The Physicians Report

Physicians Insurance A Mutual Company

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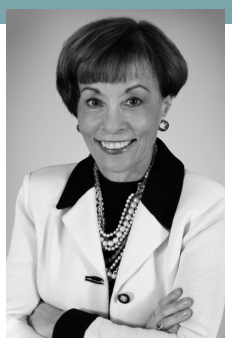
Message From the President and CEO

Leading the Way: Responding to the Changing Face of Medicine



Mary-Lou A. Misrahy, ARM
President and CEO

As health care issues continue to evolve, Physicians Insurance is anticipating the needs of our members in Washington, Oregon, and Idaho. At this time, we are engaged in a governor's task force, a national study, two federal grants, and more to respond to the needs of Northwest physicians and clinics. In more ways than ever, we are engaged in the debate, providing a voice at local and national levels so that we can influence decisions that affect local physicians and clinics.

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Governor Gregoire's Task Force

Physicians Insurance was invited to participate in an exciting new task force, Health Care Reform the Washington Way. Along with the Washington State Medical Association and executives from health plans, purchasers, hospitals, and other organizations, Physicians Insurance is participating in a plan that aims to lower the rate of growth of health care spending to no more than four percent per year, by 2014, while maintaining or bettering health care outcomes. In a recent meeting, task force members voted to pursue the following issues: care coordination, payment reform, prevention and wellness, and transparency.

RAND Institute for Civil Justice Study

Physicians Insurance recently agreed to participate in a significant RAND study titled "Investigating the Medical Liability and Patient Safety Relationship Beyond California." With our participation and the participation of a Denver-based physician-owned professional liability insurance company, COPIC Insurance Company, the Rand analysts will determine whether states with different malpractice laws result in a different relationship between safety outcomes and claims. A final publication of their studies is expected in 2013.

The Obstetrics Clinical Outcomes Assessment Program (OB COAP)

Because of the success of two of the Foundation for Health Care Quality's past programs, the Clinical Outcomes Assessment Program (COAP) and the Surgical Care and Outcomes Assessment Program (SCOAP), Physicians Insurance has agreed to participate in the full-scale launch of the Obstetrics Clinical Outcomes Assessment Program (OB COAP) following completion of the 2010 pilot. The goal of the new program is to create a database describing the care given to pregnant women during labor and delivery, and the results that occur from different treatments. A physician committee will then interpret the results and determine future activities. The goal is to develop best practice

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The Board is guided by the company's mission statement:

To provide insurance coverage to physicians and other health care providers at the lowest possible cost consistent with sound financial and insurance practices.

To anticipate and respond to changing needs and trends in a manner that is beneficial to our members.

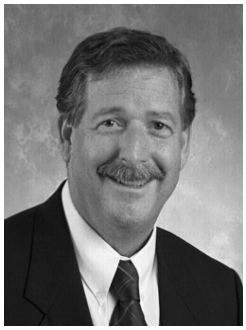
To improve the quality of medical care and patient safety.

To protect the personal and professional interests of our members consistent with sound financial and insurance practices.

Members Take CME Courses at No Charge

Register for live risk management seminars; take our e-learning courses, DVD courses, or webinars; or download and print our self-study course on our Web site. At www.phyins.com, at the top of the page, go to **CME** and choose your course. To register by phone, call us at 1-800-962-1399 (Western Washington & Oregon) or 1-800-962-1398 (Eastern Washington & Idaho).

Message From the Chairman



James P. Campbell, MD
Chairman of the Board

Changes on the Board of Directors

A Tribute to Stew Cogan, Dr. Sandy Levy, and Dr. Cheryl Wright-Wilson

Three long-standing Board members, whose terms have expired, are leaving the Physicians Insurance Board of Directors. On behalf of everyone on the Board of Directors and the management team at Physicians Insurance, I want to extend my gratitude for their tireless years of service. Their contributions are so numerous that I will be able to share only a few highlights with you.

Stew Cogan, a prominent Seattle attorney in general commercial practice who developed a well-respected commercial mediation and arbitration practice, started his work for Physicians Insurance as a lawyer for the company's Subscribers Council in the 1980s. He emphasized the role of good governance practices, and he developed an in-depth understanding of the company that would serve him well when he became one of the initial Board directors after the company mutualized in 1999. On the Board, he served on the Claims Committee, Compensation Committee, Executive Committee, Finance and Audit Committee, Nominating Committee, and Underwriting/Marketing Committee. As chair of the Claims Committee, he was an invaluable asset, helping the committee members and company staff understand how the legal system would respond to a variety of issues brought up in the cases before us. I can't say enough how his in-depth knowledge of the legal system, his years of local experience, and his dedication to Physicians Insurance empowered the company to respond effectively to the changes in the insurance and legal climate through the years.

Dr. Sandy Levy, a longtime Seattle anesthesiologist, chaired the company's Subscribers Council for six years. During that time, he published informative articles in the *Physicians Report* and wrote an annual summation for the annual report—describing the council's duties to oversee the company's finances, operations, and business affairs. As a Subscribers Council member, and later as a Board member, he served on numerous committees: the Claims Committee, Compensation Committee, Executive Committee, Finance and Audit Committee, Investment Committee, Nominating Committee, Risk Management Committee, and Underwriting Committee. On the Claims Committee, he was known for bringing his medical instruments to meetings to clearly demonstrate anesthesia procedures. On the Risk Management Committee, he took the extra steps necessary to become a certified trainer in risk management programs. On the Finance and Audit Committee, he enabled the committee to properly oversee company audits and internal controls. Not satisfied with regular Board and committee work, he also served on all the company's past subsidiary boards and on the ad hoc CEO search committee and IT subcommittee. Driven and vocal about numerous issues affecting his physician colleagues, Sandy has always been thoroughly engaged in the process, and it is hard to imagine a meeting without Sandy's valuable presence.

Dr. Cheryl Wright-Wilson, a longtime Bellevue pediatrician, brought years of pediatric experience to the Board and several commit-

tees, including the Claims Committee, Investment Committee, Risk Management/Education Committee, and Underwriting/Marketing Committee. She also served on the CEO search committee and the board of Northwest Dentists Insurance Company, a former Physicians Insurance subsidiary. On the Underwriting/Marketing Committee, she was instrumental in establishing a process by which company staff members would bring all underwriting issues to the table to ensure sound committee decisions. A compassionate colleague, she contacted physicians directly to explain company policies and listened carefully to their responses—often speaking on their behalf in committee meetings. She also helped the committee develop an excellent credentialing process and educated Physicians Insurance staff so that they knew the right questions to ask physicians about their training and experience. In addition, she was very supportive of tort reform and the company's efforts to establish more reasonable liability laws, attending numerous tort reform events to listen and respond to the speakers. Her willingness to ask difficult questions, her advocacy for her physician colleagues, her energy, and her innovative ideas will be greatly missed.

Introducing Lloyd David, Chi-Dooh "Skip" Li, and Dr. Josephine Young

It is my pleasure to introduce three talented new members to our Board. All of us at Physicians Insurance are excited to work with them.

Lloyd David, currently the executive director and CEO at The Polyclinic—a 165-physician, 750-employee multispecialty clinic in Seattle, Washington—brings recognized expertise in large clinics and a deep understanding of the issues they face today. Under his direction since 1994, The Polyclinic has opened numerous satellite clinics, merged two corporations, implemented managed care programs, and maintained financial success. Prior to his position at The Polyclinic, he worked in several positions at Harborview Medical Center. He was educated at Harvard University and the University of Washington. We look forward to benefiting from his years of impressive experience.

Chi-Dooh "Skip" Li brings his years of experience as an attorney and a board member for several notable organizations. Educated at Seattle Pacific University, George Washington University, and the University of Washington, he is well known as a former op-ed columnist for the *Seattle Post-Intelligencer* as well as a founder and board member of Agros International, which helps impoverished communities purchase land and work toward economic stability. With his wealth of experience, interest in good governance, and intellectual curiosity, we know he will ask the most important questions to keep Physicians Insurance financially successful.

Dr. Josephine Young, the chief operating officer at Pediatric Associates—a 77-provider clinic in Bellevue, Washington—understands the major issues faced by a large single-specialty clinic. She was educated at Boston University and the University of Washington. Her past experience as a medical director for Wake Teen Medical Services in Raleigh, North Carolina; as an instructor at the University of North Carolina School of Medicine and University of Washington; and as a pediatric section chief at PacMed Pediatrics has given her a knowledge of changing medical issues from different points of view. As Dr. Wright-Wilson leaves Physicians Insurance, Dr. Young's presence will allow Physicians Insurance to preserve pediatric expertise on the Board.

It is evident that Physicians Insurance has learned a great deal from the directors who are leaving our Board and will benefit from the new experience that the three new directors will bring. As the challenges of the health care community continue to evolve, we expect the work of our Board members to significantly evolve, too. We are grateful to Stew Cogan, Dr. Levy, and Dr. Wright-Wilson for their years of dedication to the company, and we will continue to call on them for their counsel. In the years ahead, we look forward to a long and productive working relationship with Lloyd David, Chi-Dooh Li, and Dr. Josephine Young.

New members in Washington & Idaho

We are pleased to welcome the newest member groups to Physicians Insurance.

Sandpoint Women's Health, in 2 Idaho locations

Seattle Premier Health, in Seattle, Washington

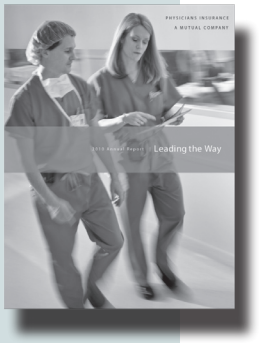
Steck Medical Group, in 4 Washington locations

Our Thanks to Annual Report Participants

The company's 2010 annual report features local physicians, staff members, a medical student, and WSMA executives. We appreciate their time and contribution to make this project a success:

Thomas Curry; Theresa Demeter; Len Eddinger; Merllie Flores, BSN, RNC-OB; Thomas Gallagher, MD; Leslee Goetz, MN, RNC-OB; Ronald Hofeldt, MD; Cindy Irwin, BSN, RNC-OB; Kurt Leinweber, DO; Timothy Melhorn, MD; David Silver, MD; Katherine Van Kessel, MD; and Christina Wong

Physicians Insurance mailed each of our members an annual report in April. You can read our report at www.phyins.com.



The Facts About Billing Errors & Omissions Insurance

By Janet Jay, Physicians Insurance Agency Sales and Service Representative

Billing Errors and Omissions (E&O) insurance is nothing new, but the face of it is rapidly changing. Ten years ago, a Billing E&O claim often meant that there had been actual fraud and that someone was going to jail. Today, it is more likely to mean that an honest coding mistake was found and that fines and penalties will be assessed.

Billing E&O insurance provides coverage for 1) the defense of alleged billing errors and 2) the fines and penalties assessed because of these errors. Allegations may be brought by governmental agencies including the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services, by commercial payers such as Regence and Premera, or by a qui tam plaintiff who files a fraudulent-billing complaint. The fines and penalties can be assessed by either governmental or commercial payers.

The insurance has seen a recent growth in popularity because the government has recently funded efforts to audit providers in a manner that we have never seen before. One such program provides Recovery Audit Contractors (RAC) with incentives in the range of 9 to 12.5% for the overbillings found. With such lucrative contracts on the line, these auditing agencies are resorting to automated reviews of files and complex reviews that make it difficult for providers to know when they may be remotely audited.

Additional Facts You Should Know

1. Each year, there is an estimated $55 billion in overpayments improperly billed to government programs.
2. Health Data Insights (HDI) is the RAC contractor for our region. Their Web site features important information to assist you in understanding RAC audits. (See http://racinfo.healthdatainsights.com.)
3. The top categories for errors found include medically unnecessary, incorrectly coded, and no or insufficient documentation.
4. The average cost of defending oneself against a regulatory proceeding is $80,000. Fines and penalties can reach hundreds of thousands of dollars.
5. Both groups and solo physicians are seeing audits.

Case Scenario 1. A federal program's routine post-payment review focused on the appropriateness of claims paid by Medicare to specific providers over a particular period. The findings alleged that one of the physicians had been reimbursed for unnecessary procedures of over $6 million. The doctor retained an attorney to challenge these findings. Two years later, Medicare revised its findings and calculated that only a $60,000 refund was due. Attorney costs: $70,000.

Case Scenario 2. Another post-payment review of claims paid by Medicare determined that a physician was overusing certain procedure codes. Medicare calculated that the provider had been overpaid $750,000. When reimbursement was requested, the physician retained an attorney to challenge the allegations. Two years later, Medicare recalculated the amount and reduced it to $635,000. After continued appeals for another two years and an appearance before an administrative law judge, the review findings were dismissed, and Medicare was obligated to reimburse money to the physician. Attorney costs: $125,000.

What's Not Covered

Billing E&O insurance is not included on your professional liability insurance policy. The coverage can, however, be purchased as a separate policy through Physicians Insurance Agency to help defend your practice and get you through what might be a difficult audit. As with any insurance policy, there are exclusions, such as fraudulent, criminal, dishonest, or otherwise intentional acts, as well as claims outside the scope of Billing E&O. Restitution—the actual owed money that needs to be repaid to the government or commercial payer—also is not covered. (However, having an attorney to help defend your case can pay off in the form of substantially reduced restitution.) Because insurance policies can vary, it is important to refer to the actual policy for its description of coverage.

Expect Change

As the demand for Billing E&O coverage increases, more insurance companies are likely to show interest in providing policies, making the market more competitive. Expect to see changing premiums and refined policy features that reflect both the growing competition and the insurers' claims experience. Also, the lawyers who specialize in Billing E&O, through experience, are becoming more adept at handling the incoming claims. This can mean faster, more efficient handling of your claim when and if the time comes.

Ask about Billing Errors & Omissions Coverage at Physicians Insurance Agency. Contact your Physicians Insurance account executive or me at (206) 343-7300 or 1-800-962-1399.

Obstetrical Simulation CME Delivers Improved Patient Care

By Celia Smith, CCMEP, Director, Continuing Medical Education

Noelle Edwards is admitted to the hospital in active labor, with an expected routine delivery. Two hours later, the fetal monitor shows a decelerating heart rate, and her nurse must set into motion the complex series of actions required for an emergency cesarean section. To meet the 30-minute "decision-to-incision" standard, her OB team needs the coordination seen in NBA playoffs. But whereas basketball players routinely rehearse their split-second maneuvers, obstetrical practitioners rarely face emergencies, and have had little opportunity to practice them—until the advent of simulation training.

Education Out of the Classroom

Simulation drills use high-tech equipment to bring a maternal–fetal crisis to life. Noelle Edwards is, in fact, a state-of-the-art mannequin, recently used in code-pink drills at Swedish Edmonds Hospital. Participants in this adrenaline-filled event included obstetricians, anesthesiologists, family practice physicians, labor and delivery nurses, scrub technologists, and unit secretaries.

Simulation training is relatively new to obstetrics, practiced at only a handful of hospitals in the nation.[1] Physicians Insurance offers this opportunity at no charge through our unique partnership with the Gossman Simulation Center at Swedish First Hill. Together, we've conducted successful shoulder dystocia drills at Evergreen Medical Center and Harrison Medical Center. The drills at Swedish Edmonds were our first in emergency cesarean section.

"Why is it hurting so much?" Noelle wants to know.

"Your baby might be happier in a different position," her nurse replies, calling for assistance. "Let's move you on your side to see if that helps." So begins the escalating drama, as a second nurse arrives to aid with repositioning. Shortly after, Noelle's family physician responds to the page, and receives a synopsis of events. The fetal heart rate remains low. With mounting urgency, the surgeon is called for, and then the anesthesiologist. Announcement of the code-pink drill sounds throughout the hospital as the team transports Noelle to the operating room. Adding to the challenge, the OR is seven floors down from the OB unit. Throughout it all, Noelle's anxious voice rings out: "Has somebody talked to my husband? I'm really scared. Are you sure this is the best thing for my baby?"

"This Is Not How I Thought It Would Be"

The intense focus on synchronizing supplies and processes, vital as it is to a successful outcome, may paradoxically neglect the patient's most important needs. In the midst of briefing physicians, obtaining informed consent, completing the transport, and preparing for surgery, a frightened patient is wondering how her dream birth experience has turned into this frantic whirlwind. In the orientation preceding the drill, Leslee Goetz, MN, RNC-OB, Clinical Nurse Specialist at Swedish First Hill, tells her audience, "One of the major reasons that patients sue is for information. They want to know what happened and they haven't been able to get answers from their medical providers." Malpractice claims at Physicians Insurance substantiate that statement. Nationwide, communication and teamwork problems are the most commonly cited root cause of patient injury.[2]

When a birth outcome differs from the patient's expectation, the relationship with key people involved in her care can determine whether she resolves the emotional aftermath or files a lawsuit. "This is not how I thought it would be," laments Noelle in the elevator on her way to the OR. "I understand," says a nurse, laying a hand on her shoulder, "This is not what we planned. But you're doing a great job working with us to get your baby delivered. We're putting on the cautery pad now, as part of a routine safety procedure, and those compression sleeves for your legs are to prevent blood clots. Keep taking deep breaths, Noelle. It won't be long now."

Teamwork Doesn't Just Happen

During the debrief session, teams review the video of their drill. Watching the filmed simulation allows participants to notice lapses in communication and ambiguity in roles that might otherwise have gone unaddressed. Their increased awareness fuels discussion of what worked well and what might work better. Teamwork is born of such collaboration, arising naturally from the mutual recognition of group strengths, as well as the humbling observation of its weaknesses.

Teamwork is also enhanced by well-timed instruction. In one part of the orientation, the anesthesiologist for each drill demonstrates the technique for applying cricoid pressure, and explains the best way for the RN to assist. Nurses are then able to practice cricoid pressure on Noelle with imme-

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Health Care Reform and Physician Assumption of Risk

By Mark Troutman, President, Summit Reinsurance Services, Inc.

Health care reform has the potential to dramatically change the delivery and financing of health care, perhaps the greatest change since the rapid growth of HMOs in the 1970s. A key component of health care reform as embodied in the Patient Protection and Affordable Care Act (PPACA) is expanded access to comprehensive health insurance for approximately 45 million Americans currently uninsured or underinsured. These individuals will be given access over time to public or private health insurance options that meet PPACA requirements (e.g., expanded Medicaid eligibility, state insurance exchanges, and other commercial insurance options) for coverage mandates or penalties.

Hospital–physician integration is increasing due to health care reform. Hospitals and physicians increasingly work together to achieve the health care reform goals of improved quality, reduced costs, and increased access to care. Integration occurs in many ways, ranging from new types of contractual arrangements between hospitals and independent practices all the way to hospital acquisition of medical practices. For those who recall the acquisitions of the 1990s, it will be interesting to see whether they are sustainable this time around.

Parallel to this development is a drive for physician practices to align with each other and become leaders in increasing efficiency while improving health care outcomes. These physicians operate on the premise that while new arrangements with hospitals are essential to control costs, physicians must lead this process.

Meanwhile, government (Medicare/Medicaid) and commercial payers will begin to modify their payment structures from fee-for-service to capitation or bundled payment or other shared savings mechanisms. Health care reform requires insurers to accept new risks that have traditionally not been covered. At the same time that health care reform imposes new risks, it limits carriers' permitted operating expenses by mandating a minimum loss ratio.

Risky Business II

The following are major provisions of the PPACA, effective 2010 to 2014, that present new risks to payers.

1. Parents can purchase coverage for dependent children up to age 26.
2. Pre-existing conditions, limitations, and exclusions will be eliminated, initially for children and ultimately for all adults, i.e., guaranteed insurability.
3. Health care rescissions for any reason will be significantly limited.
4. Limitations will be placed on risk pooling and community rating approaches.
5. Patients will not be required to pay out-of-pocket costs for many preventive care services.
6. All policies purchased must cover a defined set of benefits, including an unlimited lifetime maximum benefit.
7. There will be a more stringent rate approval process for payers.

Because of these general health care reform provisions and their increased risks, all types of payers (Medicare, Medicaid, Commercial, HMOs, PPOs, insurers, and Blue Cross and Blue Shield plans, even self-funded employers) will be increasingly motivated to contract with providers utilizing capitation or some other form of risk transfer as the payment methodology, and thereby lock in a given target loss ratio.

Assuming Risk

Accountable Care Organizations are one of the few new ideas where it is hoped that the new health care reform legislation can "bend the cost curve." An ACO is a group of providers, which may include primary care physicians, specialists, ancillary service providers, and hospitals, who agree to be held accountable for the cost and quality of health care delivered to a defined population of Medicare beneficiaries. The ACO model allows for physicians to lead both the practice of medicine and the cost-containment process rather than have those processes be led by payers.

Initially, ACOs will be paid on a fee-for-service basis by Medicare. ACOs will be eligible to receive additional payments if

the ACO meets the quality performance standards and achieves savings, to be defined in the final Health and Human Services regulations.

Alternatives to fee-for-service reimbursement and shared savings payments include bundled payments and capitation. Provider capitation may produce better results than the last time capitation was prominent, for several reasons. There are more established medical standards of best practices. Expanded health care information technology capabilities have the potential to support physicians and hospitals in maximizing best practices and better coordinating care via implementing electronic medical records. Providers have learned from the past and will be more knowledgeable purchasers of risk. They will treat capitation as a business, hire appropriate business professionals, and develop management systems to manage the risks they assume. Capitation payments will also be adjusted for age, gender, and health status for a more fine-tuned approach.

Bundled payments are an additional health care reform strategy to reduce health care costs through more focus on successful outcomes rather than the number of services. Under bundled payments, providers are paid one time for a bundled set of services rather than for each service individually. The approach promotes integration, continuity, and quality of care and cost-effectiveness. Bundled payments have demonstrated success at reducing complications and readmissions. Provisions for bundled payments are included in PPACA through a national Medicare pilot program starting in 2013.

With risk come potential rewards and potential control

Providers willing and able to create an ACO or other integrated delivery system and accept some form of capitation or bundled payments will be able to earn a profit on the "spread" if they are efficient providers, i.e., able to successfully manage the frequency and severity of health care needs of a designated population for which they assume risk and are paid a commensurate amount by payers to do so.

As providers assume more risk due to the shift in payment methodology from fee-for-service to some form of capitation or bundled payment or shared savings model, they will look for excess-of-loss coverage for catastrophic claims to mitigate their risk in these regards.

The risk can be managed with provider excess insurance

To minimize catastrophic risk, providers should consider the purchase of provider excess insurance coverage, either from the health plan or from other insurance companies. In addition, the health plan may agree to retain the risk for selected catastrophic services such as transplants, out-of-area emergencies, and referrals. The health plan may also be in a position to provide consultative medical management to its delegated provider groups and assist with the review and contracting for medical management vendors for catastrophic claims.

Alternatively, physicians themselves may negotiate coverage with an external provider excess insurance company for catastrophic claims or to mitigate other risks assumed by the provider. These products include the availability of consultative medical management to assist with controlling the cost of catastrophic claims.

Physicians Insurance, working with Summit Reinsurance Services, offers provider excess insurance products and medical management services to practices that assume risk. For more information, please contact the provider excess subject expert at Physicians Insurance, Ron Shaw, Stop-Loss Manager, at (206) 343-7300 or 1-800-962-1399.

Is an Emergency Cesarean Section Necessary? Our Free Webinar Can Help With Your Decision

The majority of obstetrical malpractice cases involve misinterpretation of the fetal heart rate monitoring strip. In this one-hour webinar, "Updates in Electronic Fetal Monitoring," national obstetrical leader Gary D. V. Hankins, MD, walks you through the decision-making process in ambiguous situations to recognize when an expedited delivery is required.

Just go to www.phyins.com, click on **CME**, and select the title from the webinar menu to "attend" the one-hour seminar at the time and place of your choosing. Take advantage of this membership benefit and receive immediate Category 1 CME credit.

AHRQ Demonstration Update

Physicians Insurance partners with the University of Washington on a three-year demonstration project, designed to improve communication to prevent adverse events and to communicate more effectively when events occur. The project is funded by the Agency for Healthcare Quality and Research (AHRQ).

Stakeholders Dig Into the Concept of an Early Disclosure and Resolution Program

On April 15, 50 leaders from our partner sites gathered to discuss the AHRQ demonstration project's Disclosure and Resolution Program (DRP). Principal Investigator Thomas Gallagher, MD, convened the meeting, which was attended by medical directors, risk management and claims executives, and defense attorneys representing 11 partner sites.

Physicians Insurance President and CEO Mary-Lou Misrahy welcomed the group. "It will take a high level of trust to do this and will require a shift in culture," she said. Meeting participants agreed that the strong foundation of trust already exists between partner sites, given the close working relationship between claims and risk staff for many years, and that this trust will be vital to the success of the DRP.

Dr. Thomas Gallagher, Rick Boothman, and Mary-Lou Misrahy met with leaders from 50 partner sites

By video conference, Michelle Mello, JD, PhD, of Harvard University and leader of the project's DRP component, presented an overview of the DRP. The model outlines the process for hospitals and clinics, practitioners, and their insurers to respond collaboratively and promptly when an adverse patient outcome occurs. Researchers want to know how the model performs in an open system with independent clinics, practitioners, and insurers.

Rick Boothman Provides Insights on the "Michigan Model"

Richard Boothman, JD, Chief Risk Officer of University of Michigan Health System (UMHS), described the experience of Michigan's DRP, which has been active for 10 years. During this period, UMHS cut its claims nearly in half and accelerated the time to resolution, benefiting both patients and clinicians.

One question raised was whether a DRP might actually generate more claims for an institution. "We haven't experienced much of this or encountered many opportunistic people. Instead we've heard from more grateful patients, not wanting to profit from a loved one's death, but who wanted to know what happened and were moved by a sense of responsibility that the complication not happen to someone else," said Boothman.

A litigator for 22 years, Boothman said UMHS's first step when addressing a claim is determining whether the care was reasonable. The Michigan Model is based on three principles:

- If we have injured someone through unreasonable medical care, we will move quickly to compensate that person.
- If our care was reasonable under the circumstances or where there has been no patient injury, we owe the staff our support.
- We must always learn from our patient's experiences.

UMHS has implemented many system improvements directly as a result of its DRP, lowering the risk of future patient injuries.

The key difference between UMHS and our AHRQ demonstration: all of UMHS's providers were employed by the university. In Washington, the DRP will be deployed in an "open" system with independent clinics and practitioners and multiple insurers.

Research on DRP programs shows that physician endorsement is vital to their success, and that an adverse liability environment brings physicians to the table. "Buy-in and com-

mitment are very strong. The question is how we move it into practice," said Dr. Gallagher.

Providence Everett Sees Results

The conference also showcased Providence Regional Medical Center in Everett, which has cultivated its own culture of transparency and disclosure. Providence has institutionalized root-cause analyses; disclosure policy, training and education; and a patient-family advisory council, among other strategies.

"In the past nine years, we have dramatically reduced the number of lawsuits and associated reserves," said Paula Bradlee, Providence's director of organizational quality. She adds, "We are now excited to move forward to the next level, which includes being a partner site and building on what we have started."

Next Steps

In the coming months, partner sites that commit to the DRP will assist the project team in customizing a process and implementation plan. Health care teams at partner sites will be trained in how to communicate effectively together and with patients—both preventively and following an adverse event.

Anne Bryant, Senior Director of Government Relations

Government Relations

Update on Federal Legislation

Physicians Insurance actively engages in the federal effort to enact effective reforms and protect health care providers from new causes of action.

We sit on the board of the Health Coalition on Liability and Access and serve as vice chair of its legislative committee. We also serve as the vice chair of the Physician Insurers Association of America Legislative Oversight Committee.

Two pieces of proposed federal legislation are particularly relevant today.

H.R. 5: Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011

This is sponsored by Rep. John Gingrey (GA), introduced 1/24/2011, with 127 cosponsors to date.

The HEALTH ACT is modeled after the effective reforms enacted under California's MICRA. As demonstrated in California and other states such as Texas, true reforms help provide for a stable medical professional liability market, increased access to care, and faster compensation to those who have been injured. Specifically, HR 5 contains the following elements:

- A $250,000 cap on noneconomic damages,
- A fee schedule for attorney contingency fees to ensure victims of negligence received the funds they need,
- Periodic payments of future damages, and
- A reasonable statute of limitations.

Efforts continue to move this bill through Congress and to include collateral source reform, which would allow evidence that claimed damages have been compensated from another source.

H.R. 816: Provider Shield Act of 2011

This is sponsored by Rep. John Gingrey (GA), introduced 2/18/2011, with 12 cosponsors to date.

There are several provisions included in the Patient Protection and Affordable Care Act (PPACA) that may have inadvertently created new standards of care and new theories of liability in medical liability claims. The Provider Shield Act provides that nothing in the PPACA shall be interpreted to create new standards of care or permit new causes of action in medical liability cases.

For more information, please contact me at 1-800-962-1399 or anne@phyins.com, or visit Protect Patients Now at http://protectpatientsnow.org.

Message From the President and CEO *Continued from page 1*

guidelines for labor and delivery and to improve the care of pregnant women in Washington.

Patient Safety Advisory Committee

In an Agency for Healthcare Research and Quality planning grant, a new committee—the Patient Safety Advisory Committee—was created, and Physicians Insurance was asked to participate. Committee members have recently asked health care facilities to send them existing patient safety tools. The committee will then analyze these tools to determine if some of them are superior and should be more widely used throughout Washington. If they determine that the tools are not adequate to achieve optimum care for patients, then they will create a pilot program to develop new tools.

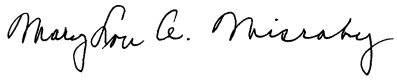
Defense Counsel Seminar

This fall Physicians Insurance will present a conference for our defense counsel. The goal is to enhance trial advocacy by promoting a healthy exchange of ideas on how to best defend our members in professional liability cases. Our claims staff and the defense counsel that we retain are looking forward to a productive meeting that will enable us to continue our very strong track record at trial.

More Ways We Are Leading the Way

Throughout this issue of the *Physicians Report*, you will read about other ways that the company continues to lead the way for our physician members. On page two, Dr. Campbell introduces three new Board members who will keep the company at the forefront of health care changes affecting the practice of medicine. On page five, Celia Smith, our director of continuing medical education, describes the success of the Physicians Insurance-sponsored obstetrical simulation drills and discusses the ways we are building on that success. On page six, Mark Troutman, president of Summit Reinsurance Services, Inc., analyzes the issues that are motivating health care providers to consider stop-loss services. On page eight, we describe the progress occurring on the Agency for Healthcare Research and Quality demonstration grant. On page nine, Anne Bryant, our senior director of government relations, summarizes the company's activities at the national level.

At Physicians Insurance, we encourage Northwest health care providers, clinics, and hospitals to stay engaged in the process so that the future remains bright for Northwest health care. Even as we are working at the local and national level to improve health care outcomes, we continue to look for new ways to make a difference. In our work with physicians, clinic managers, attorneys, and other leaders who have a say in the future of health care, we are determined to be part of the solution as new health care issues continue to emerge.



Obstetrical Simulation *Continued from page 5*

diate feedback from anesthesia. "Even though everyone involved was skilled at their own piece of the puzzle," says anesthesiologist Susan Wetstone, MD, "it was challenging to put all our pieces together. The drill I participated in was valuable for us to get practice working together in stressful situations. We found many opportunities to make easy changes that could improve patient care."

System Improvements

The lessons learned at every one of the debrief sessions are noted by Joyce Miller, RN, Clinical Nurse Manager at Swedish Edmonds, who championed the drills. "We intend to practice and hard-wire the roles," she says, "so when the emergency occurs, our response will be second nature." Several improvements suggested at these discussions are already in place. The unit now has a system, led by the charge nurse, for a three-minute debrief after difficult deliveries, and a form to summarize the event. Protocols are also established that empower nurses to transfer a patient to the next level of care without the physician being present. Agreement is unanimous during the debriefs that a vaginal delivery in the OR is preferable to the risks involved in delaying transport.

Additional ideas have sprung from the drills: having a preassembled c-section kit on hand in the OR, and utilizing spare moments for surgical preparation, such as administering the sodium citrate or putting on the surgical compression devices. Family practitioner Rachel Hollister, MD, says,

"Putting on the SCDs in the elevator is a great use of that time."

More lessons are gleaned from TeamSTEPPS, an evidence-based system, designed by the Agency for Healthcare Research and Quality (AHRQ) and the Defense Department to improve patient safety through communication skills. Examples include the check-back, in which the receiver of a request confirms that the action is completed, and the call-out, used to communicate with the whole team, but directed at a specific individual to verify that the message will be acted upon.

Can Simulation Improve Outcomes?

A growing number of studies are confirming what the obstetrical staff at all three of our simulation sites sense intuitively: simulation training will indeed improve patient outcomes. In the United Kingdom, teams taught using simulation demonstrated sustained improvement in clinical management.[3] Another UK study showed a significant reduction in neonatal injuries following the introduction of simulation training.[4]

"If we can prevent even one maternal death, these simulations are worth it," states Susan Rutherford, MD, Medical Director, Women's and Children's Services at Evergreen Medical Center. Her experience at our shoulder dystocia simulation training in November convinced her that "you can expect better outcomes, higher morale, and more accurate documentation." Staff there unanimously reported that the simulation training improved their ability to provide better care for their patients.

Joyce Miller, RN, at Swedish Edmonds Hospital, agrees. "To have a drill of this caliber, this was amazing to us. It really was."

Physicians Insurance is proud to lead the way with CME aimed at advancing patient safety and health outcomes. A note received recently from Evergreen Hospital provides a clear example:

> Following the November day of shoulder dystocia drills, a nurse and provider who attended the training shared a successful delivery of a newborn with a "severe" shoulder dystocia. When she and the provider recognized the situation, they communicated clearly what was occurring and began to perform the maneuvers they had learned during their training. To their extreme delight, the newborn quickly rotated and delivered without any noticeable delay or birth trauma. Following the delivery the provider and nurse had a short debrief where they were able to capture the essential elements of the delivery and record them into the medical record as one shared story.

Physicians Insurance anticipates bringing the program to more hospitals over the next few years, and is seeking to expand simulation training to other specialties. In the meantime, it's been an honor to collaborate with the Gossman Simulation Center, and with Evergreen, Harrison Silverdale, and Swedish Edmonds hospitals, to further our shared vision of improving health outcomes.

1. Laura Landro, "Delivering Results: Making Birth Safer," *Wall Street Journal*, March 28, 2011, R7.

2. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "Efforts to Reduce Medical Errors: AHRQ's Response to Senate Committee on Appropriations Questions," http://www.ahrq.gov/qual/pscongrpt/psini2.htm.

3. L. Birch, N. Jones, P. M. Doyle, P. Green, A. McLaughlin, C. Champney, D. Williams, K. Gibbon, K. Taylor. "Obstetric skills drills: evaluation of teaching methods," *Nurse Educator Today*, 2007 Nov; 27(8):915-22.

4. L. Wilson, J. Ash, J. Crafts, T. Sibanda, T. Draycott, "Does Training Reduce the Incidence of Fetal Injury in Cases of Shoulder Dystocia?" *Simulation in Healthcare*, 2006 Fall: 1(3):185.

Our Seattle Office Has Moved

New Mailing Address: Physicians Insurance A Mutual Company, PO Box 91220, Seattle, WA 98111

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Physicians Insurance Applauds New Obstetrics Initiative

The Washington State Medical Association has joined with the Puget Sound Health Alliance and the The Obstetrics Clinical Outcomes Assessment Program (OB COAP) in a voluntary data collection and analysis initiative with the goal that women in the state of Washington receive evidence-based obstetrical care. It is based on the proven model of ongoing Foundation for Health Care Quality programs that have an established track record for improving quality. The advantages to participation in OB COAP include

- access to your own data as soon as it is entered;
- a collection of currently recommended NQF guidelines;
- Joint Commission OPPE (Ongoing Professional Practice Evaluation) metrics available at any time;
- multiple uses for hospital administrators, including patient safety, process improvement, and quality improvement projects;
- quick turnaround of meaningful data with comparative reports provided to facilitate quality improvement efforts;
- the development of a community of providers who can learn from one another in a trusted, collaborative environment;
- the ability to provide input on setting a quality improvement agenda for the state; and
- a quality improvement initiative based on data from 90,000 deliveries per year.

The deliverables of an all-inclusive statewide OB COAP initiative are predictability, reduction in adverse outcomes, increased responsibility, and safety for the mother and the newborn.

To learn more about OB COAP, please visit www.obcoap.org or contact Ellen Kauffman, MD, Medical Director, at ekauffman@qualityhealth.org or Kristin Sitcov, Program Director, at ksitcov@qualityhealth.org.