year, Dr. Palazzo and the team at EvergreenHealth have identified four key pillars to keeping staff and patients safe.

1. **Negative airflow and proper personal protective equipment**
   In dedicated areas of the hospital, creating negative airflow moves air out of the rooms and into the atmosphere, not into the central core. Following the recommendations of the CDC and state health departments to create the right PPE provision and negative-airflow environments also lowers risk for other patients in the area, as well as for employees.

2. **Source control**
   "Once we had clearly identified how to take care of patients and make sure the staff taking care of those patients were safe, how did we deal with the fact that this was now becoming a community-transmission issue?" asks Dr. Palazzo. "I could be at the grocery store, get exposed, and bring it with me to work or home. So source control became a big piece of that, which included universal masking here in the hospital. It became very, very important to reduce and really drop the risk of a healthcare worker–to–healthcare worker or employee-to-employee exposure that could happen, totally irrespective of you being in the hospital."

3. **Symptom screening**
   For all individuals entering the facility (patients, visitors, and staff), it is important to know if they are potential carriers of the virus. Asking patients about their travel history was standard from the onset of the epidemic, but once COVID-19 symptoms became readily identified, active symptom screening, including temperature monitoring and symptom checks for all individuals entering the facility, became standard. "For employees who screen positive, they do not work and COVID-19 testing is performed," says Dr. Palazzo. "And if you're a visitor and you screen positive, you're not allowed to enter the facility, and recommendations are made for you to be seen by your care provider."

4. **Social distancing**
   While it's become the norm in American public spaces and buildings, social distancing had to become a necessity in hospital settings as well. "Here in healthcare,



"We constantly have to be nimble and ready to adjust as the science guides us, and make sure that we're ready to respond. What we know now will be different from what we know six months from now—just as what we know now is quite a bit different from what we knew in the early days."

DR. ETTORE PALAZZO, CHIEF MEDICAL AND QUALITY OFFICER, EVERGREENHEALTH

we're so used to working shoulder-to-shoulder, getting handoffs about patients when we're rounding with one another," says Dr. Palazzo. "But it became clear that we needed to make sure that when we're having meetings in the hospital, or there are visitors queued up to come into the hospital or elsewhere in a clinic, procedures were implemented to keep our staff and visitors appropriately distanced, even with the masks in place, to minimize risk."

STAYING VIGILANT FOR THE FUTURE

Dr. Palazzo emphasizes the need to stay vigilant. "In the early days, I think it was really easy to make a case for all the interventions that we're now familiar with: the hand-washing, social distancing, making sure you're wearing your mask," he says. "Our biggest challenge now, I think, is making sure we don't become complacent. Our organization needs to continue to remain nimble as new recommendations come out, whether that's a new vaccine that becomes available to us, or how we're going to administer it to frontline staff and ultimately the community. PPE recommendations may change, based on how the science comes in. We constantly have to be nimble and ready to adjust as the science guides us, and make sure that we're ready to respond. What we know now will be different from what we know six months from now—just as what we know now is quite a bit different from what we knew in the early days."

Through it all, Dr. Palazzo remains pleased with the staff's agility at EvergreenHealth. "Our successes have really been related to our ability to adjust. Our culture enables us to do that. We need to remain that way so we're not waiting—otherwise, we'll suffer the consequences of not being able to implement change quickly." PR

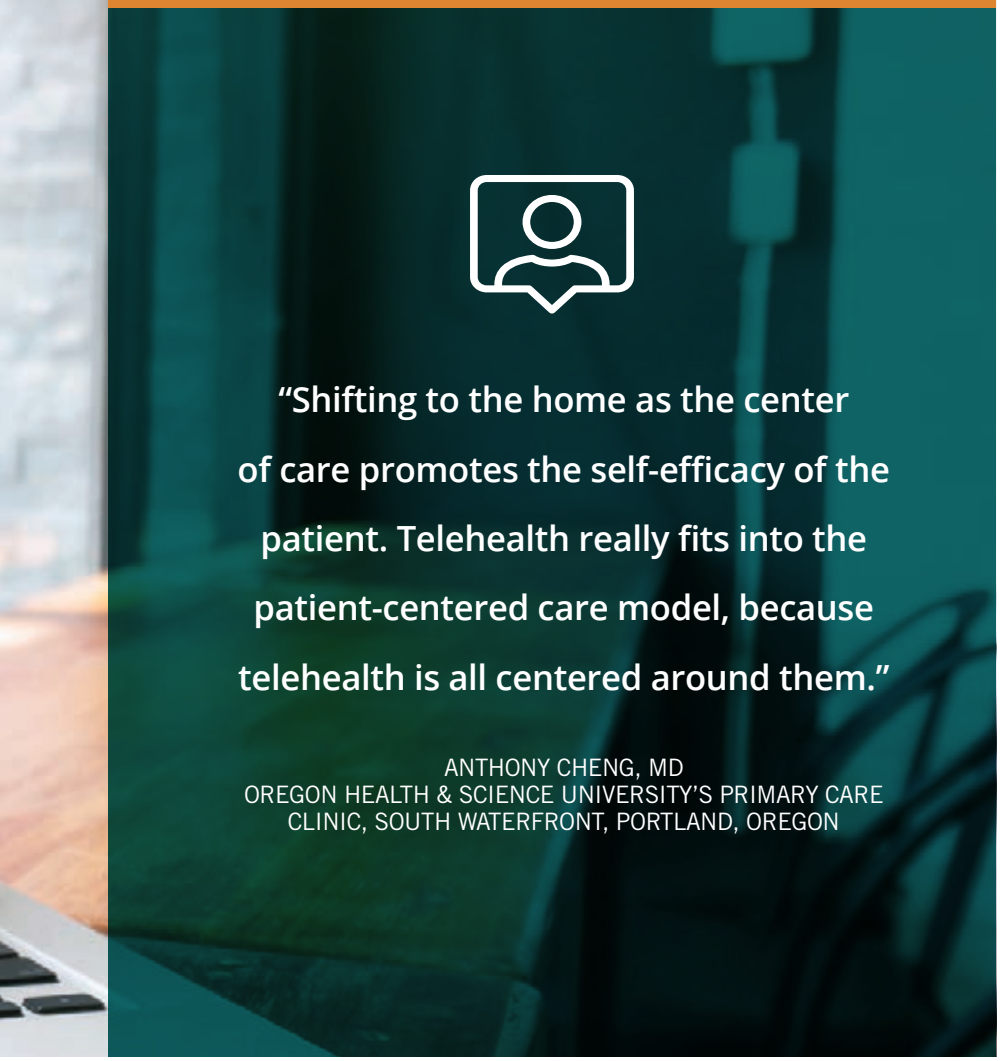
Ettore Palazzo, MD *is EvergreenHealth's Chief Medical and Quality Officer. He is responsible for EvergreenHealth's clinical quality and safety. Dr. Palazzo also oversees risk management, surgical services, the pharmacy, and medical staff services.*

A Few Words with a Telehealth Changemaker

While in rural Oregon during his residency in 2014, Dr. Anthony Cheng never guessed that he'd glimpse the future of how medicine would be delivered during a pandemic. But what he experienced during that formative time in his career intrigued him about the possibilities of telehealth.

Those possibilities have been coming to fruition—fast—during the coronavirus crisis, paving the way for lasting and beneficial changes to patient care.There are still big obstacles to the growth of telehealth, and it's certainly no panacea for every problem. But "we can do more with telehealth than we realize," Dr. Cheng says.

It was certainly more than he realized six years ago when he started working in a rural hospital emergency room. The nearest neurologist was two hours away, so the department used telehealth to care for stroke patients. That way, a specialist could help with emergency decision-making, which wouldn't have been possible without technology.



"Shifting to the home as the center of care promotes the self-efficacy of the patient. Telehealth really fits into the patient-centered care model, because telehealth is all centered around them."

ANTHONY CHENG, MD
OREGON HEALTH & SCIENCE UNIVERSITY'S PRIMARY CARE CLINIC, SOUTH WATERFRONT, PORTLAND, OREGON

More than 20% of people in Enterprise—the Eastern Oregon town where Dr. Cheng practiced—were 65 and older, so addressing end-of-life issues was a focus for the hospital. So Dr. Cheng created a telehealth program for palliative care to help patients at the end of life. "It proved to me that complex conversations can occur with videoconferencing," he says. "I had my doubts, but this, along with the medical complexity of acute stroke being managed with telehealth, helped convince me that we can do a lot of primary care this way."

And so, Dr. Cheng became an early proponent of telehealth and began pioneering its use. Since then, working with other colleagues, he's helped transform nine primary-care practices to offer meaningful telehealth options during COVID-19.

PATIENT-CENTERED CARE

Today, Dr. Cheng is a family physician at Oregon Health & Science University's Primary Care Clinic, South Waterfront, in Portland, Oregon. He is also an Assistant Professor of Family Medicine at OHSU's School of Medicine. He has a special interest in pediatrics and adolescent health, LGBTQ and transgender care, and medication-assisted treatment for opioid addiction. Pregnancy, mental health, and end-of-life care are also of particular interest to Dr. Cheng.

"I'm passionate about family medicine, because it's so personal," he says. "I want to know what makes a patient tick, so I can use this information to optimize their health."

One might think that treating patients over videoconference is less personal than in-person visits, but according to Dr. Cheng, it's an opportunity for the physician to enter the patient's personal space—a virtual house call—which can shift the doctor/patient dynamic in a positive way. Right off the bat, "seeing a patient's living situation can help with your decision-making," he says, because it provides insight into their circumstances and any health choices they might be making.

What's more, it creates a comfort level that is crucial for certain patients, such as those with anxiety or who are gender-nonconforming. For some, going to a doctor's office is scary because of past negative experiences, and talking with their doctor from home helps them communicate and absorb information better.

Then there's the convenience factor, which nearly all patients can appreciate. "Patients are less impatient waiting in their living room than in a doctor's waiting room," says Dr. Cheng. People with restrictive schedules—such as hourly workers and those caring for elderly parents and children—who may have difficulty accessing care in the office-space model, can also benefit from more widely available telehealth options.

It's also helpful for those with chronic diseases such as diabetes, who need frequent reassessments that can be burdensome. Providing these patients with medical-care kits at home and teaching them how to check their own vitals can be empowering and encourage them to be more engaged in improving their health.

"Shifting to the home as the center of care promotes the self-efficacy of the patient," Dr. Cheng says. "It helps patients and providers think about how care plans fit into a patient's life.

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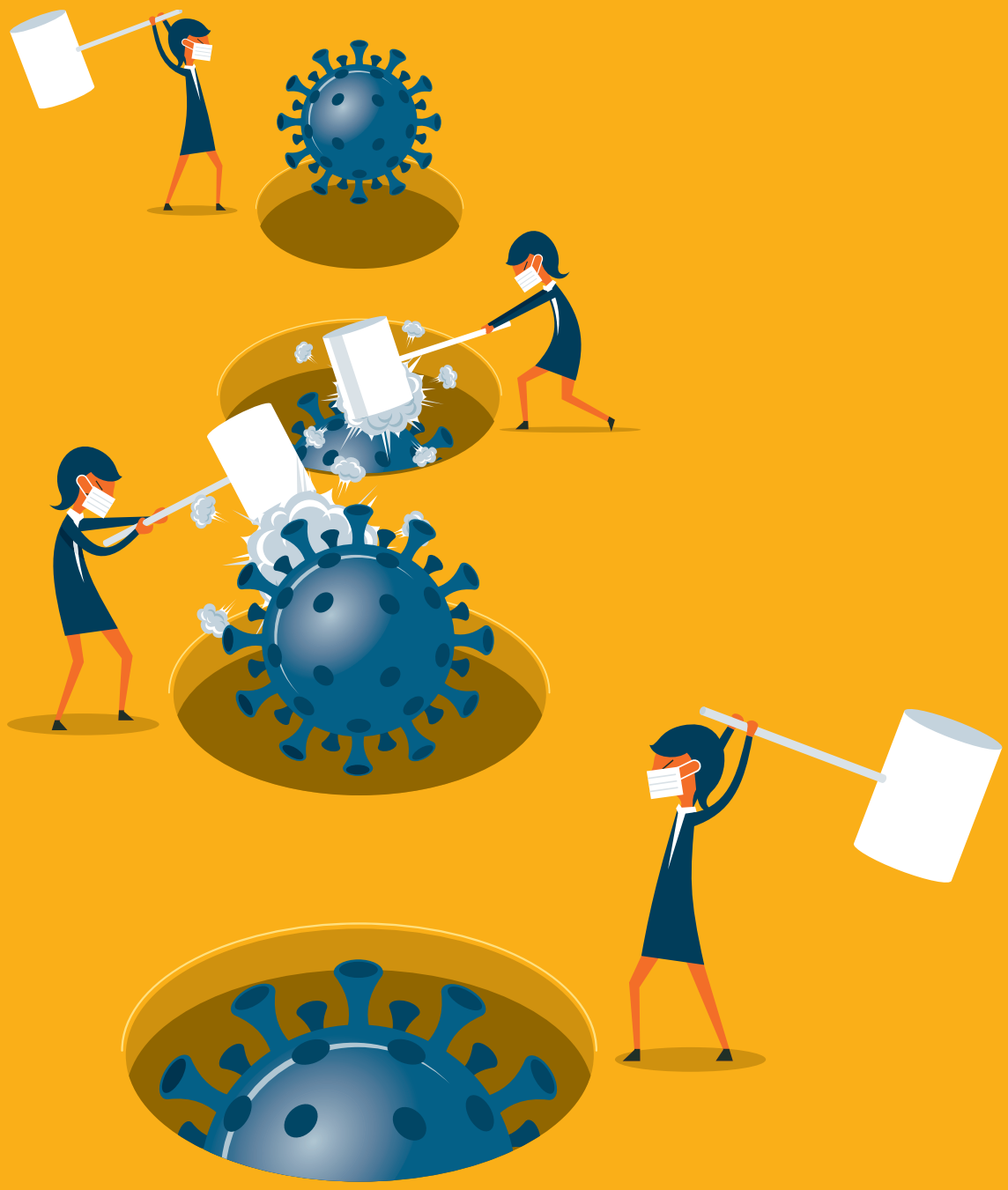

LEADERSHIP INSIGHTS 2020
Evolving with a Global Pandemic

Allegro Pediatrics—Brett Vandenberg, CMPE Chief Executive Officer

OF ALL THE SURPRISES THAT CAME ALONG WITH COVID-19, WAS THERE ANYTHING THAT STOOD OUT?

It was surprising that a health crisis became a business crisis for us, too. COVID-19 has had a huge impact on us from a business perspective. We ended up laying off 30% of our staff at the end of March, but have gradually brought back many. People in my personal life assumed, "You guys must be swamped," not realizing that—in the early days, because Washington responded quickly—we were not able to be open to see patients.

Remote learning also had a huge impact on our business—and in pediatrics, it was a double hit. We suddenly had employees with childcare concerns, because their kids weren't in school. Plus, we had far fewer visits from sick patients. I've joked, "What do you know—social distancing really works!"

IS THERE ANYTHING THAT HAS BEEN ESPECIALLY CHALLENGING?

I think the biggest challenge for us has been trying to create a level of certainty for future scheduling. When COVID-19 hit and we were shut down, we had to reschedule more than a thousand appointments almost overnight. We like to book as far out as we can, but it's hard to do when we're not certain if a visit will need to be virtual or in person, or which office it'll be in.

WHAT ARE YOU MOST PROUD OF, REGARDING YOUR CLINIC'S RESPONSE TO COVID-19?

I'm most proud that we maintained the ability to put our patients first. Rather than distracting us, COVID gave us renewed intensity in making patients our priority.

Also, within a two-week period and using internal resources, we trained every single physician in our practice on providing telehealth services. In April, we had 3,300 virtual appointments. That's trailing off now to about 2,000 a month.

WHAT WORKED WELL DURING COVID-19 THAT YOU'LL MAINTAIN AFTER IT SUBSIDES?

Telehealth was a big one. It has allowed a layer of flexibility that's provided a way for us to be more available to patients. Always refining our services, we're now working to balance the appropriateness of telehealth with the best practices in clinical care—in a time when providers aren't able to put hands on patients for an exam, we're focusing on some visit types that work well with telehealth. We also increased our use of technology to support pre-visit processes around paperwork and pre-screening. Patient acceptance of these online processes has increased.

We have renewed appreciation for the value of communicating with patients. This means connecting with them to prompt a wellness appointment or promoting our latest service, as well as in a general sense to keep them informed with what's happening in the community regarding healthcare.

We're also offering drive-though flu vaccinations this fall, which is good preparation for when a COVID vaccine becomes available for national rollout.

(Continued on page 12)

(Leadership Insights, continued from page 11)

HOW IS PROVIDER WELLNESS CHANGING DURING THE PANDEMIC?

We're very much concerned about provider wellness. When possible, we create flexibility to support wellness or seek solutions. What we're trying to solve for now is that, with our separation of clinics—some are devoted to wellness appointments, and some are devoted to sick patients—providers have a lack of variety in their day and the kind of patients they see, which impacts their job satisfaction.

WHAT WAS THE MOST IMPORTANT THING THAT YOU OR YOUR CLINIC LEARNED IN ADAPTING TO THE CIRCUMSTANCES CREATED BY COVID-19?

Communication and flexibility are, far and away, the things we have to maintain post-pandemic. They're what has allowed us to be resilient to the pressure and make quick decisions to move forward faster, on anything. For instance, when COVID-19 first appeared, we were planning around how to ramp up for it quickly. Then the next week, it was the opposite—we were shut down! We learned we had to be good at communicating and confident in our decisions, but also willing to change. The pace has now slowed, but COVID is still evolving, so we'll need to continue being flexible.

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Family Care Network Rodney Anderson, MD President and CEO

WHAT WAS THE MOST IMPORTANT THING THAT YOU OR YOUR CLINIC LEARNED IN ADAPTING TO THE CIRCUMSTANCES CREATED BY COVID-19?

During the early stages of the pandemic, when the situation was fluid and rapidly changing, we learned the importance of frequent, effective communication throughout the organization. It was not enough to simply create a new strategic approach; we had to immediately implement it and get that information to all our providers, employees, and often our patients in real time. Our team did an excellent job at this.

After the first few months, we learned the importance of pacing ourselves for the marathon that this pandemic has become. We've put a lot of energy and thought into how we can support our physicians, APPs, and employees to ensure they feel appreciated and are taking care of themselves through these challenging times.

WHAT ARE YOU MOST PROUD OF, REGARDING YOUR CLINIC'S RESPONSE TO COVID-19?

I'm extremely proud of how rapidly Family Care Network adapted to keep our patients and employees safe while still providing outstanding care. It is hard to describe how immense the changes were initially, on almost a daily basis, in literally every aspect of delivering care—telemedicine, car visits, changes in our waiting rooms, billing and EMR changes, staff working from home…the list goes on. I watched an amazing group of people draw on everything they had in order to ensure our patients could turn to us throughout the crisis. This was, and is, driven by a deep sense of obligation to our patients, our communities, and each other. As challenging as COVID-19 has been, it has been equally inspiring to see our group rally in response.

OF ALL THE SURPRISES THAT CAME ALONG WITH COVID-19, WAS THERE ANYTHING THAT STOOD OUT?

What stands out to me is how exhausting the pandemic is! COVID-19 impacts nearly every aspect of our professional and personal lives. That means we have massive professional change and uncertainty, paired with massive personal change and uncertainty. The result is that employees, including our physicians, are dealing with COVID-19 all day, every day. This constant presence can affect our patience, creativity, and professionalism. Figuring out new and effective ways to combat "COVID fatigue" will be a major ongoing challenge for us, for as long as this pandemic lasts.

WHAT WORKED WELL DURING COVID-19 THAT YOU'LL MAINTAIN AFTER IT SUBSIDES?

I expect the move toward telemedicine and the adoption of other technology to support care will persist even after COVID-19. In many ways, these new technologies have allowed patients to take a more proactive approach in how, when, and where they access care, which has been a positive change overall.

IS THERE ANYTHING YOU'D DO DIFFERENTLY, OR ANY LESSONS LEARNED?

In hindsight, it would have been helpful to think about this pandemic as a marathon right from day one. We went into full sprint mode at the beginning, and that initial pace was not sustainable. While FCN has done a decent job transitioning from sprint to marathon mode, it would have been helpful to start thinking about that in the very early stages.

IS THERE ANYTHING YOU HOPE THE MEDICAL COMMUNITY HAS GAINED, LEARNED, OR BENEFITED FROM, REGARDING THE CHALLENGE OF COVID-19?

I hope we've learned to be more nimble and adaptable in meeting patient needs—from what a typical office visit looks like to how care is funded. I hope we are more willing to adopt technology to improve access and reduce costs without sacrificing quality. I also hope different healthcare entities are willing to collaborate more closely to meet the needs of the communities we jointly serve. PR

"In hindsight, it would have been helpful to think about this pandemic as a marathon right from day one. We went into full sprint mode at the beginning, and that initial pace was not sustainable."

RODNEY ANDERSON, MD,
PRESIDENT AND CEO,
FAMILY CARE NETWORK

7 Steps to Successfully Adopting Telehealth Services

By Anthony Cheng, MD; Heather Angier, PhD, MPH; Miles Ellenby, MD; and Jen DeVoe, MD, DPhil

Before the novel coronavirus (COVID-19), telehealth adoption in ambulatory care was inconsistent.[1] Now, many clinicians have been dumped in at the telehealth deep end—and it's sink or swim.[2,3] Without the ability to provide healthcare for payment, primary-care clinicians unable to offer video visits are vulnerable to financial collapse.[4–7] And in the post-pandemic future, those without video visits will likely remain vulnerable, as telehealth has become an essential modality of care.[8] In the words of Seema Verma, "I think the genie's out of the bottle on this one."[9]

Here, we outline seven steps for successful telehealth adoption, drawn from our experience transforming nine primary-care practices (see Table 1).

1. Prepare yourself

Understand your feelings, thoughts, and knowledge gaps; educate yourself; and acquire the skills necessary for success. While in-person care is the gold standard, it is neither appropriate nor necessary in all situations in order to provide safe and effective high-quality care.

2. Prepare patients—see the digital divide

Telehealth is new to most patients, and some research suggests that increased adoption will exacerbate health inequities.[10–14] Overall, one in four Americans may not have digital-literacy skills or access to internet-enabled digital devices to engage in telemedicine visits.[15] Factors that disadvantage certain populations can be addressed with education and training for patients, and by connecting patients to free or reduced-cost broadband services through governmental digital-inclusion response efforts.[16,17]

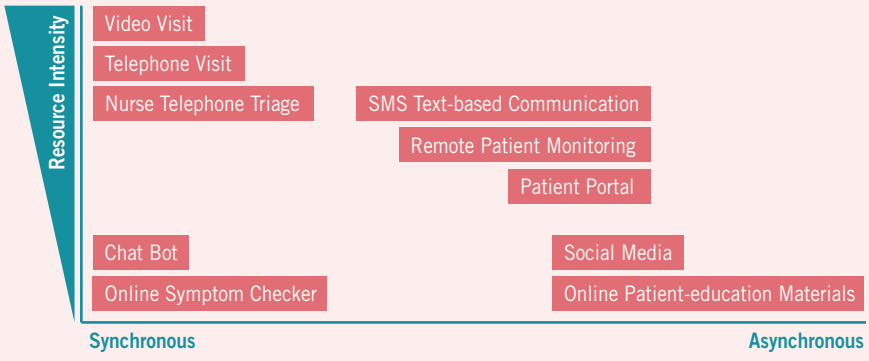
It is also important to offer phone visits as an alternative and ensure that interpreter services are available. Another digital-inclusion strategy is to reach out to patients to prepare them for telemedicine visits. We utilize a "virtual visit concierge" model, which initiates multiple outreach attempts before each visit to help prepare patients.

3. Acquire the appropriate tools and technology

There are many platforms available for video visits. When selecting one, consider reliability, ease of use, stability

Figure 1. Modalities of Telehealth and Digital Health

Patients can be engaged in many ways on a spectrum of provider- to patient-driven care, delivered through synchronous and asynchronous means. A challenge is to match the appropriate method of care to the patient's needs; this will be the focus of ongoing research.



on all types of devices (smartphone, tablets, and laptop/desktop computers), and responsiveness of the vendor to technical-support inquiries.

Complement video visits with other digital-health strategies. Telephone visits and nurse telephone triage are other forms of synchronous patient communication. We also utilize patient portals and text-based encounters to allow asynchronous communication and expand access. Remote patient-monitoring tools can further expand the scope of care; see Figure 1.

4. Prepare your team

Revised workflows can prepare you for successful telemedicine visits. We created workflows and scripting for all teams; it is important to map the standard work for scheduling, patient preparation, patient check-in, and follow-up around video visits.

Recognize that your team may have their own barriers to technology adoption, and consider appointing a digital health navigator to be a resource for patients and staff. The navigator should be available to patients and providers for consultations and problem-solving, to help implement patient-outreach strategies, to participate in quality-improvement efforts, and to monitor metrics such as equity in access, patient experience, and provider experience.

5. Have a good visit

Clinical decision-making and establishing rapport are foundational to a good healthcare visit. Clinical decision-making through telemedicine care is limited by the inability to conduct a physical exam, but there are workarounds and new opportunities available. Physical distancing need not result in social distance or the disruption of continuity of care, a fundamental tenet of primary care.[18, 19]

To inform clinical decision-making, use telehealth services to obtain patient-reported vitals, conduct a patient-directed exam (e.g., direct the patient to palpate their own abdomen), augment the exam with peripherals (e.g., tele-stethoscope information), obtain data from wearable monitors, direct the patient to adjust camera angles to better visualize pathologies, and/or have a friend or family member present at the visit (a.k.a. a "tele-presenter") to assist with any of the above. Patient-reported vitals in particular are valid for clinical decision-making and are accepted for Medicare Wellness Visits.[20]

Incorporate the new opportunities to enhance care that telehealth makes possible. Look at a patient's collection of medications, assess their living situation, interview friends and family who may not normally attend visits, and follow up frequently.

Techniques for building rapport are transferrable to video visits and are likely already a part of your practice.[21] Briefly, these techniques include preparing with intention, listening intently and completely, agreeing on what matters most, connecting with the patient's story, and exploring emotional cues. Skills specific to video visits include making eye contact by looking at the camera and selecting appropriate lighting, backgrounds, and settings to ensure visual clarity and patient privacy.

6. Assess outcomes and adapt

Consider convening a team with representation from front-desk staff, medical assistants, back-office staff, patients, and providers to assess professional, organizational, and quality metrics such as provider satisfaction, productivity, throughput time, staff effort level, and completion of healthcare-maintenance activities like depression screenings. We created a digital health dashboard to drive our improvement work in this regard.

(Continued on page 35)

HOW COVID-19 IMPACTS YOUR HR CONSIDERATIONS

Q&A with Our HR Hero BLR Expert Celeste Duke

WHAT ARE THE BIGGEST CHALLENGES EMPLOYERS HAVE FACED IN BRINGING THEIR EMPLOYEES BACK INTO THE WORKPLACE?

As employers bring their employees back to the workplace, they're facing a dual challenge: new legal issues, and employees who are experiencing increasing anxiety and burnout.

On the legal front, employers are facing new COVID-19-related laws on the federal and state levels. Most notably, the federal Families First Coronavirus Response Act (FFCRA) offers certain employees both emergency family leave and paid emergency sick leave, and states have enacted laws that expand unemployment insurance, leave laws, and liability protections. In addition to understanding and properly implementing these new laws, employers must figure out how they work with longstanding laws like the federal Family and Medical Leave Act, as well as any applicable state laws; and any employers bringing back employees from layoffs must ensure that's done in a way that doesn't violate discrimination laws.

On top of that legal headache, many of the employees returning to the workplace are now feeling stressed and anxious like never before. Stresses of the pandemic include worries about layoffs and other job losses, health concerns, isolation and loneliness, childcare and schooling difficulties, and living with the uncertainty of how long it will last and what will happen next. Add to that a particularly contentious political climate, where elements of the pandemic have been politicized, and tensions are running high in many workplaces.

WHAT ARE THE ELEMENTS THAT KEEP A WORKPLACE SAFE AND HEALTHY IN THE ERA OF COVID-19?

It's important to address two aspects here: physical health and mental health.

To keep employees healthy and reduce COVID-19's spread in your workplace, employees who are or may be sick must stay home. To ensure that, health inquiries and exams (e.g., temperature checks) are needed—but employers must

ensure they aren't running afoul of the Americans with Disabilities Act when doing so, and must handle any documentation very carefully.

To try to ease employees' anxiety, some employers have offered increased mental-health resources and reminders about employee-assistance program (EAP) resources, as well as telehealth coverage for both mental and physical health. Another way employers can support positive mental health in the workplace is to be as flexible as possible in helping employees deal with the unusual personal challenges they're facing during the pandemic. If an employee has a child who must attend online school from 11 a.m. to 3 p.m. every day, is it possible to only schedule her for meetings outside of that timeframe? If an employee is caring for an immunocompromised person at home, is it possible to extend his work-at-home arrangement or find a space in the workplace where interactions with others are minimized and include safety precautions like masks, social distancing, and disinfection?

WHAT PITFALLS OR MISSTEPS SHOULD BE AVOIDED?

Many businesses are concerned that paid leave, implemented in accordance with the FFCRA and state laws, will incentivize abuse by employees who see it as an easy way to get out of work. But the reality is that paid leave protects your workforce, and employees should be encouraged to use it when applicable. Employees who don't have access to paid leave are more likely to come to work sick, leading to a much larger impact on business continuity.

With that in mind, frame leave requests in a positive light and create a corporate culture that encourages individuals to take care of their own health, so all members of the workforce are kept safe. Also, if you choose to perform COVID-19 viral tests, temperature checks, or other symptom screening at your workplace, both the Equal Employment Opportunity Commission and OSHA make clear that these processes must be conducted on a nondiscriminatory and nonretaliatory basis.

WHAT ARE THE LIABILITY AND LEGAL CONSIDERATIONS, ESPECIALLY IN ENVIRONMENTS WHERE EMPLOYEES INTERFACE WITH THE GENERAL PUBLIC?

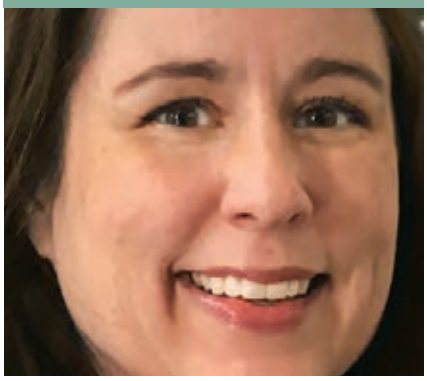
So far, the prevailing trends in coronavirus-related labor and employment litigation related to bringing employees back include WARN and mini-WARN Act litigation, wrongful termination, and discrimination claims. Now more than ever, employers should be examining employment decisions to be sure they are consistent with company policy and past practices, and that they're executed in a nondiscriminatory way.

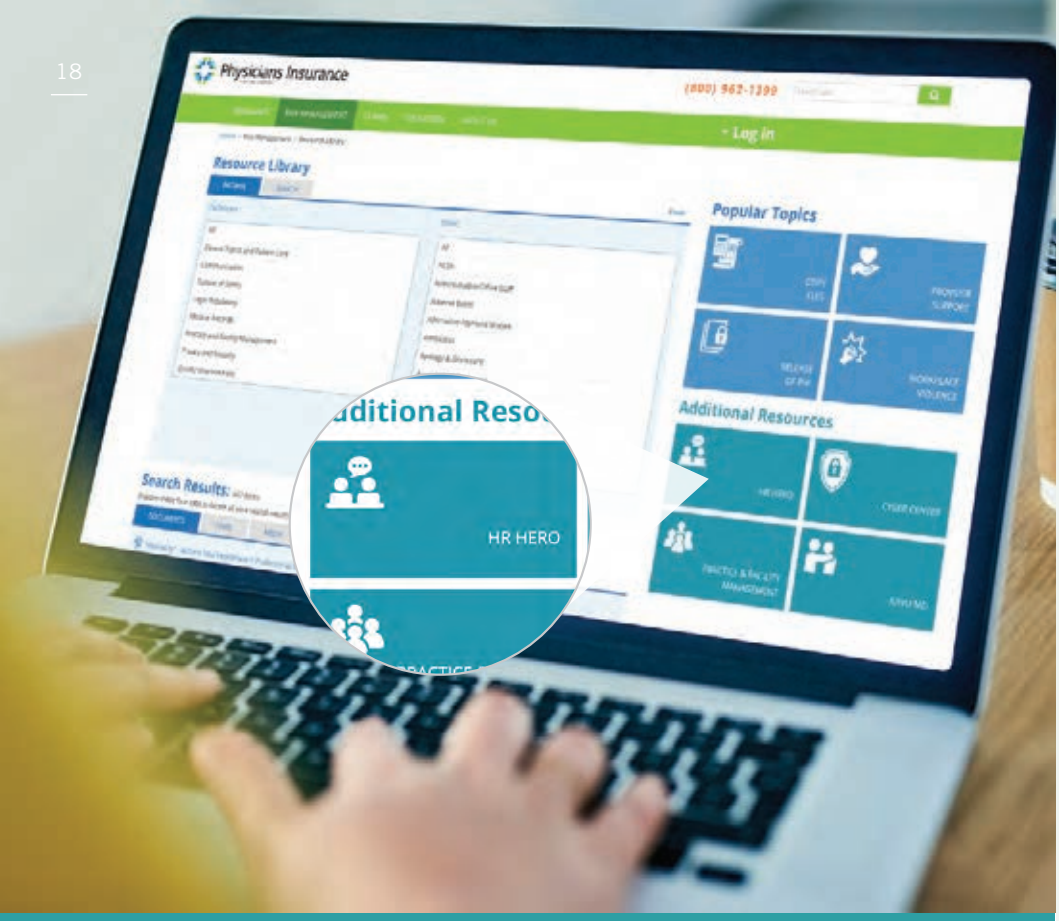
Liability issues are likely to focus on employees who got sick while at work. In apparently the first lawsuit of its kind, the attorneys for an Illinois retail worker who died of complications from COVID-19 recently blamed the death on the employer's failure to follow social-distancing guidelines. The lawsuit faulted the employer for allegedly not doing enough to clean and sterilize the workplace, not providing protective

(Continued on page 18)

"Another way employers can support positive mental health in the workplace is to be as flexible as possible in helping employees deal with the unusual personal challenges they're facing during the pandemic."

CELESTE DUKE, SPHR, HR HERO/BLR





RESOURCES FROM HR HERO AND BLR

EMPLOYERS' GUIDE TO COVID-19

Download PDF: https://bit.ly/2EuzTzD

This 80-page document is your first stop for COVID-19-related information. It is updated biweekly and explains employer obligations under the new FFCRA and CARES ACT, as well as established employment laws like the ADA, FMLA, OSH Act, and FLSA; it also includes a roundup of COVID-19-related guidance from OSHA, the EEOC, and DOL. Other topics include telecommuting programs, cybersecurity, minimizing the risk of liability, implementing a mask mandate, employees who are unwilling to return to work, creating and implementing a vaccine policy and protocol, and employer obligations to employees who are experiencing COVID-19-related childcare issues like daycare and school closures.

Visit the Resource Library at **phyins.com** to access the HR Hero portal and search resources, such as:

GUIDANCE MATERIALS:

- COVID-19 Addendum to State Termination Notices and Forms
- 11 Steps your Organization Can Take to Help Limit its Exposure to, and Disruption by, the Coronavirus

WEBINAR:

- Hiring Legally During the COVID-19 Pandemic

ARTICLES:

- "Changes to Unemployment Compensation by State Due to COVID-19"
- "Establish Better Norms to Succeed in the 'New Normal'"
- "States Enact, Amend and Clarify Paid Sick Leave Laws in Response to COVID-19"
- "3 Benefits You'll Need to Offer Post-Pandemic"

(HR Considerations, continued from page 17)

equipment for staff, and failing to provide adequate warnings. Accordingly, when fighting over whether injuries are compensable under workers'-comp schemes or through traditional lawsuits, litigators and courts alike are going to be asking questions like, "Did the employer follow state, federal, or health authorities' safety guidelines? Did they limit the number of guests in the store at a time? Did they make antibacterial soap or face masks available for staff?"

Many businesses have developed creative solutions to keep their doors open during the crisis. That same creativity should also be used to think about safety—not only around basic pandemic procedures, but also taking into account specialized guidance or concerns raised by industry and trade associations, unions and employee advocates, and employees themselves. Make sure employees are aware of any paid/unpaid sick time and personal-leave policies. Be flexible with work-from-home policies for employees who are sick or staying home to care for a sick family member. If possible, arrange for health screenings to ensure symptomatic people don't enter the workplace. For employees who must interface with the public, consider constructing physical barriers to protect workers and requiring both employees and customers to wear face masks. For some, face coverings have become a political symbol in the clash between those who see wearing them as a moral responsibility and those who view them as an infringement on their freedom. Consequently, employers who establish a face-covering policy can expect resistance, including the potential for aggression and violence—so before taking action, you should plan carefully, and prep employees on how to respond if a customer or coworker refuses to wear a mask. (PR)

> "Our standard of work needs to be centered on the margins. It's easier for us, and might be seen as more efficient, to plan for the majority in our population, but that approach leaves people out and could widen the health disparities that already exist."
>
> ANTHONY CHENG, MD, OREGON HEALTH & SCIENCE UNIVERSITY'S PRIMARY CARE CLINIC, SOUTH WATERFRONT, PORTLAND, OREGON

(Telehealth Changemaker, continued from page 9)

It shifts the ownership of their health to them. Telehealth really fits into the patient-centered care model, because telehealth is all centered around them."

INTERPERSONAL PITFALLS

There are limitations to a virtual visit too, though, so there's an inherently greater degree of uncertainty in diagnosis. Dr. Cheng makes sure to communicate that to the patient so they understand there is a potential for error, and he incorporates that into his decision-making. Sometimes a problem simply can't be diagnosed virtually, and the patient has to come in after all. But that doesn't mean the virtual visit was a waste of time, Dr. Cheng emphasizes. "It gives us a head start on resolving the complaint, and then the second visit can go deeper," he says.

One often-overlooked telehealth privacy issue that concerns Dr. Cheng is the doctor and patient settings. "Are both in a place where they truly have privacy and no one else can hear?" he says. "I worry about it more on the patient's end, especially with adolescents. Am I getting the whole story if the patient thinks a parent could overhear the conversation through a closed door?"

DIGITAL DIVIDE

Another problem area for telehealth is widening disparities in tech usage based on age, race, and income level. "There are knowledge gaps and access gaps," Dr. Cheng says, "but if needs are identified—and that may take time and multiple conversations—we can fill them if resources are built into workflows. We've got to normalize the challenges, because folks hesitate to share their difficulties with us."

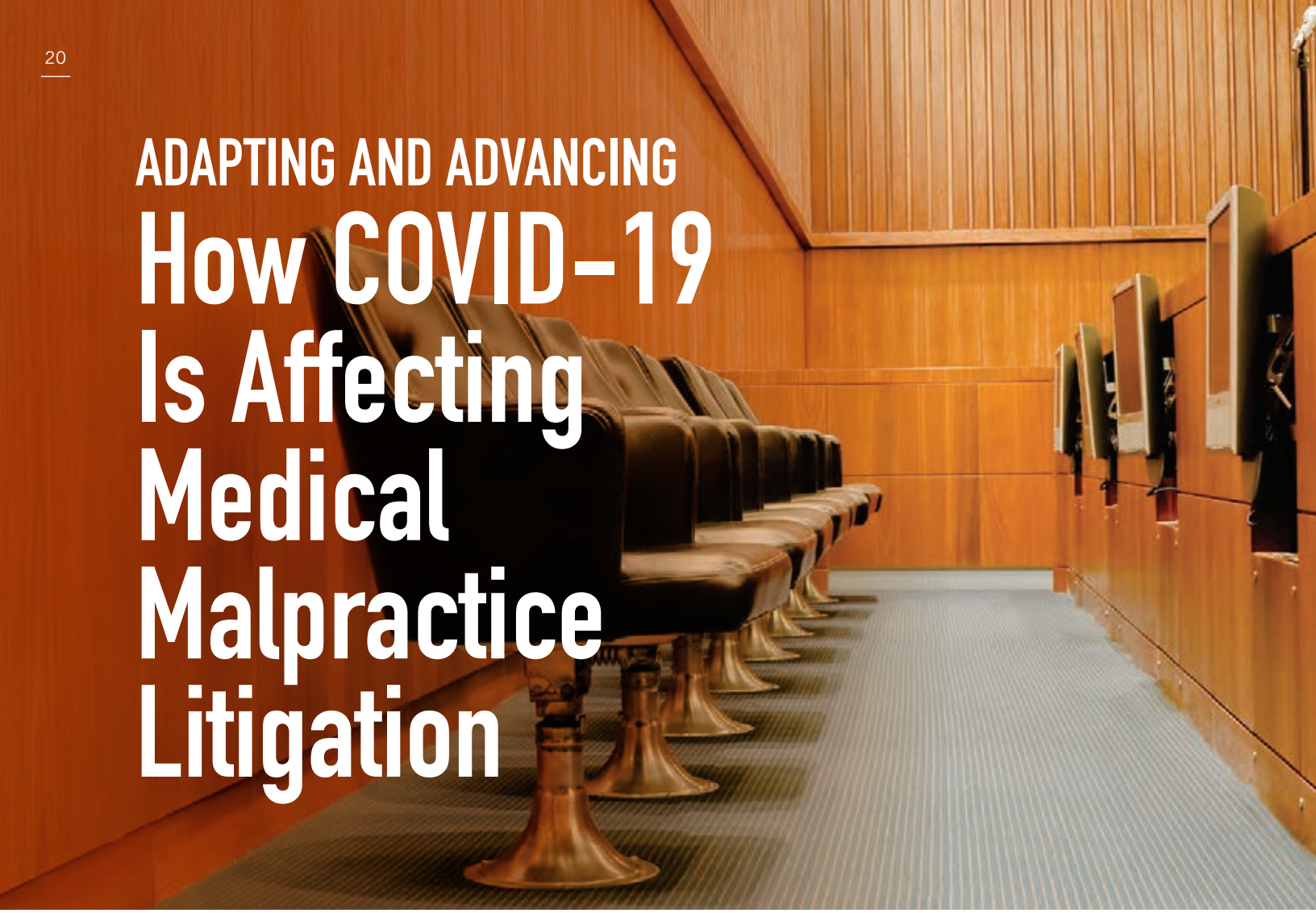
One harbinger for the digital divide in health finally being bridged, Dr. Cheng points out, is seeing how it's been done during the pandemic by schools. "It was so complicated to get technology to students during this crisis for home learning," he says. "But while challenges remain with online learning, the successes show it's possible to do the same in health and get technology to all patient populations."

In the broadest sense, we can't leave anyone out of the delivery system where telehealth is concerned. "Our standard of work needs to be centered on the margins," Dr. Cheng says. "It's easier for us, and might be seen as more efficient, to plan for the majority in our population, but that approach leaves people out and could widen the health disparities that already exist."

A PANDEMIC PUSH

Telehealth has existed in primary care for a very long time—in the form of nurse triage by phone, for example—but virtual visits weren't widely adopted until about five years ago, when Americans' use of digital devices like smartphones reached a critical threshold. It wasn't until the pandemic that many providers started using it, out of necessity.

(Continued on page 29)



ADAPTING AND ADVANCING

How COVID-19 Is Affecting Medical Malpractice Litigation

The world of legal process, including medical malpractice litigation, is not known for being particularly swift. Yet in the wake of COVID-19, medical malpractice professionals say the industry's reaction has been remarkably quick and thorough. Here, four experts in medical malpractice discuss how COVID-19 is shifting, shaping, and yes—even advancing the field.

EXPERTS

Noah Wick, National Director of Litigation Consulting, Trial Exhibits, Inc.

Amy Forbis, Attorney and Director, Bennett Bigelow & Leedom, P.S.

Nancy Pugh, Director of Litigation Management, Physicians Insurance

Jim Beatie, Litigation Claims Manager, Physicians Insurance

HAS COVID-19 AFFECTED MEDICAL MALPRACTICE CASES DIFFERENTLY THAN OTHER TYPES OF LITIGATION?

Medical malpractice clients and experts work in hospitals and sometimes with COVID patients, so we do need to be more mindful about health considerations. And that means doing more things remotely, with less face-to-face contact. *—Amy Forbis*

Our healthcare clientele is very savvy about safety requirements, so they recognize the need for us to make the changes to work and connect with them remotely. If we had clientele working outside of healthcare, [these changes] may have been more of a struggle. *—Nancy Pugh*

HOW ARE MEDICAL MALPRACTICE LEGAL DEFENSE TEAMS CREATING EFFICIENCIES DURING COVID-19?

If you'd asked me 10 years ago, very rarely would I have an expert witness testify remotely. With the adaptations in technology that we have now, we are able to take an expert deposition remotely, and it's been very effective. *—Amy Forbis*

The courts had several months of inactivity, so there is now a backlog in the court system, which may complicate getting cases into trial in the immediate future. To address this, we're looking at different alternatives to a 12-person jury trial, whether that's a private trial with a six-person jury or another solution. Our top priority is taking care of our insureds. We want to make sure they aren't waiting to get their cases resolved. *—Nancy Pugh*

We're seeing an increasing shift toward creating custom anatomical visuals and demonstratives in medical malpractice cases to help educate the jury and simplify the medicine. With the uptick in virtual remote testimony, expert witnesses need to practice making annotations to demonstratives online. To be more persuasive, expert witnesses need to be able to "show and tell" their opinions remotely, and practicing is key. *—Noah Wick*

"During virtual jury selection, we are observing prospective jurors becoming more revealing and candid when they are in their own homes than when they might be in a courtroom."

NOAH WICK, NATIONAL DIRECTOR OF LITIGATION CONSULTING, TRIAL EXHIBITS, INC.

WHAT SHOULD MEDICAL MALPRACTICE DEFENDANTS KNOW ABOUT HOW THEIR DEFENSE TEAMS ARE APPROACHING CASES NOW?

Whenever possible, we want to be present with our client for a deposition, sitting in the same room so that we can be a physical presence and comfort to them. Right now, it isn't always doable, in part because of travel restrictions. But we have seen that we really can do discovery and depositions remotely. We've had to embrace this new reality, and we're improving the process and seeing that it can be quite effective. *—Amy Forbis*

We have a culture of understanding that litigation is personal for our insureds, and even in the current environment, our clients are still able to connect with us and their attorneys. Instead of connecting in person, we're doing it on a screen, but it seems to be working well. *—Jim Beatie*

HOW ARE NEW PROTOCOLS FOR JURY SELECTION AND EVIDENCE REVIEW AFFECTING MEDICAL MALPRACTICE LITIGATION?

We're seeing more time in planning and preparation. Any medical exhibits we want to use need to be prepared so they can be presented to jurors on a remote platform, and using that technology takes more time. *—Amy Forbis*

Remote technology was occasionally used during the discovery portion of litigation or for remote witnesses at trial, but that has drastically changed since the pandemic. Now a few areas are even selecting jurors using Zoom, with breakout rooms. During virtual jury selection, we are observing prospective jurors becoming more revealing and candid when they are in their own homes than when they might be in a courtroom. *—Noah Wick*

WHAT OPPORTUNITIES ARE EMERGING FOR MEDICAL MALPRACTICE LEGAL DEFENSE TEAMS IN THIS NEW ENVIRONMENT?

The first time I presented a witness by video technology was in a courtroom in King County 10 years ago, and it was a huge deal. COVID-19 has increased access to the remote platforms and made it all more comfortable for us, and more comfortable and acceptable for jurors as well. With good technology, a good connection, and good audio, jurors can assess experts and credibility very effectively. *—Amy Forbis*

(Continued on page 34)

PANDEMIC-ERA PERSUASION

How COVID-19 Is Shifting Juror Sentiment

How will COVID-19 influence the way juries perceive medical malpractice defendants? Simply put, it's complicated.

According to new research about juror beliefs and attitudes related to the pandemic, it's a mistake to lean too heavily on the "halo effect"—a boost in general goodwill toward medical professionals during COVID-19—as a legal defense strategy.

COVID-related shifts in juror sentiment will be significant and enduring, and may surprise even those well-versed in medical malpractice defense, says Kevin Boully, PhD, a senior litigation consultant with Colorado-based litigation-consulting firm

Persuasion Strategies. "COVID-related medical malpractice is going to look different from conventional medical malpractice, because people are reacting differently to COVID, and the way that juror characteristics line up with COVID reactions are different," he says.

WHO WILL SERVE ON YOUR JURY?

As the public adapts to COVID-19's impact on their lives, the feelings and beliefs of the people comprising medical malpractice juries are changing. While those changes are still underway, some patterns are emerging, notes Boully.

First, defendants and healthcare organizations should understand that COVID-related changes in juror sentiment will vary widely by location. People's feelings about, and responses to, the pandemic vary greatly depending on their age, financial security, and political affiliation. "The differences that we are seeing are significant and meaningful," says Boully. "Expect very different challenges based on your situation. It's not just regional—it's city to city and county to county."

During the pandemic, prospective jurors experiencing financial hardship are less likely to attend jury duty, according to Persuasion Strategies surveys. These jurors are generally more concerned, sad, and anxious about the coronavirus, less trusting of the government, and more likely to have voted for Clinton in 2016.

Those living in metropolitan areas may be less likely to answer a jury summons. "We have seen a pretty strong, linear relationship with population density; people who live in more densely populated areas are much more likely to say they're not going to go to jury duty," says Boully.

As a result, medical malpractice juries may be more likely to be Trump voters, more likely to be unaffected by economic downturn, more likely to believe others generally act fairly, and more likely to trust that the government and corporations will respond appropriately to COVID-19.

"There is risk everywhere for all of us right now. Defendants can take advantage of the idea that nothing is guaranteed. That's a way that defendants can align with how people view life, and that is going to resonate more."

KEVIN BOULLY, PHD, SENIOR LITIGATION CONSULTANT PERSUASION STRATEGIES

STRATEGIES TO CONSIDER

Not surprisingly, the pandemic has produced a "halo effect" around healthcare providers that can benefit medical defendants—if they employ the right strategies. "Jurors love doctors right now, so how do we make the most of that?" says Boully.

Several months into the pandemic, jurors' trust in hospitals and healthcare providers remains high and appears stable. In a July 2020 survey conducted by Persuasion Strategies, jurors reported more trust in healthcare professionals and hospitals than in public-health officials, corporations, and local, state, and federal government.

By contrast, trust in government entities has decreased significantly during the pandemic, particularly for the federal government. In April, 49 percent of jurors said they distrusted the federal government to communicate truthfully with the public. By July, that figure had increased to 62 percent.

Along with high trust in hospitals and healthcare providers, research shows a shift toward social responsibility, says Boully. "Increasingly, people place higher importance on social responsibility; we saw an increase of seven to eight percent in the same sample of people since July of last year," he says. "There's an opportunity [for defendants] to demonstrate how their conduct is helping a greater number of people."

As the pandemic wears on, jurors may be less willing to award big verdicts to medical malpractice plaintiffs. "The financial fallout of the pandemic may affect Americans for years, and that will influence the willingness of jurors to award big verdicts," notes Boully.

A shift in juror attitudes around risk may also present an opportunity for medical malpractice defendants, says Boully. "We have been awakened to the idea that the future is truly uncertain and that we are all at risk if we get this disease," he says. "There is risk everywhere for all of us right now. Defendants can take advantage of the idea that nothing is guaranteed. That's a way that defendants can align with how people view life, and that is going to resonate more."

(Continued on page 33)

ANALYSIS

Provider Realignment Post-pandemic

By Brian Fuller, Principal, PYA, P.C. and Jordan Shields, Managing Director, Juniper Advisory

COVID-19 delivered a shock to the U.S. healthcare system that will change it forever.

The array of disruptions has been staggering, including:

- Non-essential procedure suspensions
- Global medical supply-chain disruptions
- Local, regional, and national equipment shortages
- Market-specific patient-volume surges
- An overnight switch to telehealth care delivery

As a result, the U.S. healthcare economy ground to a halt. It is important to understand how the effects of the shock—or rather, shocks—will impact what was already a changing healthcare-industry structure, and the potential implications for merger and acquisition activity in the provider sector.

EXAMINING SHOCKS: WHY COVID-19 IS SO DISRUPTIVE TO THE HEALTHCARE INDUSTRY

Shocks like these are not unusual in modern economies. But most often being driven by unforeseen, overlapping macroeconomic factors, they can reverberate globally, impacting multiple industries for varying durations. Conversely, they can be regional/national, and impact single industry sectors.

EXHIBIT 1: FOUR ECONOMIC SHOCKS RESULTING FROM COVID-19

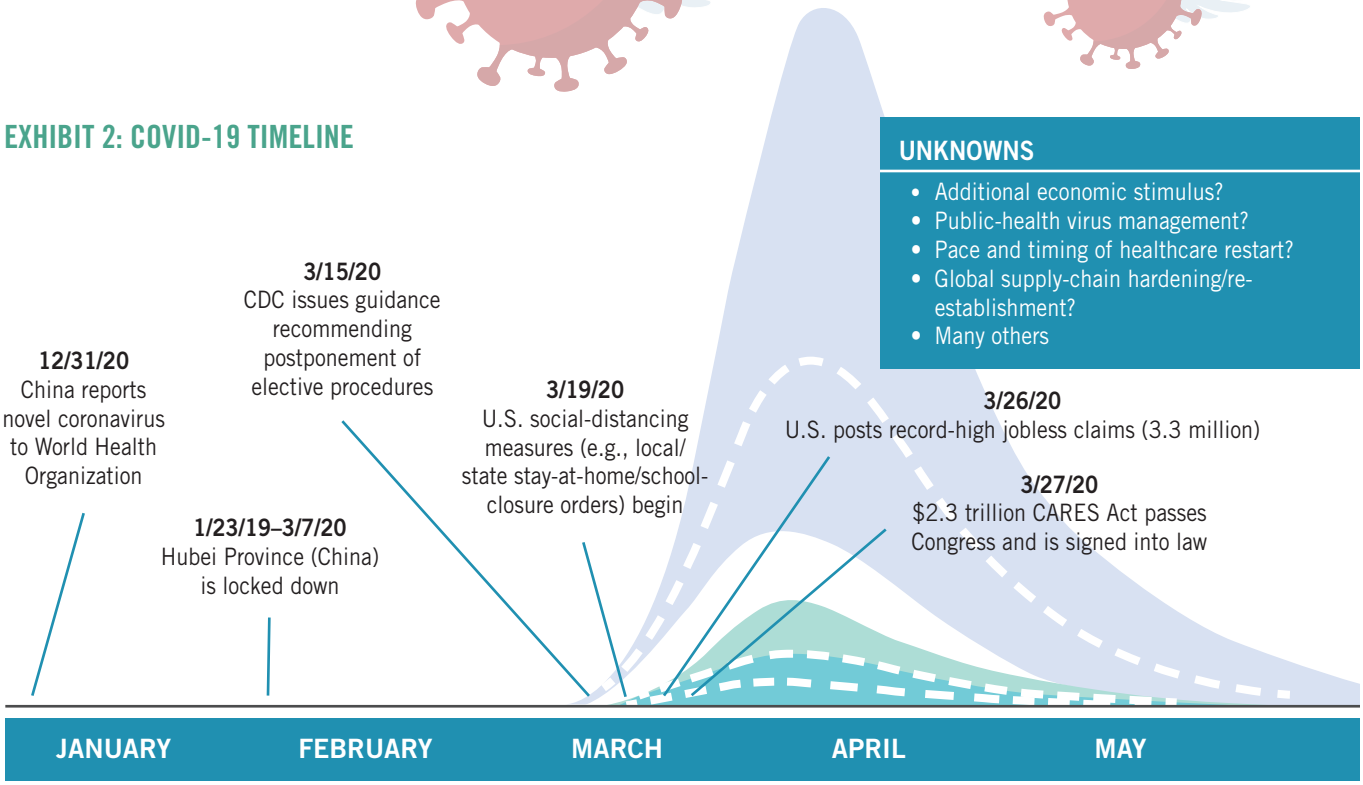
Type of Shock	Defining Characteristics	Historic Example	COVID-19 Example
Supply	Inputs becoming scarce and expensive Supply-chain disruption	OPEC oil embargo	PPE price spikes and scarcity
	Supply-chain disruption		Hot-spot clinical-staff shortages
Demand	Sudden drops in consumer or business spending	Great Depression	Elective-procedures suspension
			Fewer patients seeking care
Financial	Lack of liquidity; frozen credit markets	2008–2009 global financial crisis	50–70 percent revenue drops; resultant provider balance-sheet impairment and capital access challenges
	Falling financial-asset values		
Policy	Unforeseen governmental policy shifts	1997 Asian currency crisis	Shelter-in-place measures
	Often tied to central banks		CARES Act (and others)

As shown in Exhibit 1, the COVID-19 pandemic triggered four economic shocks (supply, demand, financial, and policy) and evolved over an abbreviated timeline, which intensified its impact (see Exhibit 2). The timeline indicates the predicted peak in cases and overlays the shocks and various events. At this point, the prospect of a quick recovery remains uncertain.

POST-PANDEMIC PROVIDER REALIGNMENT

The crisis has exposed the high "cost of fragmentation" within the healthcare industry and, we believe, will serve as the seminal event that ushers in an era of greater provider integration and concentration. We anticipate three phases in the industry's path forward:

EXHIBIT 2: COVID-19 TIMELINE



1. A turbulent restart will occupy the remainder of 2020, marked by initially sluggish M&A activity as at-risk providers seeking shelter are courted by cautious buyers assessing their positions and plotting strategies.

2. In the ensuing two years, a shake-out will occur, characterized by some of the surviving providers and hospitals—their risk tolerances battered—seeking safety and security. Strong regional systems, insurers, and private equity–backed disruptors will seize the opportunity and be hyperactive in pursuing scale during this phase.

3. In a final phase, the rise of the titans, national mega-systems, possessing regional market essentiality, may emerge to dwarf today's largest systems. These behemoths will compete directly with scaled, non-traditional, ambulatory-centric networks (e.g., integrated insurance companies) in a marketplace that no longer adheres to traditional delivery vs. financing distinctions. These organizations will vie to deliver on the promise of population health and achieve growth and stability through quality and efficiency.

HOSPITALS

Hospitals had already experienced a decade of disruptive change pre-pandemic. Post-pandemic circumstances will act as a catalyst to advance the most stubborn of the changes yet to be widely adopted, and will drastically accelerate the pace of many others.

Turbulent Restart/6–9 months	Industry Shake-Out/1–2 years	Rise of the Titans/3+ years
"Have vs. have not" phenomenon is exacerbated	Some, perhaps many, distressed sellers (especially rural ones) close, unable to find geographically proximate buyers	Declining governmental and commercial reimbursement
The financially distressed seek lifelines		Large systems leverage scale for clinical and operational advantage and aggressively move to assume insurance risk
Well-capitalized regional systems pursue opportunistic growth	Strong sellers seek partners with high quality and operational depth	
Turnaround-focused, private, for-profit operators enter aggressively	Regional systems aggressively seek scale-consolidation opportunities	A select few integrated national mega-systems (~$75B+ in net revenue) emerge
Publicly traded health systems pursue only the most attractive scale opportunities		

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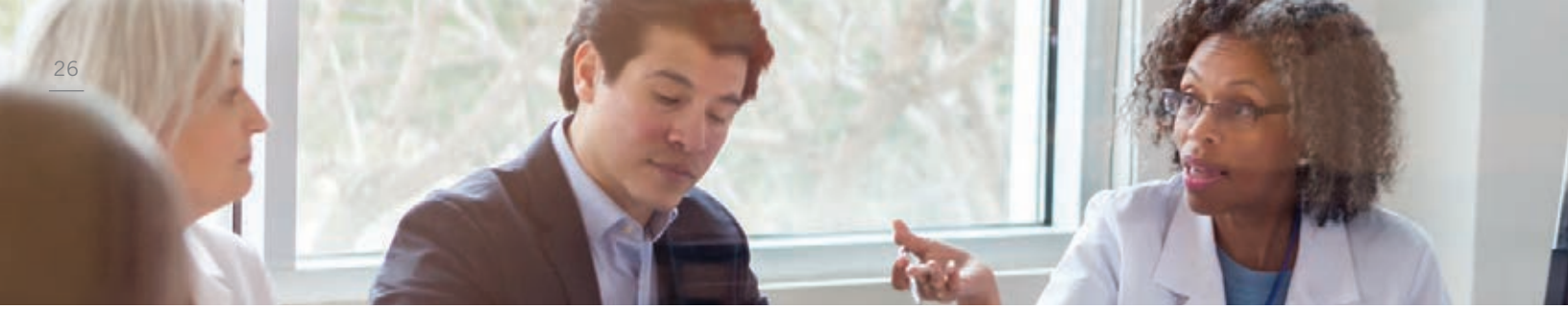

(Provider Realignment, continued from page 25)

PHYSICIANS

COVID-19 underscored the inherent risks in small independent and group practice amid economic crises. With a high fixed overhead and limited, if any, reserves or credit, some groups failed only days after elective procedures were suspended and well-care visits dried up.

Turbulent Restart/6–9 months	Industry Shake-Out/1–2 years	Rise of the Titans/3+ years
Practices reopen; pace of activity ramp-up is highly variable	Pre-crisis "physician land rush" escalates beyond previous levels	Over three-quarters of physicians are employed by large group practices, management companies, insurance companies, or hospitals
Hospitals and insurance companies that weathered the crisis with capital develop opportunistic physician-growth strategies	Fierce competition for physician services arises across health systems, insurers, and private-equity investors; primary-care and procedural subspecialists represent the hottest commodities	Private-equity investments shift from practice consolidation toward innovation to support operational and clinical efficiencies
Private equity remains active, but at lower multiples; some opportunities are lost to strategic buyers	The shift from facility-based providers to lower cost settings continues	Integrated physician enterprises lead health systems toward displacing acute care's traditional position at the center of the delivery industry

NON-ACUTE PROVIDERS (SENIOR LIVING, HOME HEALTH, BEHAVIORAL, OTHER)

Each non-acute sector has faced unique COVID-19 challenges, but their paths out of the pandemic will share similarities shaped by industry forces. Market consolidators will hedge against the cost of fragmentation by building comprehensive networks for well care, sick care, and recovery care, while private equity continues to consolidate holdings to eventually exit or, in rare and high-growth situations, take public.

Turbulent Restart/6–9 months	Industry Shake-Out/1–2 years	Rise of the Titans/3+ years
Post-acute sector is hit hard, given fewer hospital discharges	Divide between "have" and "have not" segments within sectors increases	Increasingly, integrated mega-systems and insurers add non-acute business lines and compete within these sectors
There is a relatively quiet rebuilding period as businesses stabilize	Sellers look first for buyers within their sub-industry, then to integrated systems and large insurers; troubled entities close	Large systems leverage scale for clinical and operational advantage and aggressively move to assume insurance risk
There is some activity among select investor-backed and healthy system buyers	The shift from facility-based providers to lower cost settings continues	A select few integrated national mega-systems (~$75B+ in net revenue) emerge

THE ROAD AHEAD

The COVID-19 crisis laid bare the fragility of U.S. healthcare. We paid a heavy price for fragmentation. Looking forward, boards and executive teams will need to take several actions to keep their organizations relevant and healthy:

1. Evaluate the degree to which local markets are integrating to compete on quality and efficiency

2. Identify COVID-19-era competitive differentiators, and re-visit strategic plans to incorporate

3. Identify partnerships and structures that will leverage differentiation and support the organization's long-term success

There will be no going back to the industry as it existed, only a going through to a stronger, more hardened, and—in some cases and geographies—a materially scaled healthcare system. Successfully approaching and navigating such an uncertain future will require healthcare leaders to ask a number of existential questions, including:

- Do we have the financial wherewithal to survive the crisis and a potentially slow recovery?
- Can we articulate a credible path to future practice or system growth?
- Can we continue to successfully compete in a marketplace that prizes integration and scale?

Different organizations will answer these questions differently—but all should proceed based on their answers to them, and to other questions that may be dictated by their particular markets.

Key Takeaways

COVID-19 will accelerate U.S. healthcare's movement toward a future characterized by the blurring of traditional lines between care delivery and financing. Integrated, scaled regional and national organizations that compete aggressively on quality and cost will lead. Increased merger and acquisition activity will be a hallmark of the transition.

To help their organizations navigate these changes, healthcare leaders should:

- Conduct a forthright evaluation of their organization's go-forward strategic and financial position
- Revisit growth plans to determine their continued validity
- Create a scenario plan to identify key assumptions or market events that could materially impair organizational performance
- Chart a course forward that reflects the realities of operating in a post-COVID-19 world, including partnership models of all kinds

For more information about the impact of the COVID-19 pandemic on provider alignment, please contact:

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Jordan Shields, *Managing Director, Juniper Advisory, (312) 506-3005 jshields@juniperadvisory.com*

This article was originally published by The Governance Institute in *BoardRoom Press,* in the June 2020 edition. PR

MODULAR PRIMER

Introduction to Telehealth (0.75)

Source: Oregon Health and Science University (OHSU)

This modular, telehealth primer is relevant to the Pacific Northwest area and includes statistics from OHSU's telehealth program implementation. By the end of this lesson, viewers should be able to:

- Describe the spectrum of telehealth modalities, including synchronous vs. asynchronous care platforms
- Define "webside" manners and employ them to conduct a more effective patient encounter
- Identify limitations of digital visits and strategies to mitigate them.
- Follow current rules and regulations pertinent to telehealth
- Understand the "digital divide" and use an inclusive and critical mindset in the practice of telehealth

https://bit.ly/2FWUKMv

WEBINAR

Getting Online with Telehealth: Practical Guidance for Physician Practices

Source: PYA

PYA's panel of experts provides guidance that physician practices can use to roll out, or further tap into, the telehealth opportunity as presenters discuss technology options and speed-to-implementation, solutions to process challenges, and patient engagement.

https://bit.ly/3ctJKIW

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Visit phyins.com/courses to search complimentary courses such as:

- Clinical Assessment via Telehealth Applications (1.50)
- Ethical and Legal Guidelines for Telehealth (1.00)
- Telehealth in Clinical Practice (1.50)

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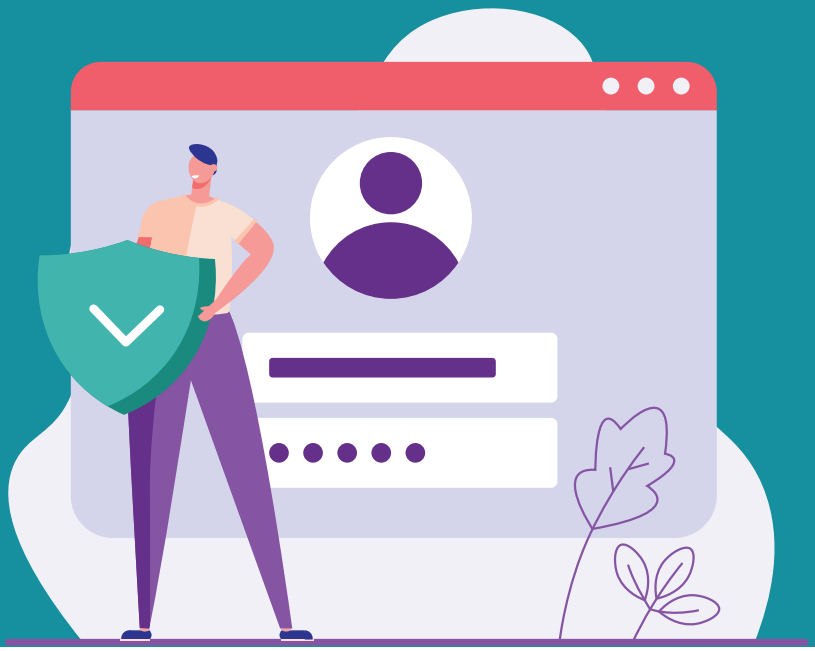
Telehealth Informed Consent Tips for Providers



Is written informed consent necessary?

Since state requirements vary, it is important to know the regulatory requirements for your state(s) of practice, as well as for the state of residency for your patient. It is standard practice to obtain written patient consent for medical care. For telehealth, informed consent should include patient education about telehealth and how it differs from an in-person visit.

A single consent form may be used for multiple visits unless the medical provider changes. At that time, the patient should sign a new form. Otherwise, it is recommended that a new form be signed annually.

Patient communication should include information on the unique characteristics of telehealth services, such as:

- Technologies used, including their capabilities and limitations
- Potential technical problems that may occur, and what to do if an issue arises
- Agreement that telehealth is appropriate for care
- Available alternatives to telehealth
- Credentials of the practitioner(s) involved

Be sure to set realistic expectations regarding the scope of service, who will be present during the appointment, billing and prescribing policies, and follow-up communications.

WHAT ARE THE TECHNOLOGY RISKS?

As most of us have probably experienced during remote meetings or webinars, technology does not always work as intended. Problems can occur for the provider, the patient, or both. Some of the technology risks include:

- Transmission errors and lost connections in audio and/or video
- Limitations and/or failure of equipment
- Limitations to privacy and/or security
- Inability to use multimedia commonly used in the office, such as an educational resource

HOW SHOULD I OBTAIN PATIENT CONSENT?

Obtain patient consent prior to the telehealth visit. Have your informed-consent document translated into commonly used languages. Determine if it is necessary to arrange a translator for a telehealth visit.

Documents may be exchanged through:

- The patient portal
- Electronic media, either via secure email or facsimile
- Standard USPS mail

Ensure receipt of the signed form. The completed documentation should be included in the patient's medical record. If a patient is unable to return a signed electronic confirmation, document that the consent was reviewed with the patient, the patient was unable to respond electronically, and verbal consent was obtained. If possible, have a second staff member listen and attest as a witness. (PR)

Sample Consent Forms

Search our Resource Library at phyins.com/resources to download the following sample consent forms:

- **Telehealth Informed Consent for Patient at Home**
- **Telehealth Informed Consent for Onsite Visit with Second Provider**

What are patients saying?

In a 2020 doctor.com study, 1,800 adults were asked their opinions of telemedicine. Among the results:

68% prefer to use their mobile phone for telehealth appointments

83% are likely to use telemedicine after COVID-19

91% agree that telemedicine would help with appointment and prescription adherence

93% are likely to use telemedicine to manage prescriptions

Source: Doctor.com. "The Future of Healthcare: Patient Perceptions, Preferences, and Adoption of Telemedicine." Accessed at https://bit.ly/341fgoz

(Telehealth Changemaker, continued from page 19)

"While promoting telehealth adoption before COVID, I heard that people didn't think the change was worth it," Dr. Cheng says. "They didn't think patients really wanted it, and they were satisfied with their current practice. So, given the limitations of virtual visits, they were hesitant to fully embrace telehealth."

The pandemic created a need for telehealth that forced our hand. "It made a lot of people realize telehealth is more powerful than they thought," Dr. Cheng says.

What the future of telehealth holds depends somewhat on how the economics play out in terms of reimbursement levels once the pandemic is over. Right now, it feels exciting and possible to make telehealth happen in a big way—and as Dr. Cheng points out, "since we want to meet patient needs the best way possible, how we get paid shouldn't limit that."

The financial aspect is only the tip of the iceberg, though. Staff need to be re-trained, doctors have to do things differently, and patients need to adjust. "It's a lot of work, and it puts everyone under stress," Dr. Cheng says. In his experience, practices could benefit from creating a staff position of "Digital Health Navigator" to re-create workflows and guide everyone through the process.

Ultimately, Dr. Cheng urges practices to adapt—because telehealth is here to stay. "It will be a proportion of our business from now on," he says. "Patients are going to become more familiar and comfortable with it, and it will become more robust in terms of options. It will bring more of the office to the patient." PR

More Telehealth Resources

Visit our online Resource Library or our COVID-19 resource page for more resources, such as:

Telehealth Modifying Requirements in Response to COVID-19
Source: Federation of State Medical Boards (FSMB)

Best Practices in Videoconferencing-Based Telemental Health Guide
Source: American Psychiatric Association and American Telemedicine Association

AMA Telehealth Implementation Playbook
Source: AMA

Telemedicine Risk Management Considerations
Source: ASHRM

The Total Cost of Risk
MPL Premiums Are Just One Factor

The headlines can be startling:

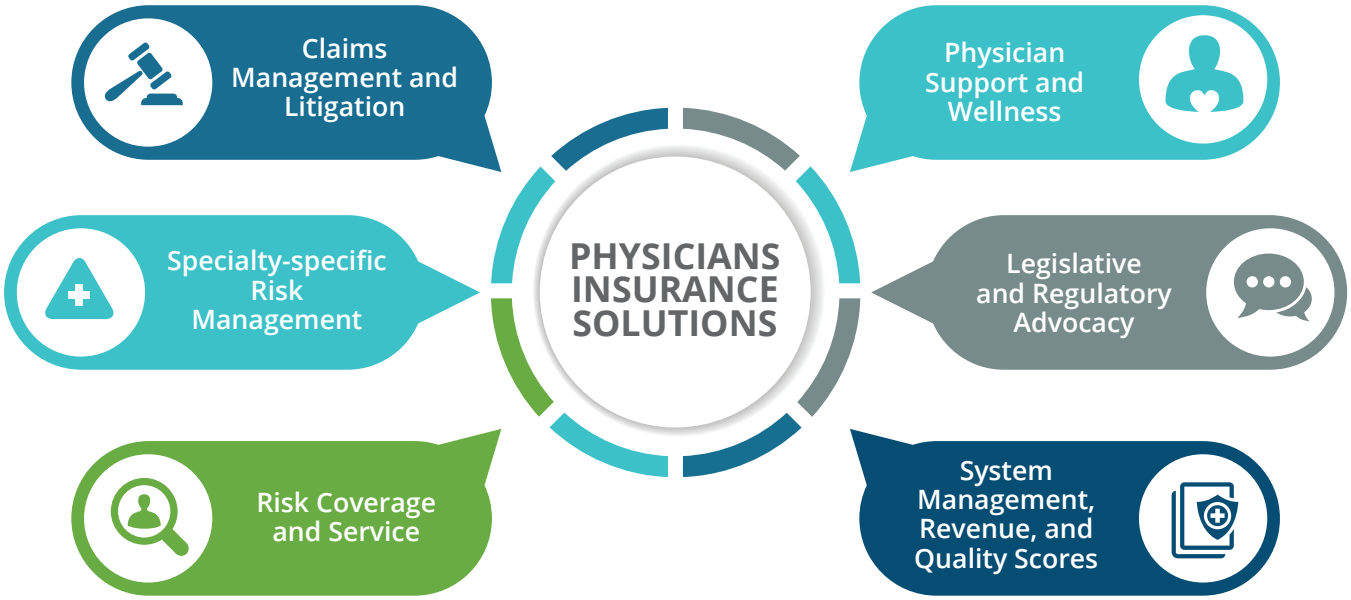
"Alleged failure to diagnose pneumonia results in a bilateral below-the-knee amputation."

"Alleged failure to communicate pathology report addendum to surgeon resulting in death of married male."

"Alleged negligent use of electrocautery during surgery ignites fire, resulting in burns to the face and neck of patient."

But headlines only cover the tip of the iceberg when it comes to the total cost of risk for a hospital or healthcare practice. And if recent events—an economic downturn, the global pandemic, business interruption, and the contentiousness of the current elections—have taught us anything, it is that risks and perils that exist outside of the delivery of medical care have a material impact on the business of medicine and the people who work in it.

When working with today's physician practices and hospitals/systems, Physicians Insurance believes the best place to start is to consider six macro-elements that impact an organization's costs, regardless of size. These six key areas are: risk coverage related to the delivery of care (e.g., your medical or hospital professional liability policy); costs associated with risk-mitigation activities, processes, and education; claims management and litigation for when a claim or trial occurs; physician and care-team support and wellness programs to restore the resiliency of providers and minimize burnout; governmental relations and the host of activities around advocacy for the protection of physicians and care providers; and services around the business of medicine, which include everything from quality scores to bundled payment programs, employment practices, HIPAA compliance, and revenue management.



- **Risk Coverage and Services:** This is the keystone to a good risk-financing program. You're basically buying coverages that will protect you when something happens. A good, comprehensive program is one that includes coverage for both direct patient treatment and for vicarious liability for the conduct of other insured parties, and may include general liability, employment-practices liability, cyber liability, and directors and officers/management liability. You want to be sure that the coverage limits and any endorsements (add-ons or exclusions) provide the right amount of coverage for your needs. It's just as possible to be over-insured as it is to be under-insured, and your premiums are largely based on what coverages you're buying and your history of losses in those areas.

  Insurance markets historically go through somewhat predictable cycles, which influence insurance limits and corresponding premium. A soft market is characterized by abundant capacity, ample competition, and low premium due to decreases in claims frequency and severity. Soft markets are followed by hard markets where capacity diminishes, competition lessens, and premium increases to match changes in claims frequency and severity. Nationally as well as in the Pacific Northwest, there is an ongoing uptrend in the frequency and severity of claims and suits. This suggests that the medical professional liability industry is in a hardening market.

  Additionally, when you negotiate your policy terms, be sure to consider the trade-offs of premium and deductibles, and any key reporting timelines. All of these items matter and will impact your overall expenses.

- **Specialty-specific Risk Management:** Risk-management and risk-mitigation services are designed to mitigate risks while lowering your costs. Without targeted and customized actions in your practice, hospital, or care setting, other people's claims and litigation headlines can quickly become your own. The goal is to find services that compliment your existing programs or efforts, maybe take you to the next level of sophistication, and do so in a manner that is sustainable. Most insurance companies will have some type of risk-management services or products, but not all programs are the same.

  Find a carrier that works with you to create a plan that can evolve over time—based on a risk evaluation or assessment—spanning at least 18 months, because it's common knowledge that true and lasting systemic change takes time. You're going to also want access to continuing education (some accredited, some simply good information) that is relevant to both your setting and contemporary practices.

Find a carrier that works with you to create a multi-year plan—based on a risk evaluation or assessment—spanning at least 18 months, because it's common knowledge that true and lasting systemic change takes time.

  Accessing these services and education on your own in the retail market could cost tens of thousands of dollars, depending on your size and the complexity of the program. So ensuring it's part of and included with your underlying policy could be an important cost savings to you.

- **Claims Management and Litigation:** Claims happen—it's not a matter of if but when. So right up there in importance with a good underlying policy is having a claims team with a proven track record of defending physicians and hospitals, for whenever that policy may be needed. Look for a carrier with a claims team who understands that this could be the most difficult experience of your professional life, and who will be there for you when you need them. Some claims teams are understaffed, which means they handle a lot of cases and spend only a little bit of time on each—or the insurance company may be publicly traded, which may mean that their incentive is often to settle as early as possible for as little as possible. Make sure you find an insurance carrier that matches your own philosophy or has consent to settle as part of the language in the policy.

- **Physician Support and Wellness:** Claims administration is part of the policy you've purchased. But support services or other important services are not always included, and could cost you thousands more if you were to purchase them yourself in an already stressful time of need.

  Another benefit of some carriers is litigation support for policyholders. This often takes the form of a psychologist or psychiatrist who can support the defending physician during litigation, or perhaps a peer-support program in which other physicians who have had similar

(Continued on page 32)

(Cost of Risk, continued from page 31)

experiences can walk alongside someone going through a claim or litigation experience for the first time. These support programs can sometimes extend to the entire care team involved in an incident or adverse outcome. Other complimentary programs could cover burnout, caregiver suicide prevention, and substance abuse.

Physicians Insurance is the only carrier in the Northwest to offer individualized and "in-the-moment" comprehensive physician/clinician-support programs, which are designed to keep physicians engaged, avoid further complications or errors, and preclude the costs of lost productivity and new-physician recruitment.

- **Legislative and Regulatory Advocacy:** Some risks that physicians and hospitals face don't originate in the exam or operating room, but in legislative chambers. Not all insurance carriers dedicate resources to protecting their members at the state and national levels, and for you to engage in these activities on your own could create unsupportable costs for your organization. Physicians Insurance believes that it's part of our mission to support comprehensive effective legislation that enhances the healthcare liability system, promotes meaningful patient-safety initiatives, improves healthcare quality, and supports communication between healthcare professionals, providers, and patients.

  That's why Physicians Insurance is the only medical professional liability carrier based in the Northwest with an in-house lobbyist registered in Oregon and Washington, who focuses on protecting members from legislation negatively impacting the care and business of medicine, and on providing advocacy on challenges to medical professional liability that may (1) create new causes of action, (2) alter the standard of care, (3) establish strict liability for providing or not providing care, or (4) impose onerous or unnecessary duties on healthcare professionals and providers.

  As you consider your total cost of risk, consider how this upstream effort impacts the downstream care you're able to provide your community and patients, and how the legislative environment itself might make it easier or harder for you to run your healthcare business.

- **System Management, Revenue, and Quality Scores:** While other services that may surround your policy are designed to mitigate risks and lower costs, another area of risk that's often overlooked is protecting your revenue and ability to conduct your business.

Physicians Insurance works to protect your revenue streams and optimize operations, going beyond the policy by focusing on practice management, revenue, quality scores, and operational efficiencies.

Part of protecting your own risks is ensuring you have access to vendors, partners, and information that support optimizing your revenue and expense management, including clinical and practice improvement reviews, physician compensation analysis, revenue cycle management, real-estate development and analysis, patient-satisfaction score analysis and improvement, data acquisition and analysis services, and cyber/privacy toolsets to protect you and your patients.

Access to these services individually can cost tens of thousands of dollars for each—but they're sometimes made available at a discount, or even at no cost, through your carrier. Through exclusive partnerships and other licensing arrangements, Physicians Insurance works to protect your revenue streams and optimize operations, going beyond the policy by focusing on practice management, revenue, quality scores, and operational efficiencies.

COMPREHENSIVE VIEW OF RISK

Providing comprehensive solutions goes well beyond just offering a policy to cover professional liability. In today's healthcare environment, your practice or hospital also needs to focus on the other elements that directly impact your business operations and the wellness of your team. These are specific resources that help to mitigate risks and decrease severity in both outpatient and inpatient settings, improve patient safety and quality scores, and build care-team resilience. It's this approach that has made Physicians Insurance the largest medical and hospital professional liability carrier in the Pacific Northwest—and it's a philosophy central to our mutual-company identity that puts relationships, communities, and our members' needs first in all that we do. PR

"Longer, more specific jury questionnaires are important because of the differences we see emerging. The more you can know about your potential jurors, the better."

KEVIN BOULLY, PHD, SENIOR LITIGATION CONSULTANT
PERSUASION STRATEGIES

(Juror Sentiment, continued from page 23)

STRATEGIES TO AVOID

Public perception of the virus itself may present a risk to medical legal defense teams in 2021 and beyond. As the public continues to absorb information about COVID-19 therapies, treatments, and outcomes, jurors may come to see COVID-19 deaths as more preventable than they did in the early months of the pandemic.

Persuasion Strategies' July 2020 survey data shows a slight decrease in jurors' willingness to align with the hospital in a scenario involving a COVID-19 death. In April 2020, 54 percent of respondents said they would lean in favor of the hospital in the hypothetical scenario involving a COVID-19 death. By July, that figure dropped to 49 percent, which may reflect jurors' increasing belief that the virus can be treated successfully.

In general, jurors report less-intense feelings about COVID-19 as the pandemic goes on. According to Persuasion Strategies surveys, fewer jurors reported feeling anxiety and sadness about COVID in July 2020 than in April 2020. But this doesn't mean that jurors feel more positively about the virus. Notably, in the July survey, fewer jurors reported feeling hopeful about the virus, and more reported feeling angry.

While this simmering anger around COVID does not seem to be tarnishing the halo effect just yet, it's still important for legal teams to consider. "I think it's a real risk to overtly overplay the halo effect," says Boully. "We continue to see that relevance to the specific case is extremely important to jurors. Their internal detectors go off if they think they are being manipulated."

This means that attempting to capitalize on a COVID-related halo effect when the scenario in question doesn't involve COVID is a mistake. "If you're not dealing with an active COVID issue but you're telling jurors that you are, they're not going to give you extra points for that," Boully notes.

PREPARATION IS POWER

As changes in COVID-related juror sentiment continue to emerge, medical defense teams should prepare to engage in a more high-impact jury-selection process. And in that situation, having more information about prospective jurors is always a good thing. "Longer, more specific jury questionnaires are important because of the differences we see emerging," says Boully. "The more you can know about your potential jurors, the better." PR

Dr. Kevin Boully has been active in litigation consulting since 2001. He has a master's degree in forensic psychology and doctorate in legal communication focus on persuasion, small-group influence, and jury decision-making. He is the coauthor of Patently Persuasive, *a book on persuasion in intellectual property litigation published by the American Bar Association's Section of Intellectual Property. As a current Board Member of the American Society of Trial Consultants and a past associate editor and advisor to the jury-research and courtroom-communication publication* The Jury Expert, *Dr. Boully has published and presented on litigation and legal-persuasion topics across the United States.*

"Jurors are more attentive, paying closer attention to detail, and able to listen to testimony effectively."

NOAH WICK, NATIONAL DIRECTOR OF LITIGATION CONSULTING, TRIAL EXHIBITS, INC.

(Medical Malpractice Litigation, continued from page 21)

COVID-19 has made everybody reevaluate the exposures in their cases. The outcomes of negotiations are more unknown; therefore, people are more willing to move forward and be more realistic with their financial expectations. *—Nancy Pugh*

Courthouses were never set up for remote-access technology, but it's now becoming the norm. We used to worry about having experts testify remotely, and now I'm not sure we'll go back to having experts spend so much of their time traveling. *—Jim Beatie*

There has been national concern about whether jurors would be attentive to the evidence being presented when viewing it on a screen, as opposed to live in a courtroom. But today, jurors are accustomed to viewing things on a screen. Jurors are more attentive, paying closer attention to detail, and able to listen to testimony effectively. *—Noah Wick*

WHAT WILL BE COVID-19'S MOST ENDURING EFFECTS ON MEDICAL MALPRACTICE CASES?

I think even post-COVID, lawyers will embrace doing certain parts of litigation by remote access, just for the sake of efficiency. *—Amy Forbis*

If the pandemic had happened a few years ago, I don't think we would have been able to pull this off as well as we have. We didn't have the technology that we have now. We're probably spending more time preparing for cases now, but also becoming more efficient as we continue using these technologies. *—Jim Beatie*

I'm on the advisory board of the Online Courtroom Project, a seasoned group of judges, trial attorneys, and trial consultants working toward more efficiencies in courtroom technology across the nation. Since the re-opening of courts, each county is handling court proceedings differently, with and without technology. One overall consistency is how much [the pandemic] has forced the legal system to adapt and advance with the use of today's technology. *—Noah Wick* (PR)

***Jim Beatie** is a claims manager for Physicians Insurance with more than 30 years of experience in medical malpractice litigation.*

***Amy Forbis** is a medical malpractice attorney and director with Bennett Bigelow & Leedom, P.S. She is regularly selected to the Washington Super Lawyers list (most recently in 2020), as well as to the Washington Super Lawyers "50 Top Women Lawyers" list.*

***Nancy A. Pugh** has been handling medical malpractice litigation claims for more than 26 years. She has spent the last 20 years with Physicians Insurance and now serves as its Director of Litigation Management.*

***Noah Wick** is National Director of Litigation Consulting at Trial Exhibits, Inc. His principal activities involve focus groups and mock trials, theme development, visual strategy, and impression management.*

(Adopting Telehealth Services, continued from page 15)

7. Advocate for payment reform

During the COVID-19 pandemic, payers have improved reimbursement for telemedicine. However, enhanced payments for telehealth services are set to expire. If rates return to pre-pandemic levels, a significant roadblock to adoption, maintenance, and sustainability will reemerge. Loss of payment for telephone encounters would be particularly detrimental to patients who do not own a computer or smartphone, have unreliable internet access, and/or are uncomfortable with technology.

Even if enhanced payments for telehealth are extended, further reform is required. In the absence of comprehensive payment reform, payment rates should be higher for medical homes than for immediate-care or telemedicine-only sites of care, since the former offer robust chronic-disease management, whereas immediate-care or telehealth-only practices provide a narrower scope of care.

Indeed, meaningful payment reform would enable the flexible delivery of care and more freedom to serve patients. Comprehensive payment for primary care would allow a focus on quality of care and enable the deployment of transformational telehealth—not just a temporary substitution for office visits.

CONCLUSION

During the COVID-19 pandemic, many ambulatory practices have quickly adopted telehealth to continue care while mitigating the risk of transmission.[22,23] Telehealth is a potentially transformative model of healthcare delivery; but like any new technology, it comes with benefits and challenges. The steps laid out above offer an approach to help implement these services and/or improve the way in which they are provided.

Advocacy for continued payment for telehealth is needed, as is research about the quality of and satisfaction with telehealth care. Finally, and perhaps most importantly, this work must be done in a way that improves access for patients caught on the other side of the digital divide. We must take advantage of this opportunity to re-envision primary care through a more equitable lens.

Indeed, meaningful payment reform would enable the flexible delivery of care and more freedom to serve patients. Comprehensive payment for primary care would allow a focus on quality of care and enable the deployment of transformational telehealth—not just a temporary substitution for office visits. (PR)

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Telehealth Post-pandemic

The Genie Will Go Back in the Bottle, Unless . . .

By MARTIE ROSS and DAVID MCMILLAN, PYA

EXCERPT: The following is an excerpt of an article originally published May 8, 2020. You can access the full article at https://bit.ly/36fih62.

Many predict that one lasting impact of the COVID-19 pandemic will be expanded use of telehealth. As more patients and providers come to appreciate the convenience of virtual home visits, the traditional office visit will become the exception, not the rule. Right?

Not so fast. Absent statutory and regulatory changes, we'll be right back where we were with telehealth.

PRE-PANDEMIC

Pre-pandemic, telehealth comprised a fraction of a percentage of Medicare spending. The story wasn't much different for state Medicaid programs and commercial health plans. According to an October 2019 report from JD Power, "Nationwide consumer adoption of telehealth services has been stubbornly low, with just 10% of healthcare consumers having used such services."

The root cause of the problem was Section 1834(m) of the Social Security Act, which defines the scope of the Medicare telehealth benefit. The statute imposes five requirements for coverage:

1. **The geographic requirement.** The beneficiary must reside in a rural area.
2. **The location requirement.** The beneficiary must be physically present at a healthcare facility when the service is provided.
3. **The service requirement.** The service provided must be listed as an approved telehealth service (as defined by CPT® or HCPCS code).
4. **The technology requirement.** The service must have audio and video capabilities that permit real-time interactive communication.
5. **The provider requirement.** The service must be furnished by an eligible provider (physicians, non-physician practitioners, clinical psychologists, clinical social workers, registered dieticians, and nutrition professionals).

PANDEMIC

In its initial response to the COVID-19 pandemic, Congress gave CMS authority to waive Section 1834(m)'s geographic and location requirements for the duration of the public health emergency. With this waiver authority, and through the publication of two interim final rules, CMS has significantly expanded telehealth Medicare fee-for-service reimbursement. PYA's complete, up-to-date summary of these temporary rules is available at https://bit.ly/360F1Xo.

State Medicaid programs and commercial plans have followed suit, temporarily providing expanded telehealth coverage and reimbursement. And the Federal Communications Commission is making available $200 million in grant funding to support providers' acquisition of telehealth technology and monitoring devices.

Essentially overnight, physician practices pivoted from clinic visits to virtual visits. According to a Merritt Hawkins survey released on April 22, 48% of physicians were, at that time, treating patients with telehealth. On the consumer side, new market research shows that 59% of patients are more likely to use telehealth services now than previously, and more

than a third would switch their physician to have access to virtual care.

POST-PANDEMIC

When the declaration of the national COVID-19 public health emergency expires, Medicare's temporary expansions of telehealth coverage and reimbursement will expire with it. Significant legislative and regulatory changes will be required to recapture any gains made during the pandemic.

First and foremost, Congress will need to act on Section 1834(m), overcoming concerns about cost, fraud, and privacy. Most likely, that will require the CBO to revise its cost estimates to account for Medicare savings generated by expanded use of telehealth.

Industry leaders will need to make a compelling case that fraud can be adequately controlled, and privacy can be properly protected. More in-depth research regarding provider and patient experience with telehealth during the COVID-19 crisis will bolster the case for expanded Medicare coverage.

Legislative action may also be required if commercial payers retreat to their pre-pandemic positions regarding telehealth reimbursement. In fact, legislation was introduced in late April to require ERISA-regulated plans to provide coverage and reimbursement parity for telehealth services, and it appears to be garnering support. Similarly, state legislatures will need to expand existing telehealth parity laws to include reimbursement parity.

In addition to actively engaging in these lobbying efforts, providers should consider expanding their use of communication technology-based services (CTBS) now covered by Medicare and other payers. In the 2019 Medicare Physician Fee Schedule Final Rule, CMS recognized a distinction between telehealth services subject to Section 1834(m) and CTBS, which are not subject to the statute's requirements. While the agency had previously interpreted the Section 1834(m) geographic and location requirements as applying to any virtual service, CMS decided these requirements apply only "to a discrete set of physicians' services that ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a healthcare professional."

By contrast, "services that are defined by, and inherently involve the use of, communication technology" are not subject to Section 1834(m). In making this distinction, CMS opened the door to new payment for CTBS, including remote patient monitoring, virtual check-ins, and interprofessional internet consultations, as well as ambulatory care management.

"I think the genie's out of the bottle on this one... it's taken this crisis to push us to a new frontier, but there's absolutely no going back."

SEEMA VERMA, ADMINISTRATOR OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, WHITE HOUSE CORONAVIRUS TASK FORCE

WALL STREET JOURNAL, APRIL 2020

While not a substitute for full coverage for telehealth services, CTBS reimbursement offers a means to maintain some of the gains made in virtual care during the COVID-19 pandemic. Also, remote patient monitoring supplements visual-only telehealth services by providing physicians with patients' physiologic data.

It's hard to find any silver lining to the COVID-19 cloud under which we now live, but a real-life experiment demonstrating the value of virtual care may be one. However, any gains made will be fleeting unless providers and patients push policymakers to cement them into law. President Trump's recent Executive Order on Improving Rural Health and Telehealth Access keeps the regulatory telehealth expansion in place post-pandemic, but only makes permanent the types of services that can be furnished by telehealth, and which providers can furnish them. The most significant restrictions—geography and location—require congressional action.

If you have questions related to telehealth reimbursement, contact PYA at (800) 270-9629. PR

Disclaimer: To the best of our knowledge, this information was correct at the time of publication. Given the fluid situation, and with rapidly changing new guidance issued daily, be aware that some or all of this information may no longer apply. Please visit PYA's COVID-19 hub frequently for the latest updates, as we are working diligently to put forth the most relevant and helpful guidance as it becomes available.

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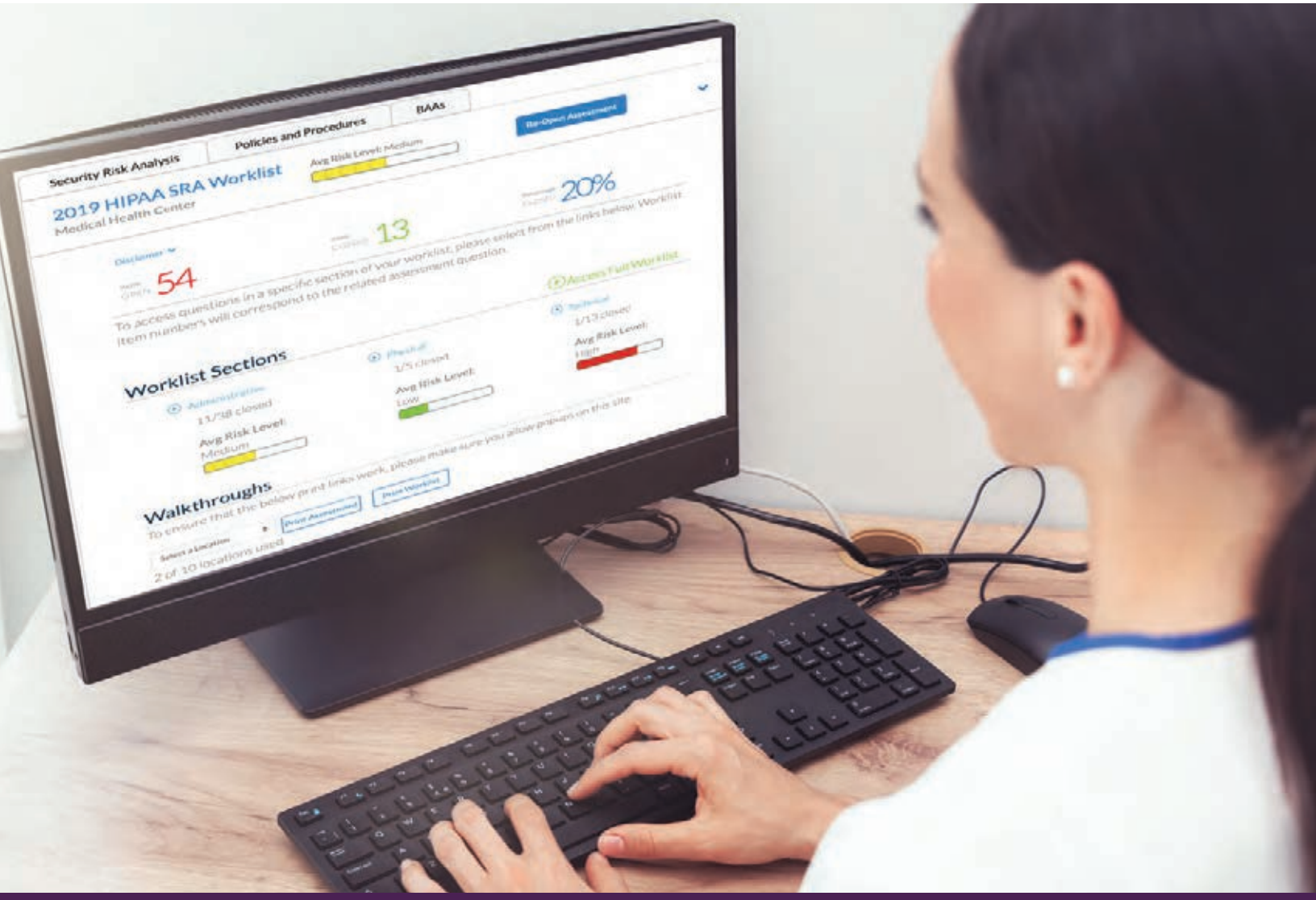

Feeling Unprepared? Get HIPAA Help

It's not something anyone wants to admit. Being unprepared, that is.

Especially when it could put patient information at risk, incur enormous fines, and perhaps result in legal fallout and loss of credibility in the community. But many clinics and hospitals are in the same situation—and perhaps could use some help.

For obvious reasons, one such physician-owned family-medicine clinic in the Northwest didn't want to be named. Like many organizations these days, this clinic's busy staff had many roles and responsibilities. And like all healthcare providers and their business partners, it had to follow the vast, complicated security

and privacy rules of HIPAA (the Health Insurance Portability and Accountability Act), the federal law that protects patient information in any form, but especially medical and financial information. But the clinic's staff, already stretched thin, didn't have the time or resources to develop deep expertise in HIPAA rules, or to create documentation from scratch. (After all, some large health organizations employ full-time HIPAA compliance officers to tackle that gargantuan task.)

Nonetheless, the clinic's physician owners knew they had to do a HIPAA Security Risk Analysis. (This is expected to be done annually, in case an organization is audited by Health and Human Services' Office for Civil Rights (OCR), which enforces HIPAA.) The owners knew all too well that "medical clinics may never truly appreciate the risk of a devastating HIPAA security audit until it is too late," as one of the physicians said to his colleagues. They were determined to ensure that wouldn't happen to them.

A healthcare consulting firm advised them to use Medcurity, a cloud-based HIPAA tools and resources platform (found at medcurity.com) that guides clinics and hospitals and their business associates through their annual HIPAA Security Risk Analysis. The platform provides recommended remedial actions and action-item tracking via dashboards, as well as customizable policies and procedures and Business Associate Agreement (BAA) management through electronic signature.

"We see stories like this nearly every day," says Joe Gellatly, CEO and co-founder of Medcurity. "The privacy and security requirements can be overwhelming for a practice. At the same time, the risks are very significant for them."

"Our platform gives them a place to start," says Amanda Hepper, Medcurity's president and co-founder. "Customers tell us that our platform makes the compliance journey process less intimidating, and they are actually excited about having tools to help them improve and track their progress."

When the clinic teamed up with Medcurity, many HIPAA-required policies had not been created or implemented yet. Some necessary security procedures were in place but not documented, leaving the clinic at risk of a failed audit. Other security procedures were not yet implemented, as the clinic did not have employees or contractors with expertise in these requirements.

Previous security-risk assessments had been limited to simple spreadsheets or tools that generated basic pass/fail answers. These assessments did not provide any clarity or recommendations for the practice. Despite the work they had done to complete previous Security Risk Analyses and draft initial policies, the clinic was still vulnerable.

Two weeks later, the clinic completed their Security Risk Analysis via Medcurity's online software, with guidance from one of the company's representatives.

The explanations and citations provided helped clarify the questions and related requirements for the clinic's team. They were relieved to learn that Medcurity also included a policy builder that could help them quickly create customized policies and procedures.

As soon as the Security Risk Analysis was completed within the Medcurity tool, an audit-ready, comprehensive report was automatically generated for the clinic.

The clinic staff then created several of the required policies using the smart policy builder. They are now using the dashboard and action items to collaborate and track their continued progress.

As part of their subscription, they have access to a support team for any questions that may arise during the year after this Security Risk Analysis.

The clinic plans to use Medcurity again for their next annual analysis. They'll be able to pull the previous analysis and update it with any changes they've made, and the practice is now better protected from breaches and associated penalties. Their staff has access to clear and appropriate policies for protecting patient information. What's more, the physician owners can now attest with confidence that they meet the required measures in the Merit-based Incentive Payment System (MIPS), in order to maximize their Medicare payments.

"Medcurity was created by a tightly focused group of experts, and their reps can skillfully navigate the chaotic waters of information security," one of the physician owners says. "We highly recommend Medcurity as a resource and partner. They can assist with security risk analyses to prevent investigation and limit damage, should the unthinkable occur."

He adds, "Medcurity allows us to focus on what we really care about, which is providing outstanding medical care for our patients." (PR)

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Congratulations, Summit Pacific Medical Center!

The Washington State Hospital Association (WSHA) has awarded Summit Pacific Medical Center the 2020 "Rural Quality—Everyday Extraordinary" Award, which recognizes outstanding improvement in the safety and quality of rural healthcare.

Summit Pacific Medical Center received the award for its powerful work in starting a Medication Assisted Treatment (MAT) clinic for people suffering from substance-use disorder. Congratulations!

Learn more: https://bit.ly/3IvcPAq

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