

THE Physicians Report

SUMMER 2015 | PHYINS.COM



**Patient Satisfaction
Your Best Defense
Against Litigation**

**Giving and Getting
Feedback
Two Perspectives**

**PNWU SIM Lab
A Valuable Tool to
Enhance Skills, Improve
Patient Experience**

Pursuing Patient Satisfaction

FEELING UNDERSTOOD

A KEY DRIVER OF THE PATIENT EXPERIENCE

One of the points made by the Washington Health Alliance in a recent report on patient experience (from a CG-CAHPS style survey) was how well the patient “felt understood” by the provider and staff. And that impacted all other scores.

When we at Edmonds Family Medicine saw this, we pondered the questions, “How can we let patients know we feel for them without impacting our precious limited resource of time?” and “Do we actively let patients know we care about their challenges (pain, fear, stress, etc.), even though we may quickly move to the treatment/action plan portion of the visit?” We landed upon empathy as a key component of the patient experience.

Empathy: Our Training Focus

Now that we had a topic, we set about finding resources to help educate and equip all providers and staff. We found a great video clip from the Cleveland Clinic on empathy. We revisited Stephen Covey's *The Seven Habits of Highly Effective People*, in particular the lesson on “seek first to understand, then to be understood.”

We also contacted Larry Mauksch, who had previously helped us with training for agenda-setting during an office visit. Professor Mauksch developed training sessions for us focusing on how to express empathy (as opposed to expressing sympathy or ignoring the patient's feelings). For some, this was a bit more warmth and fuzziness than they had anticipated as scientists, but for most in primary care, it was second nature. The timing of the empathetic statement during a patient visit was key, as well as how to proceed to treatment or action plan without negating the feelings of the patient.

We have worried about how to actively engage patients and how to interview them about their needs, while ensuring they feel heard and that we are empathetic problem solvers. We may revisit this training as we move further into managed care.

Operational Topics

Along with helping patients feel understood, we believe we also need to meet other patient expectations, such as prompt responses to their questions, expanded hours, and electronic interaction, to name a few. Stated another way, how do we cut out any hassle-factor for our patients? Anticipating what a patient wants brings us back to the simple question: “When we are patients, what do we want?”

Provider-Staff Health and Happiness

It's hard to imagine that staff and physicians who feel stressed, underappreciated, or ignored will be able to give of themselves with empathy to their patients. Physicians face the challenges of mounting documentation requirements and increased monitoring of electronic security, not to mention coding requests, care gap reports, legislative changes, and administrative forms. All this added work takes the focus off of the human interaction that patients crave.

The best marketing plan for a medical group is to have physicians and staff who believe in work-life balance and, although working hard, take care of their own physical and emotional health. One program our team began a few years ago is a Balint group. This provides support and reassurance or, sometimes, an outlet when feeling overwhelmed.

We are on a journey of improvement, and our stepping-stones rely upon expressing empathy, relieving hassle, and caring for ourselves while we care for others. We find fulfillment and joy in the journey. We also recognize that in the world of shared savings (or total cost of care contracts), patient experience scores are vital to qualifying for any of those savings.

Andrew Thurman,
Family Medicine Physician
Edmonds Family Medicine



EDITORIAL STAFF

PUBLISHER

Mary-Lou Misrahy

SENIOR EDITOR

David Kinard

MANAGING EDITORS

Catherine Kunkel

Kirstin Williams

CONTRIBUTING WRITERS

Andrew Thurman, MD

Sue Larsen

Hemant Goel

Michael Tronolone, MD

Alfred Seekamp, MD

Jessica Martinson

Robbie Sherman, MD

Clint Kelly

Rob Mackenzie, MD

CONTRIBUTING EDITOR

Diana Savage

CONTRIBUTING EDITORS—LEGAL

Catherine Walberg, JD

Kari Adams

Eric Holm

ART DIRECTOR

Jerry Kopec, Mortise+Tenon

EXECUTIVE MANAGEMENT GROUP

PRESIDENT AND CHIEF EXECUTIVE OFFICER

Mary-Lou Misrahy

EXECUTIVE VICE PRESIDENT,

CHIEF FINANCIAL OFFICER AND TREASURER

Rod Pierson

SENIOR VICE PRESIDENT AND

CHIEF INFORMATION OFFICER

Leslie Mallonee

VICE PRESIDENT, GENERAL COUNSEL

Catherine Walberg, JD

SENIOR VICE PRESIDENT, UNDERWRITING

Rick Nauman

SENIOR VICE PRESIDENT,

HUMAN RESOURCES AND ADMINISTRATION

Alison Talbot

BOARD OF DIRECTORS

Ralph A. Rossi, MD, Chairman

Josephine Young, MD, Vice Chairman

Aparna Ananth, MD

Lloyd David

Jennifer Hanscom

John R. Huddleston, MD

Chi-Doo “Skip” Li, JD

David McClellan, MD

Timothy L. Melhorn, MD

John Pasqualetto

Sheila Rege, MD

David A. Russian, MD

Walter Skowronski

Leslie A. Struxness, MD

Brian P. Wicks, MD

READ PHYSICIANS REPORT ONLINE

www.phyins.com/Summer2015

CONTACT PHYSICIANS REPORT

editor@phyins.com

HOME OFFICE:

Seattle, WA

Copyright 2015

Physicians Insurance A Mutual Company



4 Patient Satisfaction
Your Best Defense
Against Litigation
By Sue Larsen



6 Improving Patient Satisfaction Through Efficient Communications
By Hemant Goel



12 Giving and Getting Feedback
By Drs. Michael Tronolone and Alfred Seekamp



16 Managing the Patient Experience
By Dr. Robbie Sherman

ADDITIONAL FEATURES

- 14 CPIN: A Resource for Quality Improvement**
- 18 Patient Satisfaction Goes Digital**
- 20 PNWU SIM Lab a Valuable Tool to Enhance Skills and Improve Patient Experience**

MEMBER NEWS

- 24 Member Spotlight:** Willamette Valley Cancer Institute and Research Center
- 32 Trial Results**
- 36 New Members, Welcome!**
Columbia Basin Hospital Receives 5-Star Rating

GOVT AFFAIRS

- 30 Federal Standard of Care Protection Provision Included**

RISK MANAGEMENT

- 8 Communication Is Critical to Your Success**
- 34 Agency: Income Protection Tools to Fit Your Life**

CME

- 28 CMEs in 2015**
Offered at no charge to our members

SEND FEEDBACK

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

Patient Satisfaction

Your Best Defense Against Litigation

*By Sue Larsen,
cofounder of Astute Doctor Education*



When most physicians think of patient satisfaction, they associate it with patient-experience scores, quality of patient care, Medicare and Medicaid rebates or penalties, and possibly even hospital readmission rates, but few are aware of the strong link between patient satisfaction and medical professional liability risk.

In fact, patient satisfaction scores have now emerged as an important indicator of medical liability risk and can be used to identify and support those physicians at high risk of medical liability litigation.

Let's take a look at the evidence.

We've known for some time that roughly 1 percent of all hospital patients nationwide are harmed in some way, and therefore have legitimate grounds to make a claim. Yet only 3 percent of these patients proceed to file a lawsuit.

An examination of closed claims would indicate that the major cause of the litigation was a failure to diagnose or a medical error. Accordingly, a great deal of time and resources are invested into communicating the importance of thoroughly documenting the diagnostic process and explaining what to do when something goes wrong. Indeed, these approaches are extremely important, and their value should not be underestimated.

The legal process is, however, designed to report only the factual aspects of what went wrong and does not identify why the patient

We've known for some time that roughly 1 percent of all hospital patients nationwide are harmed in some way, and therefore have legitimate grounds to make a claim. Yet only 3 percent of these patients proceed to file a lawsuit.



chose to litigate in the first place. When these 3 percent of patients were asked to cite their reasons, the majority named one of four types of communication problems: feeling deserted, feeling devalued, feeling dissatisfied with the information provided, or feeling that their perspective was not understood. These “triggers” all relate to the patient’s perception of how the physician treated them.

Most patients will forgive if they feel they’ve been treated with respect, but when patients feel devalued, ignored, deserted, or when information has been delivered poorly, anger—not injury—drives their decision to litigate, and the medical error simply creates fuel for the fire.

Providing quality patient interactions may

therefore be one of the best defenses against litigation. The new research evaluating patient satisfaction scores is adding further weight to this view.

The Correlation Between Medical Liability Claims and Patient Satisfaction

Research conducted at Massachusetts General Hospital showed a clear correlation between medical malpractice claims and patient satisfaction.

For every 1-point decrease in patient satisfaction scores, there was a 6 percent increase in complaints and 5 percent increase in risk-management events. Conversely, as patient satisfaction increased, patient complaints and litigation decreased. These results were directly influenced

by the quality of the patient interaction and relationship, and not by any other patient-satisfaction measure.

Furthermore, physicians who ranked in the middle tier for patient-satisfaction scores had a 26 percent higher malpractice lawsuit rate than those physicians in the top third. Alarming, physicians in the bottom third had a 110 percent higher lawsuit rate than those in the top third of the data set. Not only does this research clearly link patient satisfaction with medical malpractice risk, but it also provides an invaluable, evidence-based means of identifying physicians who are at highest risk.

Given that patient satisfaction is such an important and multifaceted factor in determining medical malpractice risk, it makes sense to consider which patient-satisfaction measures are the most important in driving overall patient-satisfaction scores. Essentially, what do patients want most from their physicians? Analysis of the data has consistently shown physician communication is the driving force.

Key Patient Interactions

Specifically, the data has shown that to achieve high patient-satisfaction scores and subsequently reduce risk of medical professional liability litigation, physicians should address the following in their patient interactions:

1. Show respect and listen carefully.

This begins with how you start each encounter. A smile, eye contact, a personal greeting, and a general social comment will go a long way.

Ask them what they think the illness is, what their experience has been, how it is affecting them and what

(Continued on page 26)



Improving Patient Satisfaction Through Efficient Communications

By Hemant Goel, COO at Spok, Inc.

Hospitals and clinics have tracked patient-satisfaction metrics for decades to gauge the perceptions of their facilities and improve services.

Interest in this topic has significantly increased in recent years because reimbursements for care are now partially influenced by scores on patient surveys—such as the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey. These financial incentives have precipitated a closer look at the entire patient experience.

This is not surprising, because poor communications can affect the entire patient experience, from delayed admission and slow response for nurse call requests, to interrupted sleep and a lengthy discharge process. Communication is a common thread through most areas of the HCAHPS survey where patients identify dissatisfaction, with 10 questions specifically targeting the issue.

Here are five areas where communications can affect the patient experience.

1. ADMISSION AND DISCHARGE

While these two processes are on opposite ends of a patient stay, admission and discharge are similar because they require coordinating multiple departments and individuals. Delays are usually caused by inefficient communications among various departments and staff, including housekeeping, transport, physicians, nurses, the pharmacy, and more. Patients don't see all the steps required and can grow frustrated while waiting. Communications can be simplified with automated messaging on mobile devices to alert key staff of required actions. Saving time at each stage of the process leads to better patient flow and happier, more satisfied patients. For example, Lake Norman Regional Medical Center in Mooresville, NC, has simplified this process with an intelligent messaging solution. When a patient is discharged, notifications are automatically sent to a largely mobile group of employees: housekeeping, transport, and any other pertinent staff. This eliminates unnecessary time spent calling individuals and waiting for answers. Transport-staff responses are immediate, reducing patient discharge times and improving satisfaction. Instant messaging to environmental staff also improves bed turnover by decreasing response times and increasing room availability, which improves patient satisfaction through faster admissions.

2. TEST RESULTS

Thousands of diagnostic test results are processed daily in hospitals, in the lab, radiology, and other areas. Within each of these departments, communicating the results is still largely a manual process with multiple phone calls (often in a game of tag with the ordering physicians), and documenting everything in a log book. What does this mean for the patient? Extra waiting that could be avoided.

Waiting for test results can be annoying if findings are clear and the patient could be released to go home. On the other end of the spectrum, patients with life-threatening conditions could experience complications from delayed treatment. Both of these situations can be improved with workflows that automate the results-notification process.

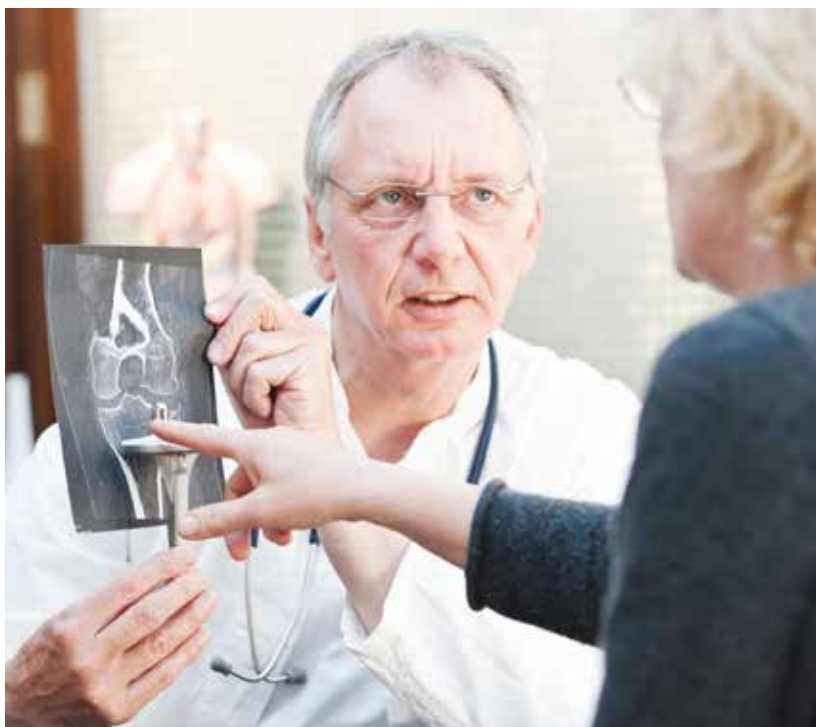
EMH Healthcare in Elyria, OH, has done precisely that. Using a critical-test-results management solution, they have improved the workflows of both radiologists and ER physicians. "We have eliminated the need for radiology nurses to track reports and dictations, maintain a document log, and make calls to notify ER physicians," said Michelle Dossa, Manager, Department of Imaging Services for EMH Healthcare. This means providers at

EMH Healthcare have more time to focus on patient care, patients receive faster treatment, and both staff and patients are happier.

3. QUICKLY RESPONDING TO THE PATIENTS

How quickly staff members respond to a patient's call for help can have a large impact on patient happiness, and two questions on the HCAHPS survey specifically ask about staff responsiveness to calls for assistance.

To tackle this challenge, Lake Norman Regional Medical Center selected a two-way communication solution between patients and nurses. "We wanted to improve nurse responsiveness," said Brian Bissonnette, Director of Information Systems at Lake Norman. "It was one category on patient surveys that repeatedly showed an opportunity for increased satisfaction." The solution includes escalation rules to alert another caregiver automatically if necessary, and it maintains a full audit trail for internal analysis and improvement initiatives. Overall, nurses are able to care for patients more efficiently and respond to queries faster.



4. COORDINATING PROVIDER COMMUNICATION

Coordinating provider communication is an indirect method of enhancing the patient experience by focusing on the clinical avenues for improving outcomes. Patient satisfaction scores may not directly correlate to quality of

(Continued on page 11)





Communication Is Critical to Your Success:

5 Changes Your Organization Can Make Today

What key factors lead to improved clinical outcomes?

Skill and knowledge, of course, are obviously necessary. But communication is also vital and fundamental to developing good rapport and helping patients become engaged in their own health care. Experience has shown us that when patients are engaged, they are more likely to speak openly and honestly about their health issues, better understand their treatment options, and follow through with recommended care.

It is, perhaps, a no-brainer that improving clinical outcomes is a primary goal for all providers, and multiple studies have found that a positive patient experience is correlated with better outcomes. Ultimately, it comes down to patient experience of care.

Patients value quality service on a par with excellent clinical outcomes. This means that

to achieve a quality patient experience of care, you need to successfully deliver both superior customer service and quality clinical care.

It's also been demonstrated that physician compensation is increasingly connected to a patient's experience of care. Both public and private payers are coming to understand how patients perceive their care is a direct indicator of quality.

Historically, providers have tended to focus on the quality of clinical care and have left customer satisfaction initiatives to administration. But today, with the prospect of improved patient outcomes and significant financial incentives on the line, everyone in your organization should have the same goal of promoting and improving the quality of patient service.

(Continued on page 10)

(Communication is Critical. Continued from page 9)

So which changes can your organization make today that will mutually benefit both you and your patients?

1

Minimize distractions and interruptions.



Your time with the patient should be free of any unnecessary distractions. Allow patients to share their story regarding their health issues without interruption. Do not communicate to the patient that you are in a hurry, even though you may be. Interrupting the patient to “get to the heart of the matter” is disconcerting and aggravating to the patient and does not promote rapport.

2

Sit at the same level as the patient and maintain eye contact.



Maintaining eye contact can be a challenge when using computer technology in the exam room to record the patient encounter. Devise strategies so that you can complete documentation but also give the patient uninterrupted time where you can maintain eye contact. This communicates to the patients that they have your undivided attention. Consider carefully the placement of technology in the exam room so you are not turning your back to the patient during the interview process.

3

Listen actively and effectively.



Concentrate on what the patient is telling you both verbally and nonverbally, noting both objective fact and emotion. When the patient has finished talking verbally, summarize the information he or she shared with you and ask the patient to confirm your understanding. Be aware of the nonverbal messages you are communicating to the patient. Avoid crossing your arms or appearing distracted with administrative duties. Leaning in, maintaining eye contact, and nodding at appropriate moments are all strong indicators that you are interested and receptive to what the patient is telling you.

4

Keep it simple and assess the patient's understanding.



It is important to develop an understanding of the patient's ability to process and understand the information that you provide. Your patients have varying degrees of education and health literacy, which may affect their ability to understand the information that you provide. In general, using lay terminology that is easily understood by the patients and their families will ensure that the important elements of medical care are understood. Certain patients may request additional or


more detailed discussion, to which you can then respond. Using the teach-back method requires the patient to repeat the information you have provided in his or her own words. This is a valuable tool to help you gauge the patient's comprehension.

5

Encourage questions.



Encourage patients to ask any questions they may have about their medical concerns and the information you provided during the exam and interview. Patients are often intimidated and fearful about asking questions, thinking they may be asking a “stupid question.” Efforts to reduce the patient's anxiety about asking questions are important. Let patients know that you have provided them “with a lot of medical information today and that this information can be confusing.” Then encourage your patients to ask anything they like regarding today's exam.

Making a conscious decision to implement these techniques can yield significant improvement in your patients' health care experiences. When you take the time to build rapport and engage the patient, you and your patient are likely to find a number of benefits, including compliance with recommended care and improved clinical outcomes, which in turn, lead to an enhanced overall patient experience of care. 



*(Efficient Communications,
Continued from page 7)*

care, but quality makes a difference. Poor communication among hospital staff is recognized as a barrier to patient safety, and disorganized communication among providers causes inefficiencies with treatment planning and care coordination. Leading hospitals are already successfully using mobile devices and intelligent software to improve provider communications, enhance care-team coordination, reduce patient length of stay, and boost patient satisfaction.

For example, The Ottawa Hospital in Ontario, Canada, is using secure messaging to improve communication among staff, including code call notifications. “Staff can easily communicate with one another on all the different devices they carry,” said Margaret Quirie, Director, Library Services and Telecommunications at The Ottawa Hospital. Physicians

are pleased to be able to use their smartphones for smoother communications, message tracking, and detailed replies. By finding the right person quickly, it’s easier for the care team to create a better care plan, which equals better care.

5. PROMOTING A QUIETER, MORE RESTFUL HEALING ENVIRONMENT

Research has shown how important sleep is to mental and physical health, as well as for the healing process. Noise not only disrupts patient healing, but it is also a common source of dissatisfaction. Some hospitals are using technology to foster a quieter environment by reducing overhead announcements and hallway phone conversations.

PinnacleHealth System in Harrisburg, PA, is using technology to route messages to staff and reduce overhead paging and noisy hallway conversations. “We used to use phones to call and ask for beds to be moved. Now, when a text is sent instead, there’s not the noise of someone talking on the phone and walking

down the hall. It’s an efficient method that is also more discreet,” said Chris Hunsinger, Telecommunications Technician for PinnacleHealth System.

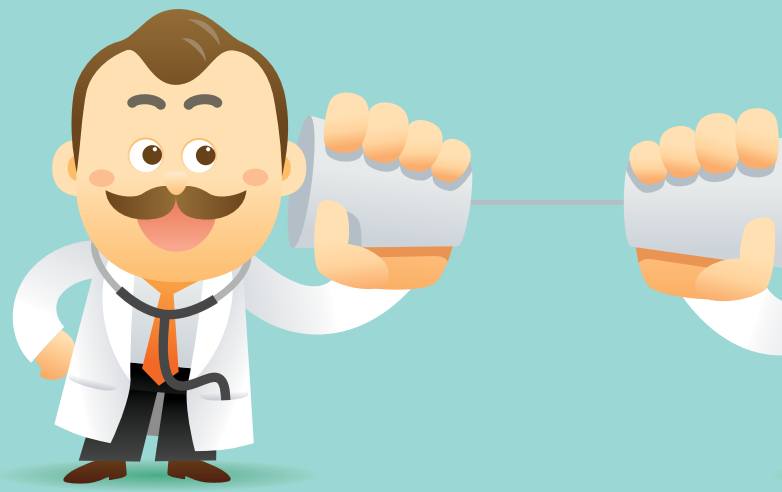
The overarching suggestion for boosting patient satisfaction is frequent, efficient, and timely communication, whether it’s in person with the patient, among care providers, or between hospital systems and staff. Replacing manual processes with efficient technology solutions that support fast, mobile communications will increase patient safety and result in more satisfied patients, from admissions to discharge. [PR](#)

Spok, Inc. is a leader in critical communications for health care, government, public safety, and other industries. Organizations worldwide rely on Spok for workflow improvement, secure texting, paging services, contact center optimization, and public safety response.



Hemant Goel,
COO, Spok, Inc.

Giving and



An Opportunity for Personal and Professional Development

By Michael Tronolone, MD

Receiving timely, nonjudgmental, accurate, and well-intentioned feedback may be one of the most important enablers of professional and personal development. Physicians, by virtue of their professional standing, often find themselves in leadership positions: leading a practice, a surgical team, a department, a clinic, or other group of people.

As part of their leadership skills toolbox, good leaders have the ability to effectively give and receive feedback. This doesn't come naturally to everyone, but good leaders focus first on self-development so they can coach and mentor their team.

The purpose of feedback is to help an individual develop. Feedback should not be confused with performance reviews or corrective actions. Feedback is not judgmental. It can be both positive and critical. Effective leaders are good at both, and they practice both in a balanced way. This is a form of coaching and mentoring that ultimately helps others achieve seemingly impossible personal and/or professional goals.

A KEY TO PERFORMANCE ENHANCEMENT

For leaders, feedback is part of the relationship that they have with their teams and a tool for enhancing team performance. It is a two-way street and should be built on trust and respect. Effective leaders are open to feedback and should encourage it for two reasons: First, this presents an opportunity for a leader to model how to constructively receive and incorporate feedback, and second, it gives the other party an

For most of us, giving critical feedback is more difficult than giving positive feedback. When faced with a situation where one must give critical feedback, it helps to remember that the purpose for the feedback is not to embarrass or chastise individuals but rather to give them insight into their behaviors that will help them become more effective professionally or personally, or both.

TIPS FOR GIVING FEEDBACK

Be timely: Feedback is most effective

As part of their leadership skills toolbox, good leaders have the ability to effectively give and receive feedback. This doesn't come naturally to everyone, but good leaders focus first on self-development so they can coach and mentor their team.

opportunity to practice giving feedback in a safe environment. These are key steps in personal and professional development.

Positive personal feedback is often more rewarding to an individual than public praise. Public praise of an individual may be seen as more of a message to the others about his or her lesser performance. In some instances it may come off as rather perfunctory or obligatory. This is not to say that public praise is to be avoided, but it should be followed up with personal positive feedback.

when it is delivered close in time to the behavior in question.

Be limited and specific: Feedback should be limited to a recent specific behavior or incident; preferably, a behavior or incident that you have directly observed. Do not layer on multiple examples of similar behaviors from the distant past or behaviors that have been reported by third parties.

Be prepared: Know exactly what you want to say and how you want to say it. Practice if you need to. Schedule a time where neither party will be interrupted or distracted.

(Continued on page 27)



Getting Feedback

Creating a Shared Vision of Improvement: A Strategy for Taking Action

By Alfred Seekamp, MD

One of my greatest passions is ensuring high-quality, patient-centered care at all levels of our organization. In my role as Chief Medical Officer at The

unblinded and includes raw scores, percentile ranks, and comments for individuals and departments throughout the organization. I review the data prior to the meeting, looking

We sit around a table and have an interactive conversation, much as a doctor and a patient would. This also provides me with additional feedback about a provider's body language and verbal skills.

Vancouver Clinic (TVC), I have had ample opportunity to talk to physicians and advanced-practice clinicians about their patient experience scores. I approach the conversation as an advocate for the provider's success, thereby engaging them in creating a shared vision of improvement and a strategy for taking action.

There are eight steps I regularly follow that decrease provider defensiveness and increase the sense of alignment going forward:

1. Initial Discussion: I personally e-mail or call providers with low patient-experience scores. In advance of the meeting, I talk to them about the purpose of the meeting and ask them to think about improvement strategies and obstacles. At TVC, patient-experience data is available on our intranet. It is

for trends, areas of success, and potential barriers to improvement. All providers have access to this data, and they can see each other's scores. This is done because providers need to be become comfortable with increasing data transparency. In time, patient-experience data will be made available to patients.

2. The First Meeting: I typically schedule a one-hour meeting in my office. I have the meeting in my office because I want to stress its importance. I greet the provider warmly and thank him or her for coming. We sit around a table and have an interactive conversation, much as a doctor and a patient would. This also provides me with additional feedback about a provider's body language and verbal skills.

3. Connection with Purpose: I start our conversation by asking the provider what he or she enjoys most about the practice of medicine. I then tie his or her personal motivation to why it's important to improve the patient experience. It's not about just improving scores; it's about improving our service and the quality of care that we provide.

4. Coaching on Customer Service: I let providers know of four simple behaviors they can easily adopt to maximize their patient-service interaction. They are:

- Smiling
- Eye contact
- Tone of voice
- Asking the patient if there is anything else that you can do for him or her.

While these seem simple and straightforward, it's amazing how often they are not consistently done.

5. Building on Successes: I look for areas in the patient-experience survey that people are already doing well. Providers are often open to building on and improving things that they are doing.

6. Identification of Barriers: I explore if the provider feels there are barriers or system issues that prevent him/her

(Continued on page 27)



CPIN: A Physician Resource for Quality Improvement

The Washington State Medical Association Foundation for Health Care Improvement (WSMA) has joined with the Washington Health Alliance and the Washington Academy of Family Physicians to create the Clinical Performance Improvement Network (CPIN), an educational program designed to assist physician practices' quality improvement efforts.

The CPIN offers opportunities for medical practices to collaborate with one another by sharing best practices, proven innovations, and resources in order to stimulate accelerated and efficient implementation of quality improvements into practice settings.

In 2015, CPIN webinars will focus on three key courses: Choosing Wisely®, Honoring Choices® Pacific Northwest, and Washington Health Alliance Reports. This activity has been approved for AMA PRA Category 1 Credit™.

For more information and to register online, please visit www.wsma.org/CPIN.

CHOOSING WISELY®

About the Courses

Physicians play a critical role in initiating conversations about appropriate care with patients and other clinicians. Choosing Wisely® is about doing the right thing for patients and avoiding care that could harm them. A national initiative of the American Board of Internal Medicine (ABIM) Foundation, Choosing Wisely has enlisted more than 70 medical specialty societies to create lists of "Things Physicians and Patients Should Question" which provide specific evidence-based recommendations for conversations on the risks and benefits of various medical tests.



The WSMA, Alliance, and The Washington State Hospital Association (WSHA) convened the Washington State Choosing Wisely Task Force, which is working to advance Choosing Wisely in Washington State by identifying opportunities for improvement, facilitating implementation and integration, and ultimately

reducing the number of unnecessary tests and procedures.

At a webinar on September 23, task-force members will provide attendees with specific strategies they can use to reduce overuse and potential harm to patients in their practice. They will also discuss specific steps systems can take to create organization-wide change.

WSMA Foundation board member and Washington State Choosing Wisely Task Force member Scott Kronlund, MD, believes physicians around the state are ready for the initiative.

"If we can put our efforts into this initiative and make it successful, then can we create a halo effect for other issues as well," Dr. Kronlund says. "We're not talking about rationing; we're talking about rational use. We're not saying 'Don't do these things.' We're simply saying, 'Think twice about it.'"

The whole point of Choosing Wisely, he says, is "to catalyze meaningful dialogue between physicians and their patients in the spirit of shared decision-making around the relative risks and

benefits of medical interventions while also becoming better stewards of valuable health-care resources.”

HONORING CHOICES® PACIFIC NORTHWEST

Honoring Choice Pacific Northwest is an advance-care planning implementation program that aims to inspire conversations about the type of care people want if faced with a life-threatening illness. This joint initiative of the WSHA and WSMA seeks to ensure that everyone in Washington State will receive care that honors personal values and goals at the end of life.

Through this initiative, physicians, hospitals and other health-care providers will access the necessary training and resources for discussing, recording, and honoring people's wishes at the end of their lives. Patients will also get the tools they need to make informed care choices and to talk to their families and health-care providers about their end-of-life wishes. Resources are available at www.honoringchoicespnw.org.

At a webinar on October 25, experts will discuss the critical need to improve the health-care delivery system's ability to know and honor patients' choices during serious or life-threatening illnesses, as well as provide specific strategies organizations can undertake to improve end-of-life care delivered to their community.

Dr. Kronlund says some of the most difficult but rewarding times in his career as a family physician have come from open, frank conversations with patients about the end of life. “I have had more people thank me for telling the truth than dodging the issue,” he says. “I have always believed one of the best services I could provide someone is a quality death, in keeping with what they wanted to accomplish in their lives.

“You actually have a professional obligation to let people know when your interventions are futile. You need to ask at that point, ‘How can I help you now?’”

WASHINGTON HEALTH ALLIANCE

Bringing together providers, patients, and insurance companies, the Washington Health Alliance is working to create a high-quality, affordable system for the people of Washington State.

The Alliance is a nonprofit, nonpartisan organization that shares the most reliable data on health-care quality and value in the state to help providers, patients, employers, and union trusts make better decisions about health care. They set

quickly, no matter how dedicated system leaders may be to change,” says Nancy A. Giunto, the Alliance's executive director. “The Community Checkup serves as a reminder that the debate about improving the value of health care, including quality, needs to be a public one with transparent data to inform the conversation.”

At a webinar on November 18, the Alliance will present on the 2015 Community Checkup results which will be aligned with the Washington State Common Measure Set for Health Care Quality and Cost. A diverse group of stakeholders convened to recommend standard statewide measures of health performance to inform public and

“If we can put our efforts into this initiative and make it successful, then can we create a halo effect for other issues as well. We're not talking about rationing; we're talking about rational use. We're not saying ‘Don't do these things.’ We're simply saying, ‘Think twice about it.’”


SCOTT KRONLUND, MD, WSMA FOUNDATION BOARD MEMBER
AND WASHINGTON STATE CHOOSING WISELY TASK FORCE MEMBER

expectations for community performance on evidence-based practices that improve health while reducing waste and cost.

In early 2015, the Alliance presented the results of the Community Checkup—its annual report highlighting health-care quality and value at medical groups and hospitals in Washington State. The community as a whole sees the report as a critical component in the overall effort to transform the health-care system and has become the go-to resource for unbiased, trustworthy data about the quality of health care in Washington State.

“Changing the health-care system is not a task that can be accomplished

private health-care purchasing, as well as propose targets to track costs and improvements in health outcomes. The final list of starter measures was approved in December 2014.

The WSMA Foundation, Alliance, and WAFP are pleased to offer this educational program to physicians across Washington State as a resource for those implementing quality improvements into practice settings. 

Contributed by Jessica Martinson, MS, Director - Clinical Education and Professional Development Washington State Medical Association, Jessica@wsma.org, www.wsma.org.



Managing the Patient Experience at The Polyclinic

By Robbie Sherman, MD

Having a great patient experience starts by putting the patient at the front and center of everything. “Our patients” are the words at the center of the logo we have for our Continuous Process Improvement initiative.

Whenever we start a process or start to drill down on policy or initiatives, we ask, “Does this keep the patient at the center?” “How does this affect our patients?” “Does this add value for our patients?” Our stated goal on that same infographic is “Every patient is completely satisfied with every interaction.”

We’ve gone about doing this in a number of ways. We monitor our patient-satisfaction surveys and comment cards closely, looking for areas that need improvement and responding immediately to complaints. Everyone on our staff has been trained in customer service, and each employee is observed monthly to demonstrate that they are continuing to follow the principles of the training. We use the tool developed by Sharp Reese-Steely called AIDET (Acknowledge, Introduce, Duration, Empathy and Thank You).



As Medical Director for the Patient Experience, I partner with our CEO to keep the clinic on track in matters of patient experience, identifying opportunities for improvement, and sustaining our growth in this matter. Pretty much everything we do touches the patient experience, so our Patient Experience Committee, which meets several times a year, has staff representatives from every department in the organization, as well as a number

and disclosure. We've even started a physician curriculum for communications skills, and I am available for coaching individual physicians who want or need more help. At most of our larger physician meetings, we have a short presentation on various ways to improve the patient experience. This might be a short video on empathy, a presentation on how to position the computer in the exam room, or a review of the Disclosure and Apology Program.


“In my work with physicians, some of the biggest challenges include getting time-stressed physicians to try new ways of organizing their visits or changing the understanding of the visit from a physician-centric point of view to a patient-centered one.”

ROBBIE SHERMAN, FAMILY MEDICINE PHYSICIAN, MEDICAL DIRECTOR FOR THE PATIENT EXPERIENCE, THE POLYCLINIC

of physicians. It's the only committee we have with this breadth of membership. In the last year, the committee chose our patient-satisfaction vendor, worked on improving our patient-education materials, and researched the variety of ways we can listen to the voice of our patient.

In my work with physicians, some of the biggest challenges include getting time-stressed physicians to try new ways of organizing their visits or changing the understanding of the visit from a physician-centric point of view to a patient-centered one.

Another example of our work to manage and improve the patient experience is our partnership with Physicians Insurance to implement an Apology and Disclosure Program. Whenever there is an adverse event or medical error, as soon as possible we disclose to the patient what happened, offer an apology when appropriate, and then do what we can to rectify the situation. This always includes an analysis of what happened and why with process improvements to prevent future errors.

Great patient experience is as much a mindset as intentional project work. The more we remind ourselves to keep the patient at the center, the more effective we are doing just that. 



Robbie Sherman is a Family Medicine physician at The Polyclinic, where she has been in practice for 17 years. She is also medical director for the patient experience.

With the help of Physicians Insurance's Dr. Ron Holfeldt and their Risk Management department, we recently trained 40 persons in the clinic in coaching skills for apology



Patient Satisfaction Goes Digital

Revenue up,
liability down



By Rob Mackenzie, MD, FACS, FACHE

- Our practice has always had a good reputation, but now patient visits and revenue growth have stalled.
- Rapport with our patients would improve if those laptops weren't in the way, or if our billing staff were less aggressive. But without "meaningful use" credits and scrapping for every single co-pay, our take-home pay would be even lower...
- ...and now our senior partner has just been hit with his second lawsuit.
- This isn't fun anymore. How can we better stay on top of issues like practice style and front-office interactions, before more patients leave us—or sue us?

For salaried and independent physicians in large or small groups, this picture is far too common. With the pace of practice faster than ever, reimbursement realities collide with best intentions. Problems that might have been caught sooner in a more relaxed environment easily snowball.

LIABILITY LINKED TO PATIENT SATISFACTION

Every physician who has attended a medical liability seminar knows that most patients sue not so much because of the extent of injury, but because they feel the doctor simply didn't care. So physicians at highest risk for malpractice suits are often those with subpar patient satisfaction scores. But can those practitioners effectively change behavior and lower their risk?

Experience with other kinds of clinical improvement suggests that given timely data on their own performance compared to their peers, physicians can change behavior for the better. Oddly, the same competitive pressures responsible for today's hectic pace are also providing tools to significantly improve patient satisfaction in as little as six months.

One such tool is the electronic patient satisfaction survey with individual practitioner alerts:

Case Study

More than 150,000 patients from six private anesthesiology





practices across the US were surveyed electronically on their experiences using a commercially available 19-question instrument. This survey incorporated elements recommended by the specialty's Committee on Performance and Outcome Measures. Automated contact via e-mail, followed if necessary by text messages and phone calls with interactive voice response, yielded a 25 percent response rate. Responses were received four days on average from receipt of contact information. Results and comments were continuously made available through portals accessible at the organization, division, and practitioner levels. Patients were given opportunities to provide additional feedback directly to the practice. Low scores (Likert 1 or 2) generated immediate alerts to both administrators and physicians.

Within six months, the 1,127 anesthesiologists in the six practices had improved patient satisfaction scores by two deciles, from the 47th to the 67th percentile:



More impressively, practitioners from the lowest decile—those most at risk for liability suits—raised their patient satisfaction scores from the 3rd to the 40th percentile over the same six-month time frame. Most of that improvement occurred during the first two months:



DIGITAL BEATS PAPER

Anyone not on a desert island knows that automated electronic survey tools are nothing special in the business world, but they are the new kid on the block in a U.S. healthcare system still burdened with paper. Traditional paper-based surveys—usually sent by hospitals to just a subset of patients for cost and processing reasons—can take months from patient mailing to final report. They often yield feedback from less than 5 percent of the patient population, can be subject to transcriber error, typically do not provide timely or statistically reliable data at the individual practitioner level, and have been prohibitively expensive for many physician practices.

Moving at the speed of business, electronic patient satisfaction surveys can now be sent to every patient for a fraction of the cost of paper surveys. They can provide results within 2.5 to 4.5 days with response rates as high as 50 percent of patients seen, and offer timely individual provider electronic feedback and alerts. Such survey tools offer patients a quick way to express concerns to the practice while their memories are fresh, so that timely apologies and corrective action can be made by the practice itself—not the legal system.

AN ALPHABET SOUP OF REIMBURSEMENT OPPORTUNITIES

The advantage of electronic patient surveys with alerts goes far beyond reducing medical liability exposure. A dizzying array of evolving acronyms—CAHPS, HCAHPS, PQRS, QCDR, and now MIPS—describes the quality improvement measures, including patient

(Continued on page 23)

Pacific Northwest
University of Health
Sciences SIM Lab

A Valuable Teaching Tool to Enhance Skills and Improve Patient Experience

Like frontline military personnel, those in medical practice must be fluid in their work and rely on split-second assessments. Often life and death hang in the balance.



by Clint Kelly

Thanks to the valuable and refined teaching tool known as Simulation-based Immersive Medical Training, or SIM, a new generation of physicians is entering medical practice with skills honed by simulated medical-crisis management.

For decades, the United States government has led the way in simulation training for space exploration, computer advancement and in military simulation of soldier-, tank-, and flight-training prior to actual battlefield conditions.

Modern medical simulation is indebted to military medical applications such as casualty assessment, war-trauma response, and emergency evacuation. Scenario re-creation from recorded data and communications between medical teams, and between medical teams and patients, owes its development to combat preparation simulation and analysis.

Perhaps nowhere is SIM more in the public eye today than in the worldwide efforts to isolate, contain, and eradicate the spread of the Ebola virus here and in West Africa. From the Centers for Disease Control and Prevention to TSA security checkpoints in the nation's airports, simulation exercises and simulation robots are in use to train medical and screening personnel in disease protocols under rapidly changing "combat" conditions.

TRAINING NEXT GENERATION OF NURSES, DOCTORS

What may be less generally known is that medical simulation laboratories are equipping the next generation of nurses and physicians in medical and health-science schools coast to coast.

“We use medical simulation to prepare our students and future doctors for highly dynamic and complex learning environments,” says Joseph DiMeo, DO, Assistant Professor and Chair of Family Medicine at Pacific Northwest University of Health Sciences (PNWU) in Yakima, Washington. “We want them to learn from identifying what they don’t know and by making mistakes in a safe environment without impacting a live patient.”

In the PNWU simulation lab, a class of 135 medical students is broken into teams of four to six students to complete ten simulations (usually ER-based encounters) over the course of their second year. Students rotate through the roles of leader, scribe, historian, and task performers. Nurses also participate in each simulation, as well as an attending physician/faculty member, a technician who operates the simulation robot/patient, and a person who acts as the “patient’s voice.”

MOCK PATIENT IS A “TALKER”

The mock patient, which DiMeo says is a highly technical piece of machinery, has the ability to talk through the program voiced by a human with a prepared script. The simulation robot is able to manifest all types of abnormal findings affecting vital signs, wounds, heart rate, the skin, and more.

“It’s as if they were at the bedside of an actual patient,” says DiMeo, adding that the students are able to perform all sorts of tasks on the robot, from IV access to catheterization, and from chest tubes to artificial airways. In the spring, “SimMom” gives students basic experience in birthing procedures.

Hands-on training through simulation is essential in developing physician and other medical staff mastery of the components of successful patient interaction, including learning to show respect, effective listening, responding quickly to patients, and other key encounters that boost care quality, as well as the patient’s overall perception of his or her experience.

It has been no simple task for third-year student Kristi Trickett, who learned to think quickly under high-pressure stress. “When studying the renal system, we had a SIM case

of a patient in acute renal failure. We had to use our early knowledge of pharmaceuticals to determine how to protect his heart, how to appropriately diurese him, and how to order appropriate testing—all in the right order.” This occurred while faculty interjected random challenges such as an agitated spouse who needed calming, or O2 saturations that took a sudden dip.

In Trickett’s renal failure SIM training, the “patient” moaned in obvious distress from stomach pain while team members yelled their findings for the team to absorb:

- Historian: “He has diabetes, has a history of A-fib, and is allergic to penicillin!”
- Team Leader: “Nurse, his fever’s still high. Give him some Tylenol, please!”
- Scribe: “Have we missed anything?”
- Task Performer: “Did you get the Foley in? Another physical please!”
- A Voice Overhead: “The encounter is now over. Please leave the room!”



Each SIM session is followed by a 20-minute debrief with feedback from the team and the observing physician. “Having someone on the microphone responding in real time while we worked away on their robot self in the lab was challenging, and at times even humorous,” says Trickett.

More often, however, the voice from above added to the emotional stress level, especially if a patient “died” on the table. Most student teams experience the loss of at least one robot patient, says DiMeo, and it can be traumatic. “There’s an attachment to the patient. Some

(Continued on page 22)

(PNWU SIM Lab, Continued from page 21)

in the medical community agonize over this. Should students be exposed to the death of the SIM man? When we ask students whether they learn more when he lives or when he dies, they often respond that as painful as it can be, they learn more from a death.”

It is that holistic approach, especially in osteopathic medicine, which brought third-year student Jarrad Morgan, a graduate of Grinnell College in Iowa, to PNWU. “The focus on the whole person and not just their symptoms, was an enormous draw for me.”

“This is an improvement to patient safety,” agrees DiMeo, who is also in private practice at Terrace Heights Family Physicians in Yakima. “Simulation allows access to some medical situations that might otherwise take months or years to encounter in practice. In the delivery of babies, for instance, there are a multitude of possible complications in birthing and delivery. Our students get exposed early.”

“It helps produce physicians who already have experience with stressful situations or complex procedures in a controlled environment before they encounter them in their careers or subsequent training. We’ll be able to respond more quickly and effectively.”

JARRAD MORGAN, THIRD-YEAR STUDENT, PNWU

“We were all worried that it could happen,” says Trickett, who earned her undergraduate degree in biology/chemistry from Seattle Pacific University. “The simulated deaths were set up so that two teams could make the same decisions, but in one case the SIM man would react to treatment as expected and survive, while in the other case the SIM man would become spontaneously unstable and die.”

GRIEF, STRESS PART OF SIM EXPERIENCE

“For some students it was stressful and emotional,” she continues. “Someone they cared for died. Others anguished over the thought they did something wrong.” Trickett acknowledges that while it might sound silly to some outside of medicine, she and her fellow students found that facing the fact and the fear of the death of someone in their care, even a robotic patient, was enough to keep them on their toes.

Trickett is convinced SIM training benefits patients, builds physician empathy and understanding, and will also will make her a better family medicine specialist. “The patient is a human being who can use words of encouragement, [give] regular updates on their condition, and an understanding of what is coming next. In the end, I must not forget that in the practice of medicine, there is always a human patient in the middle of it all.”

Morgan believes SIM lab training provides great benefit to patients. “It helps produce physicians who already have experience with stressful situations or complex procedures in a controlled environment before they encounter them in their careers or subsequent training. We’ll be able to respond more quickly and effectively.”


In his community medical rotations thus far, Morgan has encountered real patients with similar complaints to what his SIM patients presented last year. “Although not as emergent a situation as I experienced in the

PNWU is soon to graduate another class into medical residency. The student physicians have begun to see patients, guided by an experienced physician, and soon will be able to go out on their own. DiMeo says that thanks to the simulation exercises, the new physicians have built personal confidence, learned how to build and work together as a team, sharpened their medical decision-making skills, and have already experienced acute care scenarios that have prepared them for real practice. Because PNWU has a mission to educate students interested in primary care among rural and underserved populations, DiMeo is confident their intense SIM lab role-play will serve them well.

“Primary care involves a patient from



SIM lab experience, I knew how to approach the patient, what questions to ask, what symptoms to look for, and what treatment approaches to consider. SIM lab provided the framework for me to improve my understanding of the new material and new situations that come up in rotations.”

birth to geriatric care,” notes DiMeo, who graduated medical school in 1997 and says it would have been a real advantage to have had a SIM lab as part of his training. “A primary care physician in a day may see all extremes and diversities from cancer to newborns. Basic SIM lab training prepares doctors for a very broad range of possible outcomes” 



MARK YOUR CALENDAR FOR Sept. 19, 2015!

Get Ahead of the Code: Advanced Simulation Training for Physicians

Simulation event offers hands-on, technical training for complex procedures, code situations

Our culture has high expectations for physicians. Considered experts, physicians are expected to be highly competent at every procedure within their specialty. But how do you build and maintain competency in situations you face infrequently? The answer is simulation training.

Physicians Insurance, in partnership with the InSytu Simulation team of Swedish Medical Center, will offer a special, one-day simulation **Get Ahead of the Code: Advanced Simulation Training for Physicians** from 9:00 a.m. to 4:30 p.m. on September 19, 2015. The event will be hosted by Pacific Northwest University of Health Sciences at their campus' state-of-the art learning environment. This valuable, hands-on training opportunity is offered at no charge to Physicians Insurance members.

At the Simulation-based Immersive Medical Training, or SIM lab, emergency physicians, obstetrical providers, hospitalists, and intensivists will hone the skills required for difficult procedures and code situations. They will practice with colleagues on high-fidelity simulation mannequins, receive real-time feedback from faculty, and share insights with colleagues.

The training event also includes lunch and features a keynote presentation by patient safety champion John Nance, JD, who is a *New York Times* best-selling author and ABC News aviation analyst.

Watch your mail for a personal invitation to this special event soon. Space is limited, so register early by calling (800) 962-1399.

(Patient Satisfaction Goes Digital, Continued from page 19)



satisfaction, which will increasingly set future physician reimbursement from both governmental and private payers. The use of sophisticated measurement and accountability tools is fast becoming the mark of successful physician groups and hospital competitors in today's medical marketplace.

IMPLEMENTATION EXAMPLE

Arizona Digestive Health, a group of 50 providers across 30 locations, now places its practitioners' satisfaction scores front and center on Web-site bios alongside their education, specialties, board certifications, and hospital affiliations.

Ian Rogers, Director of Marketing and Patient Relations for the group through early 2015, explained it this way.


We strive to be at the forefront of technology, and appreciate that surveys are sent via e-mail, text message, and automated phone system. At intake, we gather patient e-mail addresses and phone numbers, and note which are cell phone numbers. As a result of meaningful use, we've become very good at standardizing and updating our intake forms across the organization. Through these updates we are able to gather essential patient information, which has certainly helped collect more patient satisfaction data....

I like the Contact Me feature of the [survey's] solution. The office managers are the first line of defense in contacting

patients who may need to share further concerns about their experience, but I see the alerts too, and can stay on top of what's going on in all of our locations. We take that feedback to heart and appreciate the information that patients are willing to share.

To be sure, some of the fixes identified by patients through the survey had nothing to do with grumpy docs:

"We added trash cans and coat hangers in the waiting areas," finished Rogers. "It was a simple change, but small things can really add up in terms of patient satisfaction."

Ultimately, improving satisfaction with digital surveys and other tools is simply doing the right thing by our patients. But reducing liability exposure, improving reimbursement, and gaining competitive position can help to make the practice of medicine fun again. 



Dr. Rob Mackenzie, President of Mackenzie Consultants LLC, served on the staff of Cayuga Medical Center, Ithaca, New York, as general and vascular surgeon, VP Medical

Affairs, and President/CEO. His company provides strategic advice to SurveyVitals (www.surveyvitals.com), a provider of a suite of electronic survey solutions for medical practices and hospitals, which supplied the above case study and implementation example with the practices' permission.



A Continuing Mission of Hope with New Focus on Value-Driven Care

As a young teen, Chris Achtien lost his father to lung cancer. The experience affected Chris deeply as he saw the ravages of cancer on the body and the toll it takes on loved ones. But rather than avoid the world of cancer care and research, he embraced it.

“I never thought that managing cancer centers would be my career,” Achtien says. “While I’ve always worked in health care, when I joined a cancer center in Indiana more than 17 years ago, I discovered I loved working with physicians and clinical staff to deliver cancer care. I found my interactions with patients weren’t depressing. You hear heartrending stories, but there are also uplifting stories.”

Today, as executive director of Willamette Valley Cancer Institute and Research Center in Oregon, Achtien still finds his days are filled with much more hope than sadness. “There will always be down days for our patients as they go through their cancer journeys, but mostly I see positive and often amazing things happening!”

Achtien’s optimism and confidence about meeting the complex challenges of delivering health care today underscores WVC’s mission of hope and patient advocacy.

ACA DRIVING NEW CARE MODEL

Like many health-care organizations, WVCI is adapting to changes resulting from the Affordable Care Act. And that means moving from a primarily fee-for-service model to value-based contracting and payment. "Switching our focus has been huge," Achten says. "This means we're not just doing procedures. Now we must evaluate what we do and how we do it, adapt, and demonstrate our value to patients and payers."

One way WVCI is adding value to the patient experience is through a new advance-care planning initiative which was implemented in response to patient feedback. "We are responding to patients who come into the ER not knowing they have a terminal disease," explains Achten. "At that time, they are told by a doctor they are dying, and they are completely unprepared. What we saw was the need to help people who were completely blindsided; to facilitate their understanding of the disease and make sure they and their families are informed."

WVCI's "My Choices My Wishes" program provides patients, who have especially aggressive cancers, access to social workers to educate them about their disease, its prognosis, and available

"The caliber of physicians, breadth of cancer services, and technology we offer is world-class. It compares favorably with cancer centers in much larger areas."

CHRIS ACHTIEN, EXECUTIVE DIRECTOR, WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER

treatments so they and their families can fully understand the course it will likely take. A key part of the program involves helping patients make informed choices about what treatment they want, for how long, and deciding when they want to stop treatment.

While WVCI's providers remain focused on hope and curing cancer, My Choices offers patients and their families peace of mind. In fact, Achten notes that studies have shown that having an advance-care plan actually may enable terminal patients to live longer. Along with offering peace of mind, advance-care planning may save patients, providers, and payers money. It's well documented that care costs at the end of life can be extremely high, often the highest of any time during a person's life. So Achten and his team believe it makes sense for an oncology practice to study how many people receive chemotherapy in their final days of life and the resulting costs. "You have to ask, 'What value do they get out of this therapy?'" Achten says. This is why they want to make sure they help patients make their own choices based on all available information.

Results have been positive. "It's a win all the way around," says Achten. "Our doctors win as this important discussion happens at the onset of treatment. It's a win for patients and their families as our social workers have conversations at different times during

FAST FACTS

PHYSICIANS: 16 MEDICAL-ONCOLOGY, RADIATION AND GYNECOLOGICAL ONCOLOGY SPECIALISTS

SERVICE AREA: BASED IN EUGENE, FOUR SERVICE SITES COVERING WILLAMETTE VALLEY AND BEYOND

MEMBER SINCE: 2013

the patient's treatment, thus ensuring they have a clear plan. And it's a win for everyone as costs are reduced and greater value is delivered."

AN INTEGRATED APPROACH

Focusing on the treatment of adult cancers, WVCI's team of medical-oncologists, radiation and gynecological oncologists, treat virtually every kind of cancer, including complex blood cancers, such as leukemia and lymphoma.

WVCI sets itself apart by offering a fully integrated approach to

care. In addition to providing the latest in cancer-fighting medical treatments and technologies, it also offers a wide range of support services to address the emotional, physical, and spiritual needs of patients. For example, all breast, colorectal, and lung-cancer patients receive guidance from a patient navigator who helps them anticipate, address, and overcome any challenges in the treatment process and coordinates services to improve their quality of care.

Information overload is a common problem for patients with complex diseases. So the navigators steer them to a clear understanding of their treatment course, including side effects of medication and how to deal with them, in addition to providing access to social workers, counselors, support groups, dieticians, massage therapists, and an on-site pharmacy. The goal is to ensure that the patient's holistic needs are addressed.

CLINICAL TRIALS CLOSE TO HOME

A common misperception is that patients can access clinical trials and experimental treatments only in large cities or academic medical centers, but WVCI provides this at their clinics in Eugene and Springfield.

As a member of US Oncology Research, WVCI offers patients

(Continued on page 27)

(Best Defense, Continued from page 5)

they want from you, and acknowledge their responses. This will give you insight into their values and belief systems. Facilitative responses such



as “Uh huh...” or “I see...” can show the patient they've been heard without indicating agreement. Reflective statements such as, “If I understand you correctly...” and “Let me recap what I've heard...” also show the patient you have listened and are seeking understanding.

When patients feel they have important information to contribute to their diagnosis but their contribution is ignored, they become predisposed to litigate should a missed or delayed diagnosis actually occur.

2. Spend enough time with patients: Avoid the temptation to look at your watch or to talk to them while you have your hand on the door handle to leave. Consider putting a clock on the wall behind the patient so you can keep track of time. And minimize time spent looking at your computer screen; it detracts from quality time.

Perception is reality. Leaning against a wall of the hospital room or sitting on the end of the bed can give the perception of available time without necessarily increasing actual time spent with the patient.

3. Show knowledge of the patient's medical history: Read the patients' notes before you see the patients. It shows that you respect their time and builds their confidence in your ability.

It's not rocket science and may seem minor, but it's among the top three things patients want and may prevent them from acting out of anger.

4. Adequately address health questions and concerns: Always assume patients have concerns, and ask them what these are. Don't say, “Do you have any questions?” Instead say, “What questions can I answer for you?” And when you've answered the question, make it easy for them to say, without looking foolish, that they haven't understood. For example, it is far better to say “Many people find this difficult to understand; what can I clarify for you?” than to say, “Is that clear?”

And always ask, “What other concerns do you have?” until the patient has exhausted the list. Patients often do not lead with their main concern. They may present two or three issues before finally raising the issue they really came to discuss. You can then work with the patient to prioritize concerns and arrange follow-up times, as necessary, to address them all. This simple technique could avoid a delayed or missed diagnosis.

5. Provide explanations that are easy to understand: Nearly half of all adults in the United States have trouble understanding what the doctor tells them about their condition and how to take their medicines.

Patients often say they didn't know they needed a follow-up appointment, follow-up tests, or what the out-of-pocket expenses would be, while doctors are adamant these conversations took place. Remember that patients don't do this


every day and can process only a limited amount of new information at one time.

Techniques for effectively delivering information to patients include: using diagrams, saying the same thing in three different ways, using examples, and relating to things the patient already understands.

Patients will be more likely to remember an instruction if you paint a visual picture for them and link it to something they routinely do. For example, “Keep your tablets with your toothbrush and imagine the pill sitting on top. When you brush your teeth in the morning and at night, you'll be more likely to remember to take them.”

And ask the patients to repeat back their understanding so you can be confident that they've understood it.

The impact of strong physician communication cannot be underestimated. One standard deviation-point increase in the quality of the interaction is associated with a 35 percent lower chance of a patient complaint.

In medical liability, as in medicine, prevention is always better than a cure. Patients are far less likely to sue a doctor they like, so ensure that ongoing interpersonal-skills-development is an important part of your personal risk-prevention strategy. 

Sue Larsen is cofounder and Chief Operating Officer of Astute Doctor Education, a global education company committed to transforming health care through improved physician bedside manner. Astute Doctor provides a comprehensive suite of physician interpersonal skills courses that improve patient experience and health outcomes, improve health-care efficiencies, and reduce physician risk of malpractice litigation.

The company's website is located at www.astutedoctor.com. Phone: (646) 783-1000. E-mail: SueLarsen@AstuteDoctor.com.

(An Opportunity, Continued from page 12)



Be factual and accurate: Gather as much firsthand information as you can get. If there are gaps in information, acknowledge that during your discussion and allow the person to fill in those gaps. This is a good technique to get him or her engaged.

Be nonjudgmental: Do not ascribe intentions to behavior. Try to get the person to make a judgment about his or her own actions. Questions such as “Can you see how someone might interpret your intentions?” can move an individual into a reflective space where he or she can develop a personal insight.

Maintain your cool: Do not allow yourself to be drawn into a debate or an argument. De-escalate. Keep on message. Your objective is not to win an argument but for the individual in question to hear what you’re saying

and internalize the feedback in a constructive way.

Remember, one of your key roles as a leader is to coach and mentor your team members. This starts with a commitment to your self-development. Be open. Practice these tips and ask your team for feedback on how you are doing with giving and receiving feedback. [PR](#)

Contributed by Michael Tronolone, MD, Chief Medical Officer of The Polyclinic in Seattle.

(Creating a Shared, Continued from page 13)

from being successful. I explore if the provider feels there are system issues impacting his or her success, including sufficient appointment time length, adequate staff, or other resources. If other providers are also being affected, a group problem-solving session develops physician-led solutions.



7. Identification of Goals: I encourage providers to set goals that are SMART (specific, measurable, achievable, results-focused, and time-bound) and link them to their personal purpose, which is a powerful source of motivation. I also offer a variety of resources to providers, including individual coaching (which is provided at organizational expense).

8. Wrapping Up and Looking Forward: At the end of the meeting, I thank the person for coming, reemphasize the things he or she is doing well, compliment him or her on goal-setting progress, and give reassurance that I believe in the individual. I schedule a follow-up meetings in three to six months, document the conversations in their personnel files, and send the providers an e-mails thanking them for chatting with me, summarizing their commitments, and asking them to contact me along the way if they have questions.

I thoroughly enjoy helping my colleagues to succeed in practicing medicine. I am committed to helping motivate them by connecting their patient-experience goals to their individual purpose and to the organizational vision. [PR](#)

Contributed by Alfred Seekamp, MD, Chief Medical Officer, The Vancouver Clinic, Vancouver, WA.



(Spotlight, Continued from page 25)

access to one of the nation’s largest research networks, specializing in Phase I-III trials for a wide range of cancers. Patients also benefit from a top-notch team of clinical researchers who lead numerous national studies in immunotherapy, vaccines, targeted therapies, and radiation trials. These oncologists are conducting important work that is changing the cancer treatment landscape.

Clinical trials currently underway at WVCI include investigational therapies for cancer of the breast, kidney, lung, lymphatic system, prostate, and more.

“The caliber of physicians, breadth of cancer services, and technology we offer is world-class. It compares favorably with cancer centers in much larger areas,” Achten says.

Clinical trials enable WVCI to differentiate itself and add value to the patient experience. They also help keep WVCI’s executive director—and many others—seeing the positive side of today’s evolving cancer care. “I know we have big challenges ahead, and there have been and will continue to be very significant changes to our model of care, but I find it stimulating,” Achten says. “I work with bright and dedicated people who will make it better.” [PR](#)

CME IN 2015

All CME is offered at no charge to our members

1-HOUR ON-DEMAND SELF-STUDY

Patient Complaints and Service Recovery

Strategies for Successfully Handling Customer Satisfaction Issues

COURSE DESCRIPTION: Poor communication can damage



a patient's confidence in the interest, competence, and attitude of the health-care team. When confidence is undermined, any complication or adverse result can lead to a complaint, and if the complaint is not handled appropriately, litigation can result.

This one-hour live webinar is taught by Leslie Moore, RN, JD, CPHRM, a Senior

Healthcare Risk Management Consultant with Physicians Insurance. She is based in the Eastern Regional Office and provides risk-management services throughout Central and Eastern Washington, and also Idaho. She has more than 15 years experience in the health-care risk-management and compliance field working with rural and large urban hospitals, as well as small physician practices and large multi-specialty clinics, to promote patient safety. She will address the issues

that lead to patient dissatisfaction and will present strategies to prevent the errors that result from communication failures. This activity approved for *AMA PRA Category 1 credit™*.

At the conclusion of this self-directed e-learning activity, participants should be able to:

- Review and discuss strategies to effectively and confidently address and resolve patient/family complaints..
- Identify trends and patterns that precipitate patient/family complaints in order to develop appropriate action plans.

WHO SHOULD TAKE THIS COURSE: This course has been designed for physicians and allied health staff, as well as clinic administrators, managers, and general office staff in situations of dealing with dissatisfied patients and/or their families.

www.phyins.com/patientcomplaints

Language & Cross-Cultural Communication

Overcoming the Barriers

COURSE DESCRIPTION: The Northwest is among the fastest growing areas in the country, with projected increases of diverse populations expected to reach up to 150 percent in the next 20 years. Effective cross-cultural health care involves a combination of communication skills and resources for providing appropriate services.

This one-hour e-learning module features Cathy Reunanen, ARM, CPHRM, a Senior Healthcare Risk Management Consultant with Physicians Insurance. With more than 30 years of experience in the health-care field, she provides site reviews, consultative services, and risk-management education for health-care providers and medical office staff throughout Washington State. Cathy is an active member of

the American Society for Healthcare Risk Management and the Washington Health Care Risk Management Society.

The course was planned and produced in accordance with the Accreditation Council of Continuing Medical Education (ACCME) Essentials. It is intended to help you increase proficiency at communicating with culturally diverse patients and those with low health literacy. This activity approved for *AMA PRA Category 1 credit™*.

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

www.phyins.com/languageandculture

RECORDED, ON-DEMAND PRESENTATIONS

Transitioning Care in the Face of Painkiller Addiction or Abuse



COURSE DESCRIPTION: “I’ll be going out of town next week,” says Mrs. Johnson, “so I’m hoping you can refill my prescription today.” Mrs. Johnson is a long-term patient whom you trust, but this is her second request for an early refill of oxycodone. How should you evaluate her request in light of the 16,000 unintended deaths each year from prescription opioid analgesics?

Every touch point with a patient is an opportunity to consider risks of opioid therapy and to realign management towards best health outcomes. This one-hour webinar, featuring Dr. Michael Schiesser, a widely accomplished and respected physician leader and a national expert on issues of pain care, addiction medicine, and evolving standards of care in clinical delivery involving controlled substances, will also help you to engage patients in conversations that build partnership. You’ll hear examples of dialogue that squarely address high-risk situations and options for tapering or alternative treatment. This activity approved for *AMA PRA Category 1 credit™*.

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

www.phyins.com/transitioningcare

SAVE THE DATE: September 25, 2015

PHYSICIANS INSURANCE HOSTS SUMMIT ON HOSPITAL RISK MANAGEMENT

Join us for a full day of expert speakers, networking with other hospital leaders, and hearing keynote speaker John J. Nance, JD, ABC News aviation analyst and New York Times best-selling author. Offered at no charge to Physicians Insurance members, this conference will be 8:00 a.m. to 5:00 p.m. at the DoubleTree Hotel Seattle Airport. It will provide insight about the emerging trends and risks facing hospitals today—plus you will learn from a diverse group of legal and claims experts how to manage such risks.

Register at www.phyins.com/hospitalsummit2015

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

Look for your invitation to this special event soon. It will include the full list of speakers. Space is limited, so register early by calling (800) 962-1399 or www.phyins.com/hospitalsummit2015



Featured speaker
John J. Nance, JD

Author of *Why Hospitals Should Fly* and *Charting the Course*

FEDERAL STANDARD OF CARE PROTECTION PROVISION INCLUDED IN H.R. 2



Medicare Access and
CHIP Reauthorization
Act of 2015



We are pleased to report that the 114th Congress passed bipartisan legislation H.R. 2—Medicare Access and CHIP Reauthorization Act of 2015—which repeals the sustainable-growth-rate formula and revises Medicare’s payment policies to tie reimbursement to certain quality measures. The bill passed the House with a 392-37 vote, the Senate with a 92-8 vote, and was signed by the President on April 16, 2015.

Included in the Medicare Access and CHIP Reauthorization Act of 2015 is a standard of care protection provision in Section 106(d) that Physicians Insurance has worked on for more than five years with our national insurance trade association PIAA (<https://www.piaa.us>) to promote access to care and protect health-care providers and their patients in cases of alleged medical liability.

Section 106(d) of the new law clearly states and clarifies that no federal health-care provision shall be interpreted as creating a duty of care or the standard of care owed by a health-care provider to a patient in a medical liability or medical product liability action or claim.

We applaud the 114th Congress and the President for acting and recognizing the importance of this standard of care provision to ensure that federal health-care metrics and reimbursement guidelines may not be misused to expand

opportunities in claims of medical liability. It is a step in the right direction.

Although health-care providers continue to face challenges under the current medical liability system, they now have assurances that protections are in place to ensure that

We applaud the 114th Congress and the President for acting and recognizing the importance of this standard of care provision to ensure that federal health-care metrics and reimbursement guidelines may not be misused to expand opportunities in claims of medical liability. It is a step in the right direction.

federal health-care guidelines and regulations are not misused in court to prove, or disprove, allegations of medical negligence—a section of law that protects both health-care providers and patients.

The federal law also sets out certain quality metrics. Physician reimbursement depends in part on performance against those metrics. The standard of care provision protects physicians and patients by expressly prohibiting those government performance measures from being used by plaintiffs to establish a deviation from the standard of care or by defendants in trying to show the physician-delivered care consistent with the standard of care.

CLOSING THE DOOR ON NEW CLASS OF LAWSUITS


Simply put, the new law clarifies that federal guidelines or standards regarding health care, which were not designed to establish a standard of care, should not be interpreted as creating a standard of care. Thus the law merely ensures that provisions of federal health-care law are used only as intended—not to generate new lawsuits or protect providers from claims of negligence.

This provision does not change prior law or alter the way courts seek to determine if an act of medical negligence occurred. It also offers no new protections from medical liability lawsuits. Instead, it simply maintains the status quo on matters regarding the standard of care in such lawsuits and guarantees that the playing field is not inadvertently tipped to favor either defendants or plaintiffs.

Below is an excerpt from H.R. 2 – Medicare Access and CHIP Reauthorization Act of 2015, Section 106(d)(1) below:

(d) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—Subject to paragraph (3), the development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

Please see www.congress.gov/bill/114th-congress/house-bill/2/text for full text of H.R. 2 – Medicare Access and CHIP Reauthorization Act of 2015. 



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



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

GOVERNMENT RELATIONS UPDATE

FEDERAL

We are working to promote H.R. 865, Good Samaritan Health Professionals Act of 2015, which provides protection from medical liability lawsuits for health-care professionals providing uncompensated services to victims of federally declared disasters.

WASHINGTON STATE LEGISLATURE

We defeated proposals to expand liability in wrongful death and survival claims (SB 5747) and a proposal to allow private parties to pursue private causes of action against medical providers in false Medicaid claims (SB 5287/HB 1067).

We supported a proposal that allows for coverage of telemedicine services in an effort to lower costs and improve access to health services. The new law becomes effective July 26, 2015 (Sections 2-4); January 1, 2017 (SB 5175).

We continue to seek opportunities to partner with the governor in supporting his “Healthier Washington” five-year plan to transform health-care delivery by promoting community health, improving quality of care, and lowering health-care costs.

OREGON STATE LEGISLATURE

We defeated proposals that would add insurance to the Unlawful Trade Practices Act and expand the types of lawsuits that are brought against insurance companies (HB 2248/SB 314; HB 2257/SB 313).

We continue to work to defeat a proposal that increases the \$500,000 cap on noneconomic damages recoverable in wrongful death actions and other statutorily created causes of action to \$1.5 million (SB 409).

We continue to work with the Oregon Patient Safety Commission as it develops and further implements the Early Discussion and Resolution Program, a voluntary and informal process to resolve adverse health-care incidents.

Please note: At the time of publication, both Washington and Oregon Legislatures are still in session; therefore, the status of the legislative proposals reported are subject to change until adjournment.

Trial Results



The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact health-care professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.



Failure to Diagnose

SPECIALTY: Internal Medicine

ALLEGATION: The estate of a 47-year-old male alleged failure to diagnose rectal carcinoma following episodic care which had included a negative stool guaiac test and negative flexible sigmoidoscopy. The estate claimed lost wages and general damages.

PLAINTIFF ATTORNEY: Mark Leemon and Sidney Royer, Leemon and Royer, PLLC, Seattle, WA

PLAINTIFF EXPERTS: Stephen Payne, MD, Internal Medicine, Cincinnati, OH; Douglas Rex, MD, Gastroenterology, Indianapolis, IN; Ronald Goldberg, MD, Oncology, Puyallup, WA

DEFENSE ATTORNEYS: Lory Lybeck and Ben Justus, Lybeck & Justus, PLLC, Mercer Island, WA

DEFENSE EXPERTS: Chris Pepin, MD, Internal Medicine, Seattle, WA; Jason Dominitz, MD, Gastroenterology, MD, Seattle, WA; Liana Tsikitis, MD, Oncology, Portland, OR

RESULT: Defense Verdict. King County Superior Court, Judge Middaugh

Lack of Informed Consent

SPECIALTY: Advanced Registered Nurse Practitioner

ALLEGATION: A 41-year-old female alleged lack of informed consent regarding the prescription of oral contraceptives resulting in stroke. The patient was diagnosed with a patent foramen ovale following the stroke. The patient claimed past and future medical expenses, past and future lost income, and general damages.

PLAINTIFF ATTORNEY: David Williams, Law Office of David Williams, Bellevue, WA

PLAINTIFF EXPERTS: Robert Thompson, Family Practice, Renton, WA

DEFENSE ATTORNEY: Dan Mullin, Mullin Law Group, Seattle, WA

DEFENSE EXPERTS: Andrew Kaunitz, MD, OB/GYN, Jacksonville, FL; Robin Kroll, MD, Gynecology, Seattle, WA; Neil Benowitz, MD, Pharmacology, San Francisco, CA; David Thaler, MD, Neurology, Jamaica Plain, MA

RESULT: Defense Verdict. Pierce County Superior Court, Judge Martin

Premature Newborn Discharge

SPECIALTY: Pediatrics

ALLEGATION: The parents, individually and on behalf of their minor child, alleged that due to a diagnosis of newborn jaundice on day five of life, the patient was prematurely discharged and that the health-care providers failed to educate the parents on the perils of newborn jaundice resulting in hearing loss, neurobehavioral challenges, severe communication impairment, abnormal movements, and cognitive delays. The parents claimed past and future medical expenses, educational and vocational support, future residential needs, future lost wages, and general damages.

PLAINTIFF ATTORNEY: Dan Huntington, Richter Wimberly, Spokane, WA, and Dan Hannula, Rush, Hannula, Harkins & Kyler, Tacoma, WA

PLAINTIFF EXPERTS: Gary Spector, MD, Pediatrics, Seattle, WA, Stephen Glass, MD, Child Neurology, Woodinville, WA, Greg MacDonald, MD, Pediatric Neurology, Spokane, WA, Nora Thompson, PhD, Neuropsychology, Edmonds, WA, Bonnie Baker, PhD, Psychology, Spokane, WA, Chloe Johnson, Vocational Counselor, Bothell, WA

DEFENSE ATTORNEY: Amy Forbis and

Jennifer Crisera, Bennett, Bigelow & Leedom, Seattle, WA

DEFENSE EXPERTS: James Troutman, MD, Pediatrics, Bellingham, WA, Craig Jackson, MD, Neonatology, Seattle, WA, Jay Goldsmith, MD, Neonatology, New Orleans, LA, David Brieger, PhD, Pediatric Neuropsychology, Seattle, WA, Michael Painter, MD, Pediatric Neurology, Pittsburg, PA, Jay Rubenstein, MD, Otolaryngology, Seattle, WA, Sally Stuart, PhD, Clinical Social Worker, Bellevue, WA, Carole Kenner, PhD, Neonatal Nursing, Boston, MA

RESULT: Defense Verdict. Spokane County Superior Court, Judge O'Connor.

Negligent Treatment

SPECIALTY: Pulmonology

ALLEGATION: The estate of a 75-year-old female alleged inadequate cardiac clearance prior to a knee replacement surgery resulting in myocardial infarction, emergency three-vessel bypass, aortic valve replacement, and subsequent death due to an embolic event. The estate claimed general damages.

PLAINTIFF ATTORNEY: Mary Schultz, Mary Shultz Law, Spokane, WA

PLAINTIFF EXPERTS: Jeffrey Caren, MD, Cardiology, Los Angeles, Leslie Stricke,

MD, Pulmonology, Los Angeles, CA.

DEFENSE ATTORNEY: Jim King and Ed Bruya, Keefe, Bowman & Bruya, Spokane, WA

DEFENSE EXPERTS: Darryl Potyk, MD, Internal Medicine, Spokane, WA; Dan Doornick, MD, Internal Medicine, Yakima, WA; John Peterson, MD, Cardiology, Spokane, WA; Charles Davidson, MD, Cardiology, Chicago, IL

RESULT: Defense Verdict. Spokane County Superior Court, Judge Please [PR](#)

Assessing Your Insurance Exposures for Mergers & Consolidations



Merger and consolidation activity in the health-care industry continues to be high. If you are considering acquiring another practice or selling your business, there are many things to consider, and the implications for your insurance exposure should be included in that list.

POLICY TRANSFERABILITY

From a property and casualty insurance perspective, the first thing to be aware of is that insurance policies are not transferable or assignable. The acquiring organization cannot simply continue the same coverage the acquired organization had in place. The additional exposures will need to be added to the acquiring organization's policy, or a new policy must be issued. For the seller, a policy can be cancelled once all assets and liabilities have been transferred. It is important to consider that if any operations or discontinued products were not part of the sale, separate coverage may be necessary.

If an acquisition adds multiple new locations to your business, your premises liability exposure increases. That is a good time to review your liability limits and consider adding additional umbrella liability.

IMPACT TO DIRECTORS AND OFFICERS

From a management liability standpoint, the decision to sell presents a strategic risk for your directors and officers. Derivative claims may be brought by shareholders unhappy with the sale price or the way the transaction was conducted. Potential buyers and sellers both must

conduct their due diligence before agreeing to sell. If your organization does not have management liability or directors and officers (D&O) insurance, these potential exposures will fall to individual owners, officers, and directors.

IMPACT TO EXISTING POLICIES

It is also important to remember the D&O policy for the acquiring organization will likely not include the prior acts of the acquired organization. To cover this exposure, you will need to purchase an extended reporting period, or tail coverage, for your D&O policy.

Whether you are looking to buy or sell, it is vital to involve all your professional partners. Just as you would consult your attorney and accountant before considering an acquisition or merger, remember to consult your insurance broker to discuss the impact on your exposure and what can be done to mitigate the risks. [PR](#)

For more information on insurance exposures in mergers and acquisitions, contact Reid Ekberg, Vice President, Pilkey-Hopping & Ekberg, Inc., rekberg@pheinsurance.com, 253-284-9343.

Or Janet Jay from Physicians Insurance at janet@phyins.com, 800-962-1399.



Income-Protection Tools to Fit Your Life

The Insurance Coverage You Need Can Change Based on Your Age or Stage of Life... But...

How Do You Decide What's Right for You?



The following scenarios are based on actual physicians, their lives, and income needs. You may see yourself in one of these situations. And it may help guide your evaluation and decision-making about income-protection tools, such as disability insurance and what fits your life. At each stage of life, you need different strategies for your financial planning should you become unable to work.

STAGES and STRATEGIES

New to Practice – Starting a Financial Plan

After what seemed like endless study and hard work, you have started your first medical practice. You are busy building your career, eager to earn a good income, buy a car, a home, and pay off student loans as quickly as possible. You may be married or have a partner, so you have another person who depends on you, but you may or may not have children yet.

POSSIBLE INSURANCE NEEDS:

Disability: As you're starting to practice, now is the time to protect the investment you've made in medical education and your potential future income. Purchasing a traditional disability policy early in your career will help you to lock in a good rate while age and health

are on your side. Since cash flow and debt may be concerns, an initial policy now should suffice, but make sure it has future purchase options so you can grow the disability plan along with your increased earnings without having to reapply for coverage at a time when you may have potential health issues.

Life: If you're planning to start a family, purchasing a low-cost term life insurance policy can help you establish piece of mind knowing your dependents will have financial support and that you'll also have the opportunity to direct funds later towards paying down debt and making contributions to a retirement plan.

Loan Repayment Options: Protecting your income is important but it may also be wise to plan for repayment of student loans or bank loans when

you buy into a practice. There are various options available.

Mid-Stride Professional – Asset Accumulation and Protection

You've put in more than 15 years of practice. Though your student loans are paid off, you still have a mortgage to pay, may have children with college aspirations, and perhaps you also have aging parents who may need support. As your practice has matured, you may be interested in increasing your assets and accumulating wealth, not only through income, but also through an expanded business.

POSSIBLE INSURANCE NEEDS:

Business Overhead: If you're starting or growing a practice, consider purchasing business overhead expense insurance. It can cover the expenses of running a business, such as employee salaries, rent, or hiring a temporary physician to see patients while you recover from an illness or injury.

DISABILITY FAQs


college tuition or for your own retirement.

Nearing Retirement – Redirecting Your Assets

Time has flown by! After more than 25 years in practice, you still enjoy your work, but you are eyeing retirement and possibly already working part-time. Your house is paid for and your children are grown, but you are still providing financial support now and then. You want to secure your retirement years, maintain a safety net for yourself and spouse, and enjoy an active life of travel, hobbies, and community involvement.

POSSIBLE INSURANCE NEEDS:

Disability: As you have fewer earning years left, it becomes less important to maximize disability coverage, and it makes more sense to redirect some premium dollars to another type of policy, such as long-term-care insurance or Medicare supplemental insurance plans.

Long-Term Care, Annuities: As retirement approaches, you'll need to shift from an asset accumulation to asset protection and implement a detailed plan for addressing health-care costs, Medicare, social security and ensuring that your assets last throughout retirement. If you don't already have a long-term care insurance policy, you may want to consider purchasing one. Additionally, the purchase of an annuity can help to ensure that you don't outlive your retirement assets .

For more information about any of the policies discussed above, contact Janet Jay at Physicians Insurance Agency, at (800) 962-1399 or janet@phyins.com.

Disability: Now is the time to review your traditional disability insurance coverage to be sure it's keeping up with your increased earnings. You still have plenty of working years ahead, and you'll want to be sure your future income potential is sufficiently protected. Your initial disability policy may not be keeping up with your increased income. So it's time to purchase additional policies or layers to increase coverage that can protect a larger share of your income through a lump-sum policy (designed to supplement higher-income physicians) or a disability policy that continues to make your retirement contributions.

Life: At this point it's time to convert your term life insurance policy into one that accumulates cash value on a tax-advantaged basis and can help in meeting savings goals for your child's

1. What is disability insurance?

Disability insurance is a tool to protect your earning potential or your business's earnings in the event that you or your business partner becomes unable to work due to an accident, illness, or injury.

2. What does it mean to be disabled?

Not all insurance policies define disability in the same way. Some will end disability payments if you are able to go back to work part-time or at a lower-paying job. Look for a policy that gives you "own occupation" coverage to insure that you are protected if you're no longer able to practice your specialty as a result of a disability.

3. Do all policies work the same?

Disability policies vary in many key ways that could affect your payout in the event of a disability. We recommend that your plan provides an "own occupation" definition of disability, coverage for partial disabilities, and protection against inflation.

4. What can I use disability payments for?

You may use your disability payouts how you choose, but most importantly, these payments can be crucial to help you pay your regular bills, cover business expenses, or continue retirement plan contributions and health insurance coverage while you are unable to earn an income.

5. How do I get disability insurance?

If you have questions about disability, life, or other insurance coverage, call Physicians Insurance at 800-962-1399. Our life- and disability-insurance experts can help analyze your current disability needs and recommend options that allow you to tailor the plan to meet your goals.



Columbia Basin Hospital Receives Five-Star Rating



Columbia Basin Hospital's long-term care facility was recently awarded a five-star rating from the Centers for Medicare and Medicaid Services (CMS), the highest rating such a facility can receive.

To determine the five-star rating, CMS evaluated the long-term facility based on three criteria: annual inspections, quality measures, and staffing.

"The recognition is an outward symbol of the devotion and care the staff members put into their careers," says Becky Trepanier, CBH's director of nursing services for long-term care and assisted living.

Columbia Basin Hospital, a Physicians Insurance member since February, is one of only of three facilities in the area to receive this rating.

Congratulations, CBH!



Photo courtesy of Columbia-Basin Herald. Becky Trepanier, director of Nursing Services for Long Term Care and Assisted Living, (center), displays a plaque recognizing its top rating from the Center for Medicare Services. Also pictured are staff members (from left) Jordyn Shaddix, Marie Marsh, Gina Lara, Kelsey Rodman, Irene Bowen, Tatyana Boychuk, Karrah Bell, and Minda Sage.



WELCOME TO OUR NEW MEMBERS!

PROFESSIONAL LIABILITY COVERAGE

Spine Institute Northwest, Bothell, WA

Sea Mar Community Health Center, Seattle

Sea Mar Community Care Center (Skilled Nursing Facility), Seattle/South Park

Dayton General Hospital, Dayton, WA

MEDICAL STOP-LOSS

Orthopedic & Fracture Clinic, PC, Portland, OR