A PHYSICIANS INSURANCE PUBLICATION

THE Physicians Report

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Reducing Risk Through Connected Care

Staying in the Driver's Seat
See what happens when the physician stops being in control of care

The Value of Care Coordination
A hospitalist's perspective

Yes, I Was Sued...and Survived It
A surgeon's post-trial thoughts

AFTER 30 YEARS

of pulmonary and critical care practice, just as I was contemplating retirement, I was confronted with what is now thought to be a near inevitability. It started when an established patient was seen by me for surgical clearance prior to an elective orthopedic surgery. Although mildly asthmatic, overweight, and with type two diabetes mellitus, she had no reasons to undergo further cardiac preoperative evaluation (ACC/AHA recommendations). Unfortunately, she had an unexpected post-operative myocardial infarction and died one month later from complications. To my greatest surprise, several months later I was served a letter of intention to sue. What followed was a learning process to which I hope others will not be exposed. However, the fact remains that all care givers are at similar risk.

The legal process began with an extensive review of the medical records, contemplation of supportive witness options, and lengthy discussions with a defense attorney and support staff from Physicians Insurance. The deposition was more grueling than expected, as well as frustratingly picayune and seemingly without end. I recall thinking that a 12-to-14 hour day in the ICU with multiple codes and care of septic patients would have been far more preferable. Despite several delays, the case finally came to trial three months after my partial retirement. What a relief it was to not be forced to alter clinic and hospital scheduling to accommodate trial proceedings.

Trial preparation included a focus group, review of literature and standards of care, as well as discussions with the Director of Physicians Affairs, Dr. Ron Hofeldt, and others at Physicians Insurance. The focus group provided this legally-naïve practitioner with a multitude of factors to consider during trial, none of which I would have deemed pertinent without proper guidance. I learned the value of experts—both those defending and opposing me in the courtroom, as well as the expert witnesses for both sides. I learned about the level of scrutiny that would be applied to all my communications and interactions with my patient-turned-plaintiff. I learned the role of courtroom etiquette and the value of presenting myself in a personable tone and language that is easily understood—not to mention, my appearance and attentiveness to the jury.

Fortunately the two-week ordeal of the trial ended in a defense verdict, of which I was confident throughout the proceedings. However, I now recognize that many items—other than the facts—will influence a "jury of your peers." It is my hope that you will avoid this type of "learning experience" but I also assure you that the experts at Physicians Insurance will provide you all the assistance needed to navigate the process with professionalism—and hopefully a similarly satisfying outcome.

Dr. Samuel G. Joseph
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DR. AND MRS. JOSEPH FERRYING BETWEEN HONG KONG AND KWALOON

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

Staying in the

See what happens when the physician stops being in control of care in this real-life claim story.

While physicians want to see patients take ownership of their own health, physicians also need to remain in control of the care, looking for the hand-offs that—if missed—can lead to adverse outcomes.

Two Years and Seven Providers Later…

AT THE START

Sophia had a history of thyroid cancer, hypothyroidism, GERD, esophageal stricture, an ovarian cyst, and breast/chest pain. But on that first visit to a new primary care physician, her primary concerns were her sinuses, persistent rosacea, and chronic heartburn and reflux. No breast exam was done.

AT 3 MONTHS, AT 8 MONTHS

Sophia was back for follow-up visits at three months and eight months. Complaints surrounded ongoing sinus problems, facial rosacea, and that her prescribed medications did not seem to be working. Bumps on her right underarm were noted. Again, no breast exam was done.

AT 15 MONTHS

Sophia went to her OB/GYN complaining of left breast pain and a lump. Her established provider not available, she was examined by a nurse practitioner for a well visit. An exercise plan for weight loss was discussed. From the medical chart, it is unclear what else transpired except that Sophia was referred for a screening mammogram. Chart notes were not completed until two months later.

Had Sophia's chart notes been completed on time, they would have indicated that the mammogram results were not for the purpose of merely "screening," but were ordered to evaluate a lump.

AT 16 MONTHS

Sophia saw a radiologist for the screening mammogram and gave clinical history of a breast lump. The results showed no dominant mass and no suspicious calcifications, and the result documented was of a normal ultrasound. It was recommended that the patient have the ultrasound redone at age 40. The radiologist of record took a leave of absence without signing the reports. Another radiologist signed off on the screening mammogram without review.

Driver's Seat

Sophia wasn't thinking breast cancer that day. She was more annoyed and frustrated with the persistent sinus problems, facial rash, and headaches she'd been having.

Like so many others, the 36-year-old mother of two wrestled with her weight and adult-onset type 2 diabetes, but she was a non-smoker. If only she could be rid of the persistent rosacea and the chronic heartburn she suffered!

Today, Sophia would do something about it. She had an appointment with a new primary care physician. Today, they would get to the bottom of things.

Two years and seven health care providers later, Sophia's life-threatening cancer condition, missed by provider after provider along the way, is at last revealed and she receives a double mastectomy. It is not at all the outcome she imagined when she entered that primary care physician's office for the first time. If only someone had helped her navigate the system better. If only just one of those medical experts had connected the dots sooner.

If only.

A PERFECT STORM IN THE MAKING

A perfect storm was in the making. Why did the nurse practitioner order a screening exam versus a diagnostic exam? Was it a miscommunication and would it have been caught had the chart notes been accurate and timely? What might the covering radiologist have done differently? What if the radiologist had zeroed in on the lump and asked whether the mammogram should be a diagnostic exam and not a screening exam? Instead, the providers did not consult one another, and no one provider knew the big picture or took charge of Sophia's care plan.

AT 22 MONTHS

Sophia was back in the PCP's office concerned about an enlarging of the left breast mass and a new, second area of concern in the left breast. The exam by the physician confirmed a palpable mass, and Sophia was referred to a surgeon. The surgeon ordered a diagnostic mammogram to be done at a different radiology center, and this showed a suspicious finding in the left breast. A biopsy followed with a diagnosis of invasive lobular carcinoma of the left breast. A double mastectomy was performed and her prognosis was poor.

AT 17 MONTHS, AT 20 MONTHS

Sophia returned to her primary care physician twice complaining of dermatological issues—but no mention of the lump. There is no indication in the records that the physician even knew her patient had had other tests or what the results of those tests were.

AND SO THE LITIGATION BEGINS

Sophia sued because of the delay in both diagnosis and treatment of the cancer. In the out-of-court settlement that followed, those sued—the PCP, the OB/GYN, the new ARNP with the OB/GYN's office, the first radiologist who interpreted the screening mammogram, and the second radiologist who signed off on the report—shared in the cost of the settlement.

(Continued on page 6)

(Drivers Seat Continued from page 5)

Five of the seven providers are sued for malpractice. Each of them is stunned at the accusations of poor care, of missed opportunities. Each of them must defend against accusations that they have failed their patient and left her worse off than before she saw them. They must live with the fact that Sophia's quality of life suffered, never to be regained.

"Litigation is never a fun experience," says Amy Forbis, an attorney with Bennett Bigelow and Leedom P.S. who is regularly included on the "Super Lawyer" list by Washington Law and Politics magazine. Forbis understands what a sued physician endures. "Essentially, a lawsuit thrusts a medical provider into foreign territory. It would be like pushing me into the operating room."

> What brought the patient to his or her office may not be the most important medical issue that the patient is facing.

"And it's not always about the medicine or the science of the case," notes Forbis. "Sometimes, it's about the story the Plaintiff has to tell or unanswered questions they still have." Patients who sue often want to better understand the thinking that led to the care they received. Sometimes, it is about the medical facts and individual provider's role in the care in conjunction with the other providers involved.

WHO WAS IN CHARGE?

It is widely encouraged in today's health care environment for patients to be actively engaged in their own medical care. But in Sophia's case, who ran her medical appointments? While it can be uncomfortable to disagree with a patient, the physician with the expertise can help the patient understand the treatment options, the alternatives, and the risks of declining or delaying treatment.

In this case, Sophia's care was compromised. Did her persistent concerns about her skin and other more minor health issues distract the providers from the possibly life-threatening lump mentioned along the way? Which of her issues deserved the primary focus of attention and follow-up, and by whom? When the expectations of each of her health care providers were not followed through, it contributed to the lack of coordinated care.

Patients are usually not equipped to know the extent and complexity of their medical conditions. Research shows that 50 percent of patients leave their doctor's office not understanding what the doctor told them, 50 percent of all patients fail to fill or take their prescribed medications as directed, and a startling 90 percent of all patients do not make any lifestyle change as discussed with their physicians[1].

Most patients lack a grasp of medical knowledge. They trust their medical professionals to educate them. As part of that trust, and in exchange for payment, they also have a reasonable expectation, as did Sophia, that the physician will clearly communicate at each step in the chain of care what needs to be done and why. This sets an expectation of the patient, as she too has a responsibility to communicate in return and help the physician fully understand the nature of a particular issue. It is not unusual for a physician to determine that what brought the patient to his or her office may not be the most important medical issue that the patient is facing. The physician should listen to valid concerns and at the same time keep the discussion from veering off track and burying the chief health concern. A patient can

(Continued on page 8)

[1]Hereford J. Health Coaching: A Key Role for Cardiovascular Nursing. Presented at: PCNA 19th Annual Symposium, May 2014; Las Vegas, NV

LESSONS LEARNED FROM SOPHIA'S CASE

Episodes of risk often occur when best practices are overlooked. The following are common themes for risk and brief notes on their accompanying best practices that are relevant to this case. Learn more about any of these critical topics through your Risk Management Consultants at Physicians Insurance.

Encounter planning/patient flow

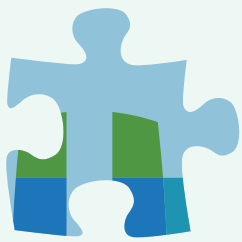
- **Schedule time according to the type of visit.**
- **For new or complex patients, consider agreeing on a number of issues to be addressed at the current visit and schedule future visits for additional, identified issues.**

Follow-up scheduling and tracking

- **If possible, schedule follow-up appointments before the patient leaves.**
- **Have a system in place to send out reminders to patients if a follow-up appointment is missed or cancelled without reschedule.**

Coordination of care

- **Be sure to talk with the patient about other providers involved in the patient's care.**
  - Agree on which providers should be seen for what:
    - *Routine specialty care, such as women's health specialists*
    - *Specialists for problem-centric or chronic care*
  - Discuss importance of need to see other providers
  - Circle back with patient about whether care has been given by other providers.
  - Document review of outside/ consultant reports.



Communication

- **Patient-provider communication:**
  - Agree on issues, importance of complaints.
  - Agree on priorities for current and future appointments.
  - Agree on plan for immediate, higher-priority complaints.
  - Agree on plan for addressing additional, open complaints.
- **Provider-provider communication:**
  - Be clear about relevant clinical information when referring a patient for a diagnostic or to a specialist.
  - Order accurately—screening and diagnostic are different.
  - Ordering provider and other treating providers should communicate and agree on a follow-up plan.

Documentation

- **Key to managing care; it builds a foundation upon which to work.**
- **Key to defending care; it is the only contemporaneously compiled history of care.**
- **Providers need to clearly document plans for:**
  - Treatment
    - *For work-up of high-priority complaints and next steps for additional complaints*
  - Follow-up
    - *Tracking and communication with patient about expected follow-up*
    - *With specialists/other care providers*

(Drivers Seat Continued from page 6)

fulfill their role and responsibilities better when the provider sets clear expectations for the patient.

THE TEAM, COMMUNICATION, AND RECORD REVIEW

In working as a health care team, the team must identify early with one another their respective roles in treatment. The team must communicate with one another to clarify how they will assemble a 360-degree view of the patient's clinical presentation and course of treatment. That communication should include reaching a consensus on prioritization of all the clinical issues presented.

In such situations where multiple providers are involved in the care of a patient, it may be useful to identify a central provider (PCP or OB/GYN, as an example in Sophia's case) to whom all other providers can send their notes, tests, and plans, and who can coordinate the care. This is important to avoid redundancy and waste. More importantly, this will avoid issues getting missed as each provider assumes that someone else is taking care of it.

Can a physician with a busy practice realistically be expected to read all chart notes and talk with all other providers on a team in advance of each patient visit? Forbis believes that expectations and good practice are case specific. "It honestly depends upon the medical circumstance and the patient's issues. If the circumstance warrants more in-depth review of the chart and expanded conversation with other providers, it should be done. If not, less review is acceptable. The key is thinking about and considering the circumstance and determining if more information is necessary or potentially helpful." Make sure you consider the information provided by the patient through written questionnaires and oral history to determine what, if any, additional information should be obtained."

> "No matter how certain you may feel in your assessment of what happened, it is best to comment about your own care and not pass judgment or finger-point at another provider's care."

Such diligence can have significant impact. In Sophia's case, a screening mammogram may have been more affordable, but a diagnostic mammogram done that much sooner might have caught the cancer in time. Appropriate triage and follow-up are key, and when handing a patient off to the care of another provider, clear communication and ordering of the right medical procedure at the right time improves the opportunity for successful outcomes.

TAKING THE HELM FOR A PREPARED DEFENSE

The time to assume the helm of a patient's chain of care is at the very beginning. Juries are often not sympathetic to "the patient was negligent" arguments. Nor do they like to hear, "I did everything right. It was that other provider who dropped the ball." Says Forbis, "No matter how certain you may feel in your assessment of what happened, it is best to comment about your own care and not pass judgment or finger-point at another provider's care."

What does help your case is consulting with a professional liability lawyer or calling the risk manager at your insurance company at the time of an adverse event or outcome and not waiting for a lawsuit to happen. If you are concerned about the care a patient has received or that a lawsuit might result, consult those who know and keep them in the loop.

Ultimately, there are three prongs in medical professional liability litigation, and the Plaintiff must prove the physician owed a duty to the patient, that there was a breach of that duty, and that the breach of that duty resulted in harm to the patient. A few observations about those elements:

1. **Standard of Care**. "What would a reasonably prudent provider do in the same or similar circumstances?" asks Forbis. Medical record documentation, besides providing the primary source of information for defending a claim, is the only contemporaneously recorded history of a patient's treatment. It is the foundation for immediate and future assessment and for treatment planning.

"Document the treatment provided at the time," Forbis advises physicians. "Include in the documentation your history, assessment, and plan. The charting should include your thinking, such that the chart notes tell the story of your patient encounter." Remember

that the standard of care applies whether the provider is a physician or a physician's assistant.

2. **Proximate Cause**. That which was done caused a harm that would not have happened otherwise. In Sophia's case, had her cancer been diagnosed sooner, she may have fared better and thus avoided the personal toll and expense of late-stage cancer.

3. **Injury/Damages.** These include reasonable value of past and future medical expenses and past and future lost wages; disability, disfigurement, and loss of enjoyment of life; pain and suffering, both mental and physical; and loss of consortium (love, affection, care, and services).

"Notes should be done at or near the time as part of the official record," says Forbis. "When care is prolonged and fragmented (as in Sophia's case), it is easy in a busy practice to cut and paste from appointment to appointment." The speed and ease of electronic medical records create ample room for error.

Legal experts caution that notes added later, in anticipation of litigation, can be called into question. Frequent views of the electronic medical record after the fact also raise red flags and, in comparison, can confirm a jury's concern that there was not enough attention paid to the medical record, or the patient, before the poor outcome.

"When care is prolonged and fragmented—as in Sophia's case—it is easy in a busy practice to cut and paste from appointment to appointment. The speed and ease of electronic medical records create ample room for error."

CAREFUL DOCUMENTATION IS EVERYONE'S FRIEND

Comprehensive chart notes are critical for both team communication and for the documentation of care. As burdensome and time-consuming as they can be, notes need to be specific and relevant. You won't necessarily remember months or years later why you chose a treatment path or diagnosis. The rationale should be clearly stated for treatment decisions made, such as "Patient refuses diagnostic exam because of cost concerns." Your notes are an electronic footprint in the medical chart. No private notes or shadow charts. Pay close attention to informed consent, too. Consider individualizing your consent form to address specifics of the treatment or procedure.

"Assess and control your office procedures, too," Forbis cautions physicians. "This includes protocols and office staffing responsibilities." No matter how busy the medical practice, a system of "tickling" or follow-through is vitally important. Did the patient make that appointment with another provider? What did that provider recommend? How realistic are your protocols for covering each other's leave? Or, for instance, is it a matter of course that a radiology technician at your clinic will confirm the reason for the patient's test? A simple confirmation with Sophia addressing whether she was having a routine screen or addressing a specific health concern might have diverted her to the appropriate diagnostic (rather than screening) mammogram sooner.

MAKING APOLOGIES

Care must also be taken when a physician feels an apology to a patient is necessary. The point of an apology is to convey compassion after an unexpected outcome, not provide an admission of guilt or wrongdoing. The right words at the right time can help physicians keep a supportive dialogue going with their patient, even under the most difficult of times. However, in many cases, an apology should be given in consultation with an attorney or your insurance company. They can help you with the crucial wording so that an apology supports your relationship with the patient but does not work against you should a claim be filed.

NOT IF, BUT WHEN

All physicians face adverse outcomes over the life of their practice, and most physicians experience a claim or a lawsuit at some point in their careers. Medical providers who succeed are those who are compassionate, caring, and current in their field. Today's successful physician also takes care by being savvy about what can lead to litigation and what resources are available to help defend against liability.

These reasons are why Forbis likes working with physicians as clients. "My clients are educated and highly knowledgeable. I have the pleasure of being able to rely upon my clients as experts on the very issues that are in dispute and being litigated." The key is to remain the attentive expert during patient encounters, document the encounter in a complete fashion, and watch for the hand-offs that may require extra attention and follow-up. PR

The Value of Care Coordination:

A Hospitalist's Perspective

By Viral Shah, MD

After a few days of a low-grade fever and night sweats, 68-year-old Jack, a retiree living in a rural community in Washington State, decided to pay a visit to his local primary care physician. His physical exam was normal, and Jack went home. His symptoms persisted, however, and Jack returned to his doctor. This time, labs were drawn.

The lab results suggested lymphoma.

Because it was the Friday before the 4th of July weekend, Jack's doctor recommended that Jack make the 90-minute trip to the nearest major hospital for further evaluation.

At the tertiary care center ER, the labs were repeated with consistent results, leading to a presumed diagnosis of lymphoma. After being notified of the results, the on-call oncologist recommended an excision lymph node biopsy and requested that Jack follow up with him after the results came back.

TIME FOR A CARE PLAN

When the hospitalist service received the ER physician's admission request for Jack, they questioned why it was even necessary for Jack to have come to the tertiary care center since the services he needed were all available in his rural community. The primary care physician explained that he felt the work-up would have been faster in the tertiary care center because of the delays that the long holiday weekend could cause.

The hospitalist contacted the on-call general surgeon at the tertiary care center who reviewed the case and determined that the biopsy wasn't really an emergency, especially given the scarce resources caused by the holiday.

So would Jack stay in the hospital, far away from his home, for the next three days? A second nighttime on-call oncologist was consulted who also agreed that there was no need for Jack to stay in the hospital. The oncologist also suggested that the biopsy could be done as an outpatient procedure in Jack's hometown.

After hearing back from the second oncologist, the hospitalist called another on-call oncologist, this one in Jack's hometown. The two physicians agreed that Jack could go home and be seen in the local oncology clinic that Monday. All Jack would have to do was call the office on Monday morning to request an appointment.

Armed with a plan, the family headed home late Friday evening.

On Monday morning, when Jack called the oncology clinic, nobody knew who he was. The oncologist they had spoken with on Friday was working at a different clinic, and Jack couldn't reach him. Unaware of his story, the clinic staff informed Jack that he wouldn't be seen for a few weeks.

Frustrated, Jack and his wife returned to the tertiary care center emergency room Monday afternoon. The blood work was again repeated, and admission was again requested. After a different hospitalist spoke with a different on-call surgeon, Jack was admitted, the lymph node biopsy was performed, and Jack was discharged to his home on Tuesday.

Both oncologists, the one at the tertiary care center and the one at the rural clinic, received the biopsy results. Jack has since received his care at the oncology clinic in his local community.

FRAGMENTED CARE BRINGS UNINTENDED CONSEQUENCES

This case is an example of our fragmented care model and the unintended consequences of the way our current health care system has evolved over time.

(Continued on page 24)

Yes, I Was Sued

And Survived it

By Paul Inouye, MD

Yes, I was sued. Though I'm now able to compartmentalize the legal action against me, how do you brush aside the fact that someone is attacking you in a very personal and public way? It began with being served the subpoena and seeing my wife's name listed as a co-defendant. The attack is not only directed at you, but at your family, and that stings at a very deep level.

I imagine medical liability insurance attorneys and claims managers frequently work with surgeons facing lawsuits for the first time. Some have a natural ability to adjust to the new circumstances and respond smoothly and confidently. I think my defense team members would all agree that I didn't fall into that category! Just after trial, I decided to share some thoughts that might benefit surgeons in the future, surgeons who require more remedial coaching and instruction, as I did. Without extensive instruction and coaching, some of us are virtually "lambs to the slaughter." I fully appreciate that now that I am sitting at the other side of the experience.

The world of litigation is quite different than what we are used to.

In our training, we are taught to be accountable for complications and missed injuries. And yet, for the most part, accepting responsibility is not equivalent to a deficiency from the standard of care. Indeed, we (as a society) would probably not want surgeons who too easily and quickly deflect accountability and responsibility for adverse outcomes. This principle is deeply ingrained in surgical culture.

With that in mind, physicians become confused when we enter the world of litigation, where we quickly begin to see that an admission of accountability easily translates to an admission of a breach of standard of care.

I'm recalling my university department of surgery mortality and morbidity session (M&M). The process is practically a hazing of surgical residents, who present complications in their medical cases in front of an auditorium of students, residents, and attending surgeons. The presenting surgical resident is berated by attending surgeons for various breaches in management. As a general rule, if the resident quickly admits accountability, then usually the berating is milder. In fact, the decision leading to the surgical complication is usually made by an attending surgeon, not the resident at the podium. All know this, and yet the presenting resident is expected to accept the blame.

The point is, we're accustomed to being accountable for complications and unaccustomed to having to be defensive. At trial, where the stakes are higher and the setting unfamiliar, the structure of leading and closed-ended questions is unsettling. All our lives, even in unpleasant conversations, we're used to being able to express ourselves in a certain way. The structure of the "yes/no" questioning in deposition is very strange and disorienting, as is the sequence of loaded questions that we well know will lead us in a bad direction.

The frustration that occurred in the preparation process is like a clash of cultures. My attorney showed some disappointment when I didn't know small details in the chart. As a physician, things like "possible vs. probable" and "stellate vs. complex" are all clinically meaningless. What I didn't fully realize is that tiny discrepancies are magnified and used tactically to discredit the witness. I now understand why any irregularity in education or training is dredged up, even if it occurred decades ago. It's a brutal business! And of course, in mock questioning, things went so miserably. It's like asking a slow guy to run fast or a short guy to dunk a basketball. It wasn't that I wasn't trying; I cannot even now explain why I constantly drew mental blanks in the office during preparation but thought clearly during trial.

Dr. Ron Hofeldt, a psychiatrist and Director of Physicians Affairs at Physicians Insurance, provided me with excellent preparation. It was vital to have a physician's perspective. He gave useful insights and spent hours on the phone with me, providing me with an overview of the process, as well as useful and encouraging statistics. Right before trial, he spent about three hours on the phone going over what to expect. Ron's interaction definitely complemented the work of my attorney.

This whole process, over two years since receiving my subpoena, has been challenging. My attorney indicated that many in my situation would have chosen to settle, and I'll admit that a good part of my enthusiasm for pushing ahead was out of ignorance for the amount of work involved in defending. I had no full appreciation of what lay ahead, or that we could be expected to be fully prepared and then have the trial date moved several times. Without question, it was worth it, and I think I would have felt that way even if the verdict was not in my favor.

I will admit that this whole experience got into my head to some degree and has soured me on clinical practice. I'm sure that's not an uncommon reaction. I know that the verdict could have gone either way, but the fact that it favored me has restored some faded enthusiasm that I've had for my job, which I think I do well. I'm probably going to order a few more MRIs and CT scans occasionally, but overall, I don't think it will change my clinical practice very much. I've tried to be philosophical about it. We get compensated well, and part of that is taking on litigation risk.

But I'm no longer sure what it feels like to be vindicated. In retrospect, I missed an injury. For that, I could not help but feel badly for the patient. But whether it's a missed injury or a technical or judgment error, such mistakes do not necessarily mean a breach of the standard of care. Once accused, we become so unsettled by the accusation that we don't want to admit anything… *anything!*

> "I see people at terrible times in their lives and I always try to be empathetic and understanding of their situation. The litigation process has not changed that for me."

I have been around physicians who cynically look at all patients as potential plaintiffs. Did going through my lawsuit cause me to take a similar view? For the most part, I can say it has not. I see people at terrible times in their lives, sometimes at the end of their lives, and I always try to be empathetic and understanding of their situation. Fortunately, the litigation process has not changed that for me.

How does that expression go—what doesn't defeat us makes us stronger? (PR)

Paul Inouye is a general surgeon and trauma specialist who has been in practice thirteen years.

WASHINGTON SUPREME COURT REPORT:

How an Amicus Brief Helped Earn a Victory for Washington Providers

By Gregory M. Miller and Justin P. Wade, Carney Badley and Spellman, P.S.

An integral part of the mission for Physicians Insurance is preserving a level judicial playing field for health care professionals when their care is challenged in the court system.

When issues arise in the appellate courts that could threaten a level playing field, Physicians Insurance joins entities like the Washington State Medical Association (WSMA) and the Washington State Hospital Association (WHSA) to educate the court about the impact of an appellate court decision on the delivery of care to patients.

Providing educational information to the appellate courts is done through a mechanism called an amicus brief (a brief from a friend of the court). We use these types of briefs to give voice to the perspective of the health care providers and the patients they serve.

Recently, Physicians Insurance had the opportunity to support WSMA and WSHA in the filing of an amicus brief in Anya-Gomez v. Sauerwein, 331 P.3d 19 (Washington Supreme Court 2014). As a result, physicians and other health care professionals can now communicate effectively with their patients about pertinent results without the fear of an unjustified lawsuit. Following is a summary of the key facts and key rulings by the Supreme Court in the Anya-Gomez decision.

SUMMARY: ANYA-GOMEZ V. SAUERWEIN, 331 P.3D 19 (WASHINGTON SUPREME COURT 2014)

In June, 2014, the Washington Supreme Court affirmed a defense verdict and pre-trial dismissal of an informed consent claim in a misdiagnosis case. The decision is a victory for physicians and other health care providers who, if sued for alleged negligent misdiagnosis, otherwise could have faced an additional claim based on informed consent if they did not tell the patient about every test result, including unconfirmed, preliminary results. If allowed, such "informed consent" claims for a failure to disclose test results could amount to strict liability. Fortunately, common sense prevailed on a majority of the Court, who affirmed the lower court rulings and the long-held distinction between medical negligence and informed consent claims.

FACTS

An immunocompromised patient with type 2 diabetes mellitus presented to the local community hospital on the 20th complaining of urinary tract infection symptoms, samples were sent to a lab for analysis, and she went home the next day, the 21st. On the 23rd, she presented to the emergency room feeling ill, and, after having her bladder drained, felt better and went home. On the 24th, the lab preliminarily determined that the patient's blood sample taken on the 20th tested positive for yeast. The lab reported those findings to the patient's primary care clinic where the defendant family physician was covering for the patient's usual physician.

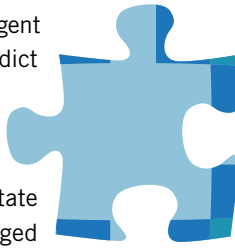
The family physician was concerned about the test results. He quickly consulted one of the treating physicians from the 20th to the 21st, an internal medicine specialist, who advised contacting the patient to find out if she was feeling ill and, if so, to bring her in for treatment. She was immediately contacted on the 24th and reported that she was feeling better and had no fever, so they determined it most likely was a false positive. The family physician did not tell the patient of the preliminary test result. On the 26th, six days after the initial hospital visit, the lab positively identified candida glabrata as the yeast strain in the blood sample but failed to report those results to the family physician, the patient's clinic, or anyone else.

The patient's condition deteriorated, and she was admitted to a hospital three days later on the 29th, where for the first time, her urine tested positive for yeast. Treatment for the candida glabrata infection came too late, and she died 10 weeks later.

> An amicus brief can be used to give voice to the perspective of the health care providers and the patients they serve.

LEGAL PROCEEDINGS

The estate of the deceased patient sued the family physician for medical negligence for the misdiagnosis of the yeast infection in the blood. Three weeks before trial, the estate added an informed consent claim for failure to disclose the preliminary test result received on the 24th. The trial court declined to dismiss the belated informed consent claim until after the close of the plaintiff's evidence and instructed only on the negligent misdiagnosis claim. The jury returned a defense verdict on the negligence claim, finding no breach of the standard of care.



The issue for appeal was whether the patient's estate could bring an informed consent claim for an alleged failure to disclose preliminary test results based on the same facts giving rise to a medical negligence claim for misdiagnosis. The Washington Supreme Court held that the physician had no duty to disclose to the patient the preliminary lab test result of the patient's blood, which the physician believed was a false positive result for yeast.

(Continued on page 19)

Best Practices to Avoid Employment Disputes

By Justin A. Steiner, JD

Employment Disputes Affect Employers of All Sizes

Smaller employers frequently believe they are "too small" for employment laws to apply, but federal anti-discrimination laws apply to employers with 15 or more employees, and state anti-discrimination laws apply to employers with even fewer employees. Smaller employers are also often the most vulnerable to employment disputes because they frequently lack a dedicated human resources professional with the necessary experience and knowledge to navigate in this tricky area. And while larger employers can typically absorb the costs of employment disputes, smaller employers may be forced to shut their doors.

Type of Discrimination	% of Total Charges Filed In Washington	In Oregon	In Idaho	In Wyoming
Retaliation	44.0	37.7	37.7	46.2
Disability	37.7	39.7	51.9	36.9
Sex	33.1	30.8	27.3	29.2
Age	28.4	23.5	28.6	27.7
Race	28.5	19.0	10.4	23.1
National Origin	11.9	13.4	2.6	12.3
Religion	8.7	6.5	10.4	4.6
Color	4.3	4.0	5.2	0.0

In 2013, 93,727 charges of discrimination were filed with the U.S. Equal Employment Opportunity Commission (EEOC). Of those, 1,285 were filed in Washington, 247 in Oregon, 77 in Idaho, and 65 in Wyoming. The chart above shows the percentage of charges of discrimination filed in Washington, Oregon, Idaho, and Wyoming by type of discrimination.

The top five allegations in charges of discrimination filed in the Pacific Northwest in 2013 are (1) retaliation, (2) disability, (3) sex, (4) age, and (5) race. Notably, the high frequency of alleged retaliation in the Pacific Northwest mirrors a nationwide trend. From 1997 to 2013, the percentage of charges of discrimination filed with the EEOC making allegations of retaliation increased from 22.6% to 41.1%.

While not all charges of discrimination turn into lawsuits, many do. In fact, employment disputes continue to be one of the fastest growing areas in civil litigation. In 2013, there were a total of 253,914 federal dockets, of which 20,704 were filings relating to employment practices such as discrimination. Thus, employment disputes remain a fact-of-life for employers.

EMPLOYMENT DISPUTES ARE A COSTLY FACT OF LIFE FOR EMPLOYERS

According to Jury Award Trends and Statistics published by Westlaw, in 2011, the median jury verdict awarded to employees in employment litigation of all types was $325,000. The chart on page 18 shows the median jury verdict by type of discrimination

While settlement is often a less costly resolution, the median average settlement was still $100,000. Beyond settlements and verdicts, attorney fees and costs in employment litigation frequently range from $200,000 to $300,000 (not to mention the employee's attorney fees and costs, which an employer may have to pay if it loses at trial).

BEST PRACTICES TO MINIMIZE THE IMPACT OF EMPLOYMENT DISPUTES

Fortunately, there are proactive steps an

(Continued on page 18)

(Employment Disputes, Continued from page 17)

employer can take to minimize the likelihood and impact of employment disputes based on discrimination.

1. **Enact an Employee Handbook.** A thorough Employee Handbook consolidates an employer's policies and procedures into a single source, communicates an employer's expectations and obligations to employees, and helps to lessen an employer's exposure to employment disputes. Among the most important policies in any Employee Handbook is the Equal Employment Opportunity (EEO) policy. An EEO policy should express commitment to a discrimination- and harassment-free workplace, explain the procedure for employees to report discrimination and harassment, outline the steps the employer will take to investigate, and describe the disciplinary process. Once an employer has enacted a proper Employee Handbook, it should be consistent and rigorous in adhering to it.

Type of Discrimination	Median Jury Verdict
Disability	$292,500
Age	$247,800
Race	$215,652
Retaliation	$208,275
Sex	$150,000

2. **Provide Training.** All employees should be provided anti-discrimination and anti-harassment training on hire, as well as periodically after hiring. Managers and supervisors should be provided additional training on properly handling and responding to complaints of discrimination/ harassment.

Document, Document, Document. A frequently encountered scenario in employment disputes is that a legitimately disruptive and poorly performing employee is discharged. The employee alleges he or she was actually discharged on the basis of a protected characteristic, such as gender, and files a lawsuit. When the employee's file is reviewed, there is little to no documentation of the employee being disciplined for behavioral issues, and performance evaluations reflect an average performing employee rather than a poorly performing employee. Under these circumstances, the employer will struggle to convince a jury that the employee was fired for the legitimate reasons claimed. Thus, for all employees, immediately document disciplinary issues and complete regular performance evaluations that are truly representative of performance. Other helpful documentation includes records of anti-discrimination and anti-harassment training and records of past and current complaints of discrimination, investigations and outcomes.

4. **Be Consistent.** Employers should ensure that actual practice consistently matches policies and that policies are consistently applied to all employees. Selective application and enforcement of policies is a frequent basis for alleged discrimination that juries often find persuasive.

5. **Protect Against Retaliation.** Once an employee has made a complaint, the potential for actual or perceived retaliation is acute, difficult to manage, and substantially increases an employer's potential exposure. To protect against this, employers should:

- Ensure their EEO policy also prohibits retaliation and provides adequate reporting, investigatory, and disciplinary processes for retaliation complaints.
- Provide training regarding retaliation.
- Maintain confidentiality as much as possible. Although employees accused of discrimination should be informed, one cannot retaliate against a complaint they are unaware of.
- Consider protective measures, such as allowing the employee to report to a different supervisor, although the complaining employee should be consulted to ensure the protective measures themselves are not perceived as retaliation.
- Be proactive and engage with the employee, rather than isolating or

Fortunately, there are proactive steps an employer can take to minimize the likelihood and impact of employment disputes based on discrimination.

ignoring the employee to avoid the perception of retaliation.

- Closely scrutinize subsequent employment actions for retaliation, including asking if the action is consistent with the employer's policies and practices and whether the action is supported by adequate documentation of a legitimate, non-retaliatory reason.

Physicians Insurance members have access to employment-related forms and policies at www.phyins.com/EmployeeRelated, phone support for employment-related risk management questions at (800) 962-1399, as well as access to an EPL HR Specialist Hotline at (800) 387-4468. PR

For more information on employment insurance coverage, contact Janet Jay from Physicians Insurance Agency at (800) 962-1399

Justin A. Steiner *is an attorney with Bennett Bigelow & Leedom in Seattle who advises and defends physicians, clinics, and hospitals in both employment and medical malpractice matters.*

(Amicus Brief, Continued from page 15)

IMPACT ON HEALTH CARE PROVIDERS

According to the Washington Supreme Court, where a "health care provider rules out a particular diagnosis based on the circumstances surrounding a patient's condition, including the patient's own reports, there is no duty to inform the patient on treatment options pertaining to a ruled out diagnosis." However, as before, physicians (and other health care providers) can be liable for negligence for a failure to diagnose or a misdiagnosis if the circumstances meet the elements of a medical malpractice claim.

Demonstrating an understanding of the practical implications of its ruling, the Washington Supreme Court declined to adopt a rule that would have required health care providers and patients "to spend hours going through useless information that will not assist in treating the patient." Keeping with common sense, Washington courts thus do not expect health care providers who do not believe a patient has a particular disease to inform the patient about the unknown diseases and possible treatments for it. There is no "informed consent" claim for such a "failure to disclose." Nor is it the rule that physicians must inform patients of all preliminarily positive test results given the fact of false positives. But as has long been the case, once the physician uses the test results and other tools to make a diagnosis, the physician must inform the patient about possible treatments and risks related to that diagnosis.

Finally, in terms of health provider advocacy, it is worth noting that the WSMA-WSHA amicus brief was cited and relied on three times in the majority decision, which gave the Associations credit for knowing the reality of practice situations (particularly as to false positives) and bringing that reality to the Court. Both the result and text of the decision confirm that those efforts helped make a difference in this case, a rare-but-welcome physician-friendly decision from the Washington Supreme Court. PR

Gregory M. Miller, *a principal at Carney Badley Spellman came to the firm in 2008 with Mike King to join Jim Lobsenz and Ken Kagan in forming the firm's uniquely experienced Appellate Group. He is a founding member of the Washington Appellate Lawyers Association and has been recognized by Seattle Metropolitan Magazine as one of King County's "Top Lawyers 2010."*

Justin P. Wade *joined Carney Badley Spellman in 2010 and his practice focuses on civil litigation and appellate advocacy. Before joining the firm, Mr. Wade clerked for Judges Susan Agid and Mary Kay Becker of the Washington State Court of Appeals.*

Other times in life—

When You Might Need an Attorney

Life can be complicated, especially for physicians in private practice. Leaving aside for a moment the specter of professional liability arising from claims of malpractice, today's physicians must be adept at navigating a variety of non-medical challenges that represent significant aspects of their professional lives.

So where to turn? Professional risk managers may be an important resource for certain questions, but for attorney Christopher Keay of Johnson, Graffe, Keay, Moniz, and Wick, the counsel sought by his physician clients ranges from professional relationships, employment issues, fraud prevention, and equipment and building leases to practical concerns such as the death of a member/partner or the impact of divorce upon their clinic—whether their own or a partner's.

"Most professionals—physicians or otherwise—can benefit from having a 'go to' attorney resource," says Keay. "Physicians have studied and worked hard to achieve their professional goals of helping and healing, but they might not have specific training or experience in some of the practical aspects of starting or maintaining a medical practice. Sometimes they forget that not everyone shares their goal or perspective. They are focused on delivering medical care, not always the practical matters that keep them safe from legal entanglements."

The value of having a trusted relationship with an attorney, someone who knows you and your life (professional and personal), is that you'll have

someone who can help manage some practical aspects of your legal needs or refer you to other professional resources you may require. Just as in medicine, there are specialists in different areas of the law—tax, corporate partnerships, family law, real estate, state and federal regulatory compliance, etc. A key legal adviser can help direct you to the right resource or combination of resources for the best possible outcome. When you allow yourself to rely upon other experts, you can focus on the expertise for which you have been trained.

The following is a short list of non-medical liability issues a physician may contend with:

PERSONNEL

Personnel issues include conflicts with and between staff around pay, hours, benefits, work rules, and/or termination considerations, etc. Many times, these issues are delegated to an office manager or a lead employee who needs to manage the situation. Sometimes this works out fine; other times, not as well. Regardless of whether a clinic is large or small, personnel issues can escalate to such a level that a lead physician or manager may not know how to direct the problem to the satisfaction of all parties, leaving the clinic or individuals exposed. It is most prudent to err on the side of reaching out for legal support sooner rather than later, before a situation becomes unsalvageable.

PREMISES AND PROPERTY

The liability around clinic property is a broad topic in itself. An attorney can help you identify a variety of future scenarios you'll want to consider as you sign off on commitments. For instance, a bad lease can stay with you many years. You'll want to make sure you've negotiated an office lease that includes a renewal clause or other options that will serve you well as your clinic needs shift.

An issue that is far more common than people would realize is embezzlement—when clinic property or resources are stolen by an employee or partner. The most common occurrence is when one employee or partner is responsible for receiving the mail, opening the mail, making deposits, and writing the checks to pay the bills, which can easily be falsified. Another instance is when cash co-pays are received and then pocketed. These kinds of scenarios occur when too much trust and responsibility is given to one person and there is little to no oversight. A reasonable checks-and-balances system to have in place, for instance, would be to have one person authorized to write the checks and another authorized to sign the checks. Says Keay, "I have a client who experienced three embezzling bookkeepers in a row before calling me. Management always seems surprised to find their trust violated."

A short summary of common property issues requiring legal assistance includes:

- **Real estate**—the lease or purchase of property
- **Equipment**—the rental or purchase of equipment necessary to successfully do your job
- **Embezzlement**—how to avoid it and what to do when it happens at your clinic
- **ADA compliance**—managing issues around accessibility laws for which you may have responsibility, but limited expertise

PARTNERSHIP AND MEMBER AGREEMENTS (OR DISPUTES)

Practices are dynamic. The needs, goals, and motivation levels at the start of a professional relationship may be profoundly different than at the end of a relationship. At the rosy outset of a relationship, partners often don't want to think through the possible changing needs of partners.

Developing successful agreements includes objective, long-term thinking and planning for a variety of outcomes that might crop up, such as purchases, sales or mergers of clinics, or the impact of a death or divorce of a partner. The foresight and experience to know what situations can crop up will help create the most clear partnership documents when changes take place.

> "Most professionals—physicians or otherwise—can benefit from having a 'go to' attorney resource."

Also, younger physicians often ask about a demonstrated path to partnership. With this in mind, some additional considerations for agreements include whether a member is or can become:

- An equity partner vs. non-equity partner
- A junior partner vs. a senior partner with voting rights

RETIREMENT PLANNING

The sale of a practice (or a percentage buyout) at the end of a career is likely the most complex transaction a physician will ever face. The agreement—and its impact on related others—should be carefully considered with the help of an experienced professional. Legal counsel who is able to prepare the appropriate documents may start with a boilerplate document but may also explore the many customizable options possible in order to pin down clear executional details. A successful exit strategy may be 12–18 months in the planning; don't make the mistake of investing time in this pivotal stage of your career without legal support.

Most physicians have met that stubborn patient who has long avoided going to the doctor when what they need most is the care of a professional. Similarly, make sure you've covered your bases and that you get the legal help you need to keep you in the exam room and out of the court room. PR

When Do You Make the Call?

By Kari Adams

These situations all indicate a claim is being made against you, and you should contact the claims department of your medical liability insurance provider immediately.

Even if you have never been involved in a lawsuit, you probably have some concept of what a lawsuit entails. You may know that documents are filed with a court, allegations of negligence are made, and—depending on the state—the actual dollar amount being sought by the patient is stated. You may know that these documents would be served upon you or, if your organization has a registered agent, the documents would be sent to the registered agent. You probably wouldn't hesitate to call and would rightly assume that as long as the lawsuit is covered, an attorney would be assigned to represent you. You may understand a formal process of discovery would occur, including depositions, and the case may be dismissed or settled, or would proceed to trial, where a jury would award a verdict for or against you.

What you may not realize is that pre-litigation claims can be made against you and require the same attention as a lawsuit. It is never a good idea to handle these situations on your own or to disregard any communication from a patient that may indicate a claim. Reporting these events is necessary to preserve your insurance coverage and allows your claims team to extend advice to you in "gray area" situations with patients or handle these reports as pre-litigation claims. Our claims philosophy is to be as proactive as possible, when indicated, as it can allow for the best resolution for the provider, organization, and patient while reducing publicity, stress, and inconvenience. Claims can generally be investigated and resolved in a matter of months while lawsuits may take 1½ to 2½ years (or more) to completely resolve. Appropriate attention to a claim or claim-like communication from your patients can help you avoid litigation altogether.

HOW IS A CLAIM DIFFERENT FROM LITIGATION?

The claims process mirrors the litigation process but without the formality, as there are no interrogatories, depositions, or trials. Interviews or obtaining documents supporting a patient's claim are all performed through cooperation with the patient or their attorney. When a claim report is received, one of our

What do the following three things have in common?

- You receive a letter from a patient expressing dissatisfaction with your care—although what the patient is actually requesting for resolution is unclear.
- You practice in Washington and receive a letter from an attorney requesting mediation that cites Washington Code RCW 7.70.110.
- You receive a phone call from a patient expressing dissatisfaction with care, requesting compensation for medical expenses, lost wages, and pain and suffering.

experienced claims representatives will conduct a thorough investigation, including, but not limited to, discussing with you the medical care provided, handling all communications with the patient or patient's attorney, collecting medical records, and interviewing medical consultants retained to express an opinion on the standard of care. The same elements necessary to establish negligence in a lawsuit are used:

1) The medical provider's care deviated from that of a reasonably prudent provider in a same or similar situation;
2) The deviation from care caused the patient's injury; and
3) The nature of the injury.

Your claims representative will discuss the outcome of the investigation so that you can make an informed decision whether you wish to settle or to proceed in defending the claim. If the case is to be settled, the benefits can be a lower settlement as the patient and their attorney may have little to no expenses incurred. Also, there will be no public record of a lawsuit, and the parties will not endure lengthy and acrimonious litigation. However, if the investigation indicates no negligence, a denial of the claim is issued. Many times, claims are abandoned at this point as the patient or their attorney may not have an expert, or, having had a preview of the strength of our case, they might conclude that legal pursuit would be unproductive.

Claims, like lawsuits, become part of your claims history regardless of the outcome. Settlements must be reported to the National Practitioner Data Bank. A copy of the National Practitioner Data Bank report may also be sent to your State Board of Health. Generally, additional coverage is afforded to you for State Board of Health investigations following a settlement for incurred legal expenses, as attorney representation for State Board investigations is necessary. Incident reporting, where you simply receive advice or put us on notice as a precaution but the situation does not rise to the threshold of a claim, are never a part of your claims history.

Differences between patient complaints and claims can be subtle, and legal-sounding letters can cause concern. Understanding what may constitute a claim and seeking assistance right away can prevent troubles in the long run. The ability to transfer the handling of a claim to your medical professional liability carrier is one of the most valuable features of your insurance coverage. (PR)

WANT TO TALK TO SOMEONE IN PERSON AT PHYSICIANS INSURANCE?

Call (800) 962-1399 and ask to speak with someone in our claims department.

WANT TO REPORT AN INCIDENT ONLINE, AT YOUR CONVENIENCE?

Visit www.phyins.com and select the secure "Report an Incident" link from the home page.

CLAIM REPORTING GUIDELINES

THE FOLLOWING SITUATIONS SHOULD BE REPORTED TO PHYSICIANS INSURANCE:

- Unexpected brain damage following any treatment or procedures
- Any surgical procedure performed on the wrong patient or at the wrong site.
- Cardiac arrest in the operating or recovery room resulting in unexpected death, brain damage, or other serious injury to the patient.
- Suicide attempt resulting in death or serious injury to the patient.
- Misdiagnosis in the Emergency Department resulting in death or permanent serious injury to the patient. Death within 48 hours following discharge from the Emergency Department.
- Anesthesia complications resulting in coma, death, paralysis, or other serious injury.
- Unexpected amputation due to poor outcome of any treatment or procedure.
- Second- or third-degree burns as a result of any treatment or procedure.
- Unexpected return to surgery during the same admission, regardless of reason.
- Obstetrical occurrences:
  - *Maternal or neonatal death.*
  - *Infants with five-minute Apgar scores of less than six.*
  - *Infants born at less than 34 weeks in hospitals without NICU or neonatology coverage.*
  - *Infants born at greater than 34 weeks transferred to any NICU.*
  - *Term infants that experience seizures before discharge.*
- Unexpected patient deaths:
  - *Occurring from slips or falls, medication error, or equipment failure.*
  - *Following usually non-fatal procedure, i.e., cholecystectomy in 30 year-old healthy person.*
- Incidents resulting in impaired patient/visitor functioning or injury:
  - *Slips or falls resulting in fracture, sprain, head injury, etc.*
  - *Transfusion error/serious reaction; i.e., wrong type of blood infused, given to the wrong patient.*
  - *Major IV therapy errors; i.e., wrong rate resulting in overloading/under infused, tissue/vein damage, wrong solution.*
- Major biomedical device failure/damage resulting in injury or having the potential for injury to a patient or visitor. This is also important for compliance with the Safe Medical Devices Act (SMDA).
- Equipment or supply defect or damage resulting in injury to a patient. SMDA reporting requirement, as well.
- Neurological deficit not present on admission (exception: transitory deficit resolved by the time of discharge).
- Organ or system failure not present on admission (exception: patient admitted in critical condition or terminal condition).
- Patient or family says that they will sue.
- Receipt of demand letter from patient or attorney.
- Request for records by an attorney unless you know it regards a situation not directly involving your medical care, such as a patient involved in a motor vehicle accident or Workers' Compensation claim.
- Lawsuit.

(Care Coordination, Continued from page 11)

In all fairness, it cannot be said that things would have been better if the roles were different, if a rural physician was trying to coordinate care for a patient at a tertiary care center, or if the patient was trying to navigate the system himself. Perhaps it would be even more dysfunctional in one of these other scenarios.

The following physicians were directly or indirectly involved in the care: one primary care physician, two emergency medicine physicians, two hospitalists, three oncologists and two general surgeons, and one anesthesiologist. But the patient only needed the primary care physician, one oncologist, one surgeon, and one anesthesiologist. The preliminary diagnosis was already known. In an ideal world, a single phone call from the primary care physician to the local oncologist could have arranged for Jack to be seen in a timely fashion and formulate a treatment plan, including the biopsy.

One can imagine the cost of care for the patient who went through two ER visits and two hospitalizations for what could have been an outpatient procedure and an office visit, both handled locally.

Stories like these are not isolated examples. The complexities of care only increase with the number of chronic conditions our patients develop over time.

COORDINATING THE CARE

It is not always easy to coordinate care for patients with simple or complex needs. Primary care physicians spend countless hours answering phone calls and MyChart e-mails, reviewing

test results and notifying patients, refilling prescriptions, filling out FMLA paperwork, calling insurance companies for pre-authorization on medications and imaging, and so on. This is in addition to 15–20 minute encounters that include seeing patients, applying active listening and other communication skills, gathering history, performing a thorough physical examination, making recommendations, using a health coach approach for lifestyle changes, writing prescriptions, and of course, documenting everything in an electronic health record by the end of the day.

This patient example demonstrates that care coordination is an important aspect of the healthcare delivery for organizations that want to achieve the Triple Aim (quality of care and positive patient experience at lower cost). It will help our patients get the right care at the right time in the right setting, ultimately reducing the cost of care. Until now, this care coordination has been an important aspect of care that has gone unpaid.

INCENTIVIZING CARE COORDINATION

"Healthcare is changing, and part of delivery system reform is recognizing this and making sure payment systems account for these changes," says the Principal Deputy Administrator at the Centers for Medicare & Medicaid Services (CMS), Jonathan Blum. He adds, "We believe that successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs, through reductions in hospitalizations, use of post-acute care services, and emergency department visits."

Starting January 2015, the CMS will pay primary care providers $42.60 per month per qualifying patient for care coordination management (CPT code 99490), provided certain requirements are met. The cornerstone of this service is a requirement to provide 20 minutes of non-face-to-face care coordination services to the enrolled patients. The actual services may be provided by licensed social workers, nurses, medical assistants, certified nursing assistants, and other licensed providers under the supervision of the billing provider.

"When providers realize they will be paid for the work of coordination, more will begin to see this as a responsibility they can embrace as a part of the care they give patients, and their clinics may provide the structure and systems to do so."

Dr. Viral Shah

Additional criteria is that the patient must have two or more chronic conditions expected to last for at least 12 months or to result in death (CMS has not identified specific chronic conditions for this rule, but rather provided a broad definition to be interpreted by the physician). The provider must also obtain the patient's written consent to be included in this care coordination program, for which the patient is also required to pay a nominal monthly co-pay.

The providers must maintain an electronic health record and a care coordination plan based on each enrolled patient's needs. CMS has specified requirements of this care coordination plan. This plan must be accessible to all members of the care team. The providers must follow up with beneficiaries after ER visits and provide transitional care management after a discharge from an acute care facility.

How will compensation for coordination change scenarios like Jack experienced? When providers realize they will be paid for the work of coordination, more will begin to see this as a responsibility they can embrace as a part of the care they give patients, and their clinics may provide the structure and systems to do so. In Jack's specific case, the first physician he saw—in his local town—might have more readily taken on the task of coordinating a local effort.

Whether commercial payors will follow suit and also pay for care coordination remains to be seen; however, the fact that CMS now pays for it may make it more likely. It is a pivotal step to see the payers recognize coordination as an important pillar of care that increases efficiencies and reduces costs and reimburse healthcare professionals for this effort. PR

Ritchie, Alison. "2014 Medicare Fee Schedule Expands Chronic Care Management, Keeps SGR Pay Cuts." Medical Economics. (Dec. 9, 2013). http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cms/2014-medicare-fee-schedule-expands-chronic-care-management-keeps-?page=full

Consistency and Connectivity Are Key

When Your Goal Is Satisfaction

For Bellingham Anesthesia Associates, anesthesia is not just about a pain-free surgery. They are invested in being a part of the greater surgical team to deliver stellar patient care and service. With a service footprint of 12 facilities in three counties—Whatcom, Skagit, and San Juan—they have a range of facility types to satisfy. Within this mix, they provide services for three hospitals, two ambulatory care centers, and a slew of surgical suites.

CONSERVATIVE APPROACHES

Though located in the extreme northwest area of Washington, Bellingham Anesthesia Associates (BAA) does not take an extreme approach to the care they provide, preferring instead to be conservative, safe, and patient centric, even if it means canceling a surgery if additional medical workup is deemed necessary. Everyone is unhappy when a planned procedure cannot go forward, but says CEO Carole Lefcourte, "We're not cowboys. We want to make sure patients are safe and have as few complications as possible." Luckily, BAA works with surgical centers that are also very invested in pre-operative vigilance.

INTERCHANGEABLE

One way BAA sets themselves apart is that their physicians are comfortable with and skilled at working in a variety of surgical settings. Anesthesia care services are delivered seamlessly from provider to provider, and coverage is guaranteed. This means facilities relying upon their anesthesia services can be confident they have consistent, quality anesthesia resources in place when they need it—whether routine or emergent.

Lefcourte says they accomplish this consistent standard by first hiring the best physicians they can, then onboarding them in a way that provides intense exposure in their larger facilities under the mentorship of their more seasoned team leaders. By training at a larger facility where there are always peers nearby, there is a strong mentorship process in place. Says Lefcourte, "We talk about the BAA brand and what that means in terms of clinical excellence, good citizenship, and value-added service to the surgical team and medical community." The first few months a provider spends with BAA are an immersion in that brand of care delivery. The result is that their facilities have a consistent, reliable anesthesia resource at all times.

DID WE MENTION DATA YET?

"A few years ago, with patient satisfaction and positive clinical outcomes in mind, we started collecting quality data. We were pretty sure we were doing a good job for our patients, but we wanted to get more than just anecdotal feedback," says Lefcourte. Because of a sincere interest in knowing how they were doing when compared to national standards, it is now in their framework to measure meaningful performance outcomes. BAA outcomes, in turn, are factored into the overall performance achievements of each facility and can also be used to market themselves to new ones.

Now that the ACA and performance-based payments have come along, they are in a good position to demonstrate their value for continued success. Measurement is baked into their framework. While some may focus on the burdens of data tracking and attendant costs, BAA prefers to keep their eyes on the end goal—improving the patient care experience.

FAST FACTS

PHYSICIANS: 42

SERVICE AREA: 12 FACILITIES IN THREE COUNTIES

LOCATION: BELLINGHAM, WA

MEMBER SINCE: 1987

Says Lefcourte, "If you limit the goal to compliance of regulatory standards, then you're missing the bigger picture. Doesn't it make more sense to focus instead on how to provide the best patient experience in terms of safety, communication, and patient comfort? Why wouldn't you want to be looking at the data to help make that happen? Then data collection is in support of your primary goal and government mandates become almost secondary."

PATIENT SATISFACTION = FACILITY SATISFACTION

Many procedures can be routine for providers, but for patients, any surgery can be intimidating or frightening. BAA is well aware that they are the last person a patient sees before surgery begins, and usually the first person they see when they wake up. Their relationship is not just with the surgical team at the facility they serve, but also with the patients themselves.

While anesthesia providers have a short duration of face time with patients, it is highly concentrated and critically important. "Our providers need to be very skilled communicators to get through a long pre-operative check list while establishing a high level of trust with the patient in a narrow window of time. They need to be kind, reassuring, thorough, and efficient," says Lefcourte, because they are fostering relationships with patients as members of an entire care team.

"Many of our anesthesiologists have developed a deep 'fan base' among patients and are frequently requested by new patients because someone they know recommended them from their own surgery experience. It's a great word-of-mouth grapevine. We do the best we can to accommodate these requests because we know it's pivotal to making the patient feel comfortable with the entire surgical process."

Now, that's satisfaction. PR

> "Many of our anesthesiologists have developed a deep 'fan base' among patients and are frequently requested by new patients because someone they know recommended them from their own surgery experience."
>
> CAROLE LEFCOURTE, CEO, BELLINGHAM ANESTHESIA ASSOCIATES

THE WASHINGTON STATE SUPREME COURT – A HISTORICAL PERSPECTIVE

As Provided by WA Representative Matt Manweller

Only two of the four Washington Supreme Court seats had challengers (SC 4 and SC 7) in the last election. Physicians Insurance recently had the opportunity to sit down with Representative Matt Manweller (R-13) to discuss the value and importance of engaging in Supreme Court elections.

"Over the past 20 years, health care practitioners have achieved significant improvements in the tort environment only to see those victories halted by the Washington State Supreme Court. The first, in 1986, placed caps on noneconomic damages in wrongful death cases. The second, in 2005, required medical experts to certify there was a reasonable basis for a claim before moving to trial, established a 90-day cool down provision to give participants a chance to work issues out, and created a statute of limitations provision as applied to minors," noted Representative Manweller.

The Washington State Legislature passed these provisions with bipartisan support. To date, all of those provisions have been struck down by the Washington Supreme Court. Manweller believes to achieve meaningful reform and improve effectiveness in Washington State, government relations programs need to engage and enhance the focus to the Supreme Court.

Manweller further stated, "In the 1989 Sophie case, the Court eliminated the cap on noneconomic damaged by arguing it violated your rights to a trial by jury. In 2009, the Putman ruling struck down the certificate of merit provision, reasoning that because the Legislature adopted a law that conflicted with the internal rules of the Court, the Legislature had violated the separation of powers doctrine. A year later, in the Waples case, the Court used the exact same reasoning to eliminate the 90-day cool down provision. And finally, in 2014, the Court invalidated the statute of limitations provision for minors in medical malpractice suits on the argument that any privilege given to one class of people cannot be denied to anyone else."

Monitoring the activities of the Supreme Court, much like a legislative voting record, Physicians Insurance engages in judicial elections as a valuable and effective component of our government relations program. The company also sits on the Board of Directors of the Washington and Oregon Liability

Representative Matt Manweller WA State House of Representatives, 13th District, Republican

Representative Manweller was first elected to the Washington State House of Representatives in 2012. He is a Professor of Political Science at Central Washington University, teaching political economy, constitutional law, and classes for the Williams O. Douglas Honors College.

Reform Coalitions. Each year, the Washington Liability Reform Coalition publishes a Judicial Scorecard (visit www.walrc.org).

In addition, Physicians Insurance seeks opportunities to create a political environment in all areas of government (including the court) that respond to and promote negotiated results with a balanced, fair approach to issues of interest to our members and their patients.

As we begin the 2015–2016 biennium sessions and work in close cooperation with organizations that pursue similar goals in Washington, Oregon, Idaho, and the nation's capital, we carry the concerns of our members and their patients, ensuring they are heard by lawmakers at both the legislative and judicial levels. Engaging with the Supreme Court is just one way we demonstrate our commitment to being a strong advocate in all areas of effectiveness in our states and across the nation. (PR)

For more information on the government relations and community outreach program, please visit our website at www.phyins.com or contact Anne E. Bryant, Senior Director of Government Relations at Anne@phyins.com.

LEARN MORE ABOUT YOUR STATE SUPREME COURT

IDAHO
www.isc.idaho.gov/appeals-court/sccivil

OREGON
http://courts.oregon.gov/Supreme

WASHINGTON
www.courts.wa.gov/appellate_trial_courts/supremecourt

WYOMING
www.courts.state.wy.us/WSC

SHIFTS IN LEADERSHIP

Election Update and Analysis

WASHINGTON STATE LEGISLATURE

In Washington State, the Republicans now control the Washington State Senate by one Republican. In addition, one Democrat, Tim Sheldon (D-35) will continue to caucus with the Senate Republicans, creating another session of Senate control by the Senate Majority Coalition Caucus (MCC). The MCC is made up of the Senate Republicans and one Democrat for a 26–23 majority.

The Democrats continue control of the Washington State House; however, the Republicans narrowed the margins by picking up four seats in the last election. For the last two years, Democrats have held a comfortable majority. It takes 50 votes to control the House, so the new Democratic majority will be down to a slim swing vote. House candidate, former Senator Dr. Nathan Schlicher (D-26), was defeated by Republican incumbent Jesse Young.

OREGON STATE LEGISLATURE

Oregon bucked the national trend of Republican gains. Governor John Kitzhaber won his re-election by a slim majority but resigned effective February 18, 2015. Democrat Secretary of State, Kate Brown, has succeeded Kitzhaber as the Governor and will hold the seat until the next election. Both the Oregon State Senate and House Democrats increased their margins in the legislature. These gains put Democrats in both chambers within one vote of the 3/5 super majority. In addition, three physicians won their elections, Dr. Alan Bates (Senate D-3), Dr. Knute Beuhler (House R-54) and Dr. Elizabeth Steiner Hayward (Senate D-17).

IDAHO AND WYOMING STATE LEGISLATURE

Both Idaho and Wyoming continue to maintain strong Republican majorities in the Senate and House. Unlike Washington and Oregon, we anticipate a quiet year with no affirmative legislation and relatively inactive plaintiff trial lawyers. (PR)

NEW CME IN 2015

All CME is offered at no charge to our members

RECORDED, ON-DEMAND PRESENTATIONS

Prescription Monitoring

Time-saving Strategies for Using a Life-saving Resource

COURSE DESCRIPTION: A CDC report released in mid-2014 details a continuing upswing in overdose deaths from prescription pain killers in the U.S.—with the greatest increase in 55-to-65 year-olds! Why is this epidemic continuing? What is your role as a physician in curbing it?

Your state Prescription Monitoring Program (PMP) offers an essential answer. Enhanced technology has made for much easier use in the course of a busy day. This one-hour webinar featuring Dr. Michael Schiesser will show you how the PMP fits into the context of a thoughtful care plan, key workflow solutions that support providers, and how your office staff can facilitate the process. You'll get pointers on talking with patients to gain their acceptance and increase rapport. This activity approved for *AMA PRA Category 1 credit™*.

$25,000 PER YEAR

The potential productivity value of physician time saved by having a medical assistant perform the PMP-query.

WHO SHOULD TAKE THIS COURSE: Physicians of all specialties and affiliated providers involved in direct patient care.

www.phyins.com/PMP

VBAC Revisited

Avoiding the Swinging Pendulum

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

In this one-hour seminar obstetrical leader Dr. Steven L. Clark will address these issues through a reasoned approach to VBAC, based on careful patient selection and a focus on patient safety. This activity approved for *AMA PRA Category 1 credit™*.

Attend this session and learn about:

- Implementing careful pre-labor stratification of women considering VBAC.
- Using predicted success rates and medical evidence to counsel prenatal patients with a prior cesarean birth.
- Ensuring immediate availability of emergency operative intervention for patients undergoing trial of labor after cesarean.

WHO SHOULD TAKE THIS COURSE: Obstetrical practitioners and anesthesiologists

www.phyins.com/VBAC

1-HOUR ON-DEMAND SELF-STUDY

HIPAA Maintenance

Document Control and Quality Improvement

COURSE DESCRIPTION: Medical records are the legal record of care. Billing and accounting records are the heart of the clinic's finances. HIPAA's documentation requirements similarly address the privacy and information-security aspect of the practice. As the first step toward implementing safeguards specified in HIPAA's Security Rule, the Department of Health and Human Services requires organizations to conduct a risk analysis. But what does a risk analysis entail, and what do you absolutely have to include in your report? This activity approved for *AMA PRA Category 1 credit™*.

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

www.phyins.com/HIPAAdocumentcontrol

LIVE SEMINAR

Tools for Your Team

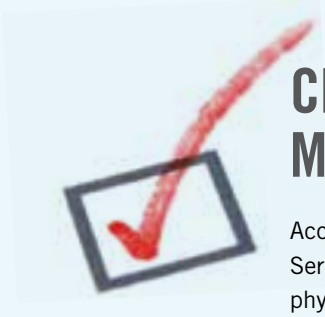
Equipping Your Staff to Improve the Patient Experience

COURSE DESCRIPTION: The crux of improving the experience that patients have in your practice is understanding basic risk management principles and engaging patients to become partners with their health care team. This course will provide strategies to improve communication, enhance documentation in the electronic health record, and increase patient satisfaction.

This two-hour live course was developed by our risk management experts to introduce best practices to improve patient safety and patient satisfaction.

WHO SHOULD TAKE THIS COURSE:
The entire medical office staff, including providers, front and back office staff, supervisors, administrators, and managers.

www.phyins.com/ToolsForYourTeam



Check the Washington State Risk Management Mandate Off Your List!

According to the Washington Health Services Act of 1993, Washington State physicians are required to complete a risk management training program once every three years. This training is a condition of renewal of liability insurance coverage and is often provided by the physician's malpractice insurance provider. Don't worry. We're here to help!

It's Easy to Register: Go to **www.phyins.com/cmemandate1** to register for live seminars or online or printed self-study courses.

All our courses are offered at no charge to our members. While any ONE meets the state criteria, you are welcome to take as many courses as you wish.

The Risk Management Department at Physicians Insurance is committed to offering medical education aimed at improving patient care and reducing adverse outcomes. If you have questions about our educational programs or the Washington State mandate, please contact our Risk Management Department at (206) 343-6526.

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Washington State Seeks Applications for Their Medical Quality Assurance Commission

Application deadline: April 17, 2015

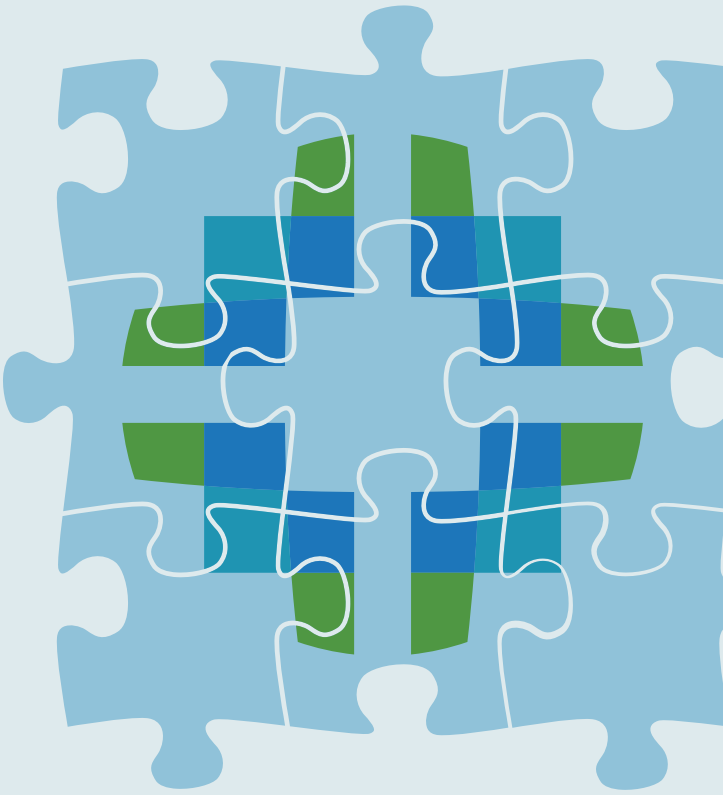
The Washington State Department of Health (DOH) is currently accepting applications to fill upcoming vacancies on the Washington State Medical Quality Assurance Commission. Applications, along with a current résumé, must be received by April 17, 2015.

Member selection for the commission reflects the diversity of the profession and provides representation throughout the state. The commission has openings for:

- One physician representing Congressional District 2
- One physician representing Congressional District 4
- One physician representing Congressional District 10
- One physician at large
- Two public members

The commission consists of 21 members appointed by the governor. It meets approximately eight times a year, usually on Thursday or Friday, every six weeks. Additional information and the application can be found on the Department of Health web site at: http://1.usa.gov/1lwCo45

To address questions about serving on the commission, contact Julie Kitten, Operations Manager, at (360) 236-2757 or email Julie at julie.kitten@doh.wa.gov.



WELCOME TO OUR NEW MEMBERS!

PROFESSIONAL LIABILITY COVERAGE

Coho Medical Group PLLC, Bellevue, WA

Columbia Basin Hospital, Ephrata, WA

Three Rivers Radiology Associates, Grants Pass, OR

MEDICAL STOP-LOSS

DSU Peterbilt & GMC Truck, Portland, OR

Kittitas Valley Healthcare, Ellensberg, WA

ZoomCare, Seattle, WA