Volume 90 ■ Number 21 ■ Fall 2009

PROTECTOR

Setting clinical risk management standards since 1913.

MEDICAL PROTECTIVE

Strength. Defense. Solutions. Since 1899.

a Berkshire Hathaway Company

Your patient speaks only Tagalog. Do you?

Did you know:

- **Government regulations mandate that physicians and dentists must facilitate communication with patients affected by language barriers?**
- **Poor patient compliance and less successful healthcare outcomes occur more frequently in populations unable to participate in the give-and-take of diagnostic and treatment planning discussions?**
- **Public health policy and the courts stipulate that individuals have the right to receive clinical information and to ask questions about proposed treatment as a basis for valid informed consent for medical or dental care?**

On-site, on-demand language interpreting services have traditionally been available only to hospitals and large healthcare centers. Now you can meet the needs of your patients with Limited English Proficiency (LEP).

To help you accomplish this goal, Medical Protective has teamed up with one of the nation's most experienced language-related service companies, DT Interpreting (a service of Deaf Talk, LLC), to help physicians and dentists provide on-demand interpreting services via the telephone.

DT Interpreting offers a network of experienced interpreters available 24/7 in over 150 languages, within seconds, by dialing DT Interpreting's toll free number.

Medical Protective insureds receive a special reduced rate of $1.47/minute. No subscription fee, per doctor charges, or a base user fee. $1.47 for only the minutes you use.

To learn more about this program brought to you by Medical Protective, visit our website at www.medpro.com. Or to register, go to the DT Interpreting website at www.interlanguagephone.com.

Other services offered by DT Interpreting:

- **American Sign Language Video Interpreting** is the most effective way to access nationally-certified ASL interpreters via wireless video technology, within minutes, 24/7, to assist you in communication with your hearing-impaired patients.
- **Document Translation Services** to help you ensure that patients can read important health information in their native languages, increasing treatment plan compliance and the validity of informed consents.
- **Transcription of documents and information material into Braille,** so that you can adequately communicate with your vision-impaired patients.

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.
a Berkshire Hathaway Company

dt interpreting
A service of Deaf-Talk, LLC.

10.2009

Dear Medical Protective healthcare provider:

It's a big challenge to provide high quality healthcare day after day. And it's an even bigger challenge to maintain those high standards when the economic picture is glum—and your own bottom line is less than stellar.

In spite of the rocky economy, this may be an ideal time to take stock of your practice. Of course you want to maintain your patient safety goals. But a review of business processes and internal communication may help you do an even better job of interacting with your patients. And, at the same time, you might find ways to increase savings and income by cutting waste, improving efficiency, and supporting staff morale.

In this issue of *Protector*, we examine some of the internal processes in medical and dental practices. We look at ways in which communication influences the doctor-patient relationship—and also doctor-staff partnerships. We share tips that help retain satisfied patients and office teams.

We hope that some of the strategies will be useful to you and those with whom you work. As always, we welcome your feedback and suggestions.

Sincerely,

Kathleen M. Roman

Kathleen M. Roman
Editor

Protector is published three times a year by Medical Protective as a risk management service to insured physicians and dentists.

Editor
Kathleen M. Roman
Risk Management Education Leader
Kathleen.Roman@medpro.com

Please share with us topics you would like to see addressed in *Protector*. Send your questions, topic suggestions and comments to:

The Clinical Risk Management Department
P.O. Box 15021
Fort Wayne, IN 46885-5021

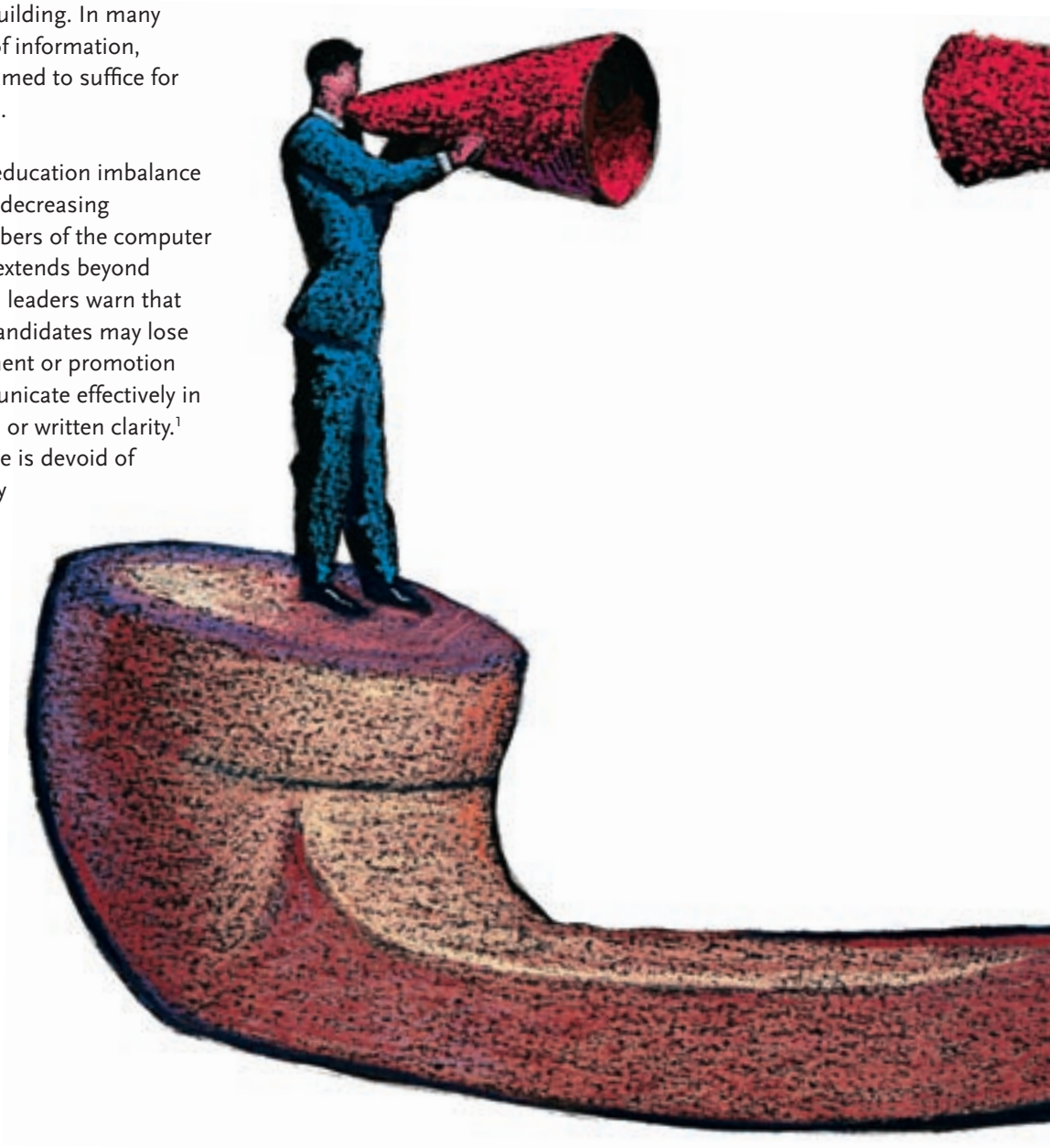
Your valuable input helps us to ensure that this risk management publication is useful to its readers. Thank you for your contributions. Contributions from named authors represent solely the view of those authors.

Quality Measurement

The success of human endeavor is always reliant on communication. Yet this important human skill is rarely taught in a formal context. Most people assume that communication comes naturally. And, even in highly complex systems – such as healthcare – curriculum planning has traditionally given priority to the "hard" clinical sciences and overlooked the contribution that the "soft" skills bring to clinical successes through group problem solving, dispute resolution, and consensus building. In many schools, the dissemination of information, data, or instructions is presumed to suffice for communication competence.

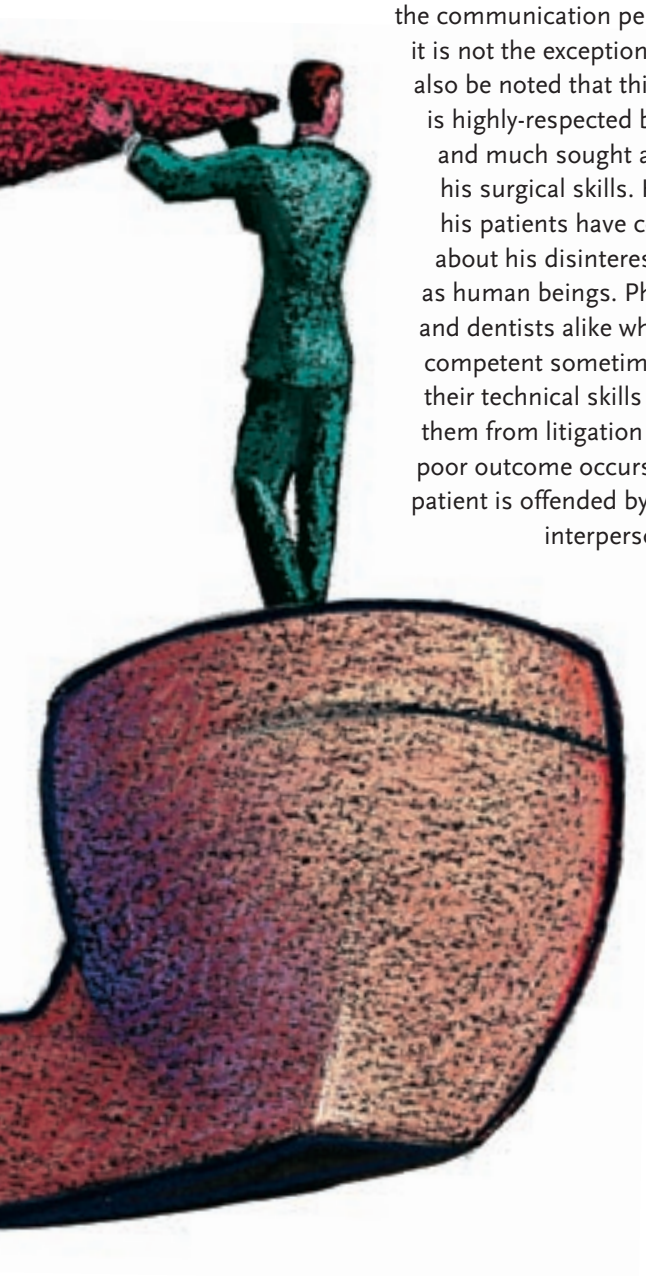
The negative impact of this education imbalance is often compounded by the decreasing conversational skills of members of the computer generations. This challenge extends beyond healthcare as many business leaders warn that educated and qualified job candidates may lose the opportunity for employment or promotion due to the inability to communicate effectively in situations that require verbal or written clarity.[1] For example, a voice message is devoid of feedback and the opportunity to confirm or disagree. An email does not include the conversational give and take that occurs when participants can see each other's facial expressions, hear each other's tone of voice, or read each other's body language. The superficial nature of texting thwarts conversations in which accuracy or urgency may be essential.

Experts in all areas of professional liability litigation, from underwriters to risk managers, to claims experts, to defense counsel, note poor communication skills are often interpreted as bad manners, callousness, disrespect, and lack of professionalism. The tipping point for many patients-turned-plaintiffs is the belief that their physicians or dentists were rude or dismissive.



Doctors' Communication Skills are Important Too

While communication experts advise doctors to become more empathetic, more sympathetic, many doctors are frustrated by their inability and candid disinterest in attempting to master a skill set they perceive as unnecessary and unreasonable. As one surgeon said to this writer, "I can take good care of my patients or we can stand around and hold hands all day and sing 'Kumbaya.' I don't have time to do both." This doctor's comments represent one extreme of the communication pendulum but it is not the exception. It should also be noted that this surgeon is highly-respected by his peers and much sought after for his surgical skills. However, his patients have complained about his disinterest in them as human beings. Physicians and dentists alike who are highly competent sometimes find that their technical skills don't protect them from litigation when a poor outcome occurs and the patient is offended by the lack of interpersonal support.



When Medical Protective offers risk management education programs, physicians and dentists sign up for them with the desire to learn how to reduce their risk of liability. The discussions of actual lawsuits are used to show how things went wrong and how they might have been prevented. Each program includes numerous tips. When the faculties discuss the clinical aspects of cases, the doctors' specialties and the types of diseases and treatment plans the patients received, the interest is palpable and the "science" of the cases spurs participation, discussion, and even some debate.

When analysis of a case turns toward those "soft" skills – such as a doctor's willingness to answer a patient's questions, or the family's perception that the doctor doesn't care – some doctors lose interest and a few may even grumble. "We wanted to discuss cases," one doctor wrote in a program evaluation, "but you talked too much about communication and not enough about the liability issues." This doctor missed the point. Poor communication was the common element among all the cases, regardless of the doctor's specialty or the nature of the treatment provided.

If a physician or dentist is unable or unwilling to explain the treatment plan, the patient's surprise at an unexpected outcome may trigger a lawsuit – sometimes regardless of the fact that the actual treatment was well within acceptable standards. The clinical care may be only the "final straw" in an already dysfunctional partnership. Better communication before-the-fact might prevent these disputes. If a doctor is curt or condescending when a patient voices questions or concerns, the patient may be disinclined to talk with the doctor at all following an adverse event. If the doctor is evasive or defensive following a poor outcome,

the patient may feel justified in seeking counsel from an attorney. Self-awareness benefits every human interaction. From a professional perspective, it makes it easier for members of the healthcare team to take good care of patients while reducing the friction in a high-stress environment. From a risk management perspective, studies have repeatedly shown that self-awareness and the willingness to improve one's communication skills, significantly reduces malpractice lawsuits.

It has been suggested that – regardless of the environment – different personality types have different expectations when working in groups. The Meyers-Briggs Type Indicator (MBTI),[2] to name just one well-known example, divides personalities into categories based on how individuals perceive and interact with the world around them. The point of many of these tests is to identify ways in which individuals may differ in their approaches to work, to solving problems, and to interacting with others. The various personality types may have significant differences – extroverts and introverts, intuitives and analyticals, task-oriented and people-oriented, etc. – but the differences aren't labeled right or wrong, normal or abnormal – they're just differences and the purpose of identifying them is to help people increase their own self awareness and to better understand and respect the different approaches and attitudes that others may bring to interactions.

Over the past decade, medical schools and dental schools have begun to change the way they teach communication skills. In 1995, the accrediting bodies for medical school education in North America recommended "specific instruction and evaluation of [communication] skills as they relate to physician responsibilities, including communication with patients, families, colleagues, and other health professionals.[3]

Subsequent to this recommendation, a clinical skills communication test was added to the United States Medical Licensing Examination (USMLE),[4] over the strong objections of the American Medical Association and numerous medical schools and residency programs.

Yet in spite of some beefing up of communication teaching, many of today's practicing physicians and dentists report that their interpersonal skills have posed difficulties for them in their professional relationships.[5] And patients agree. According to a review of malpractice claims, bad manners among members of the healthcare team is named as a

Do You Participate in a Medicare Fee-for-Service Program?

Is Your Office Ready for Government Audits?

The Recovery Audit Contractor (RAC) program was created by the Medicare Prescription Drug Improvement and Modernization Act of 2003. This comprehensive overhaul of the Medicare system included a mandate to find and correct improper Medicare payments paid to health care providers participating in fee-for-service Medicare. A demonstration project, conducted in advance of program finalization, revealed many improper billing practices.

Four regional auditing entities have been selected to begin performing RACs across the country. Rollout by state will take place over the next six months, with the entire system expected to be in place and functioning by February 2010. Now is the time for providers who participate in Medicare plans to review their corporate compliance and billing procedures to ensure that, in the event of a RAC audit, they will be prepared to verify the accuracy and integrity of their policies and procedures.

RESOURCES

Medicare Modernization Update. Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov

New Report Shows CMS Pilot Program Saving Nearly 700 Million Dollars In Improper Medicare Payments
Accessed at: Medical News Today. July 12, 2008. *www.medicalnewstoday.com/articles/114759.php*

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
www.treas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf

cause of litigation in nearly seventy-five percent of all malpractice lawsuits.[6] Obviously, there is still room for improvement.

To what extent do quality initiatives – such as outcomes measurement or responses to patients' complaints – analyze providers' interpersonal skills? While numerous oversight bodies advocate for national standards relative to communication effectiveness in large healthcare institutions, smaller healthcare facilities, including many medical and dental practices, aren't doing a very good job of measuring patient satisfaction *with the communication aspects of their care.* Just as the old saying goes, "all politics is local," so too should quality initiatives be relevant to the specific region, practice specialty, and patient demographic.[7]

Effective communication can be taught but sometimes it is also "untaught." In other words, it's difficult to teach people effective communication skills if the teachers themselves aren't modeling that behavior. According to one study:

> ...(the) challenge to medical educators and learners is the disconnect that many students perceive between the high-minded rhetoric of lectures and classroom discussions about professionalism in their pre clinical years, and the actual behaviors they witness during their clinical rotations.[8]

Between two equally well-trained and skilled clinicians, the one with excellent communication skills will have better patient compliance, better patient outcomes, and fewer lawsuits. So it's not an "either/or" equation. Doctors don't have to hold their patients' hands and sing "Kumbaya." But they should take into account the fact that the inability to communicate well will always have a negative effect on clinical care. Always. ■

Is Courteous Communication Part of Your Practice's Quality Initiatives?

If quality measures should include the communication skills of one's own team, the following questions may offer a starting point for beginning – or taking the next step – in the process:

1. Is courtesy part of the organization's mission statement, core values, staff indoctrination, individual key accountabilities ...?

2. Has everyone in our practice been educated about respectful and diplomatic methods for asking challenging questions, disagreeing, or pointing out an error? Such conversations may have real value from a patient safety perspective.

   Common misassumptions about the process may prevent it from being used effectively. First, people who raise questions may be labeled as troublemakers or pests. Sometimes the individual's communication skills are inadequate to the task and as a result their good ideas or timely warnings may go unheeded, occasionally with catastrophic results. Second, in some organizations, the workers are so stressed and the challenges of the job so overwhelming that anyone who poses a question or proposes a change in the status quo automatically becomes "the enemy." Third, in some social circles any suggestion of disagreement is seen as an act of hostility. Friends don't disagree with friends; it just isn't the courteous thing to do – even if the friend is right.

3. Do human resources policies mandate a courteous and professional work environment? Does this include everyone associated with the practice? Without accountability for compliance, policies become meaningless.

4. Are patients routinely surveyed relative to their experience with doctors and staff? Are complaints used as opportunities to improve the communication process? Is patient perception of the quality of their interactions with the practice addressed with the same vigor as, say, a complaint about infection control?

1. U.S. Department of Labor Employment Update. Statistical Report on Unfilled Jobs. Occupational Outlook Quarterly. June 2009. http://www.bls.gov/opub/ooq/
2. Your Life's Path Career Counseling and Consulting. Meyers-Briggs Foundation. http://www.myersbriggsreports.com/?gclid=CPyB_sPzkZwCFRkWswodd0Kldw
3. Liaison Committee on Medical Education. Functions and Structure of a Medical School. Washington, CD: Liaison Committee on Medical Education: 1998.
4. United States Medical Licensing Examination. Available at http://www.usmle.org/Examinations/index.html Accessed July 25, 2009.
5. Makoul. G. Communication Skills Education in Medical School and Beyond. JAMA. 2003;289(1):93
6. Allegations of Negligence. National Practitioner Data Bank. 2003.
7. Werner, R. M., McNutt, R., A new strategy to improve quality. JAMA. 2009;301(13):1375-1377.
8. Cruess, R. L., Cruess, S. R., and Steinert, Y. Teaching Medical Professionalism. Cambridge University Press. New York. 2009. 123.

This Prescription Calls

You don't have to be "warm and fuzzy" to be loved by your patients. So says Dr. Michael W. Kahn, assistant professor of psychiatry at Harvard Medical School and a psychiatrist on the staff of Beth Israel Deaconess Medical Center, Boston. Rather than urging healthcare professionals to be more sensitive to their patients' feelings, Dr. Kahn suggests that a simpler and more effective route may be for doctors to practice good manners.

Not everyone is capable of engaging in sympathetic or empathetic behaviors. These are personality traits that people either have—or not, Kahn says. "It's very hard to teach empathy," Kahn says. "In general, people either get it or they don't." It's also frustrating for many fine clinicians who just don't understand why they're faulted for an apparent lack of compassion. And, when they try but fail to establish a warmer relationship with patients, they become irritated or defensive, worsening the situation.

But anyone can learn manners. And should, according to Kahn, whose own surgery was overseen by a European-trained surgeon who wasn't a "buddy" to his patients, treating them instead with courtly manners. Kahn came away from the experience convinced that this approach might have value.

Recalling that simple procedure checklists had dramatically reduced ICU infections, Kahn wondered whether a similar approach might have a major impact on the doctor-patient relationship. "If we introduce checklists to enforce the use of hand washing ... and the results of this simple intervention were swift and dramatically effective ... (then we ought to) develop checklists of physician etiquette for the clinical encounter."[1] He began working on a checklist of the common, everyday niceties that could help establish a positive framework for doctor-patient communication. It wasn't his intention to phase out programs that encourage humane behavior; rather, he believed that courtesy would complement these efforts. Kahn's research resulted in an etiquette checklist, published[2] in 2008.

Patients love the approach, Kahn reports. "The good news is that patients respond in a positive way to courtesy. They are more cooperative. It's as though the doctor's changed behavior helps them (challenging patients) to be less difficult."

"I tell others that this is a way for you to get more thank you's," Kahn says. "Manners are part of the service we provide. Just as Nordstrom's or an Apple store sell their products through responsiveness, courtesy, and respect, we should do the same thing. And, I've seen patients respond in the same way. It really helps resolve those situations where patients have become uncooperative or difficult to work with." If for no other reason than the prevention of angry exchanges, doctors should try a little courtesy.

According to Dr. Kahn, doctors should start with the basics (See *Build Your Own Courtesy Checklist* on page 9) but modify it to fit their own clinical situations.

for Manners

A few examples might include explaining an ongoing workup, preparing the patient for home care or delivering bad news.

"This is a skill that can be learned relatively easily. Practice makes perfect," Kahn concludes. And it's a more honest approach. It doesn't ask doctors to be someone they're not or to try to fake emotions or behaviors that they really don't feel.

The training can be implemented throughout the educational program – in medical schools and dental schools alike. And once doctors graduate and are out in practice, it can be reinforced in orientation programs–in hospitals, in medical or dental offices, and in continuing education.[3]

Repetition and reinforcement of the new skill can help prevent communication breakdowns and the dreaded disruptive behaviors that can undermine the success of any healthcare team.

"I think we're past the day where a patient will say, " My doctor can be a jerk as long as he does a great job," Dr. Kahn concludes. Courtesy's not the most important element in the doctor-patient relationship–but it sets the tone for all of those other steps along the way." It's certainly worth a try. ■

1. Op. cit.
2. Kahn. M. W. Etiquette-Based Medicine. The New England Journal of Medicine. Volume 358:1988-1989. Number 19. May 8, 2008.
3. Jerrard, J. Mind Your Manners. The Hospitalist. November 2008. www.the-hospitalist.org/details/article/186104/Mind_Your_Manners_.html

Dr. Michael Kahn
Assistant professor of psychiatry
Harvard Medical School

Build Your Own Courtesy Checklist.

Use Dr. Kahn's list as your starting point:

1. Ask permission to enter the room; wait for a response.
2. Introduce yourself. If relevant, show your ID badge.
3. Shake hands (wear gloves if appropriate).
4. Sit down. Make eye contact. Smile (if appropriate).
5. Briefly explain your role on the team–or your understanding of the meeting with the patient.
6. Ask the patient for his or her feelings, input, concerns.

Don't be afraid to add to the list. Seek consensus among the clinicians on your team. Agree to the same set of courtesies, e.g., always introduce other staff members and explain their role(s) in patient care; always confirm action agreements at the end of an appointment, "I will call you with the results. If you don't hear from me by XXX date, please do call me. I will definitely want to talk with you." Focus on building courtesies into the way staff interact with patients as well. Don't be afraid to ask patients for their suggestions.


TECHNOLOG

Y: Is It Worth the Cost?

Katie Baeverstad, M.D., Medical Advisor, Medical Protective

Technology—a word that conjures up visions of computers, email, websites, PDAs, and cell phones. Technology *should* decrease the potential for errors in communication and documentation. Technology *should* help you streamline your workday. It *should* reduce the workload of your sometimes-beleaguered employees. It *should* do these things—but sometimes it may do just the opposite if it is misunderstood or used ineffectively.

Technology probably also conjures up visions of money hemorrhaging from your budget. Since times are tough for everyone, how can you harness technology without spending a lot of money, or possibly without spending anything at all?

Many medical and dental office processes can be improved without the expense of new software installations or complicated telephone systems. Most of those processes have to do with utilizing the skills of your staff. So, before you are tempted to purchase new technology to make your practice more efficient or more patient-friendly, evaluate the ways you're implementing the skills of the people who work in your office. Here are some factors to consider:

- Is everyone who works in your practice convinced that communication is the cornerstone of their jobs?
- Has your team implemented a reliable method for notifying patients of test results?
- Have you asked your patients if they've ever hung up the phone in disgust because they found your telephone system too cumbersome?
- Are doctors and staff alike using your computer systems in ways that are consistent with the systems' intended purposes?

While a snazzy computer system or new personal digital assistants (PDAs) have the potential to increase your practice's efficiency, a cohesive team of employees who care about every detail of your practice—and who know how to *use* those snazzy computers—hold the keys to the success of a smoothly run office.

Assess your staff's strengths as well as their weaknesses. *Ask them* about their views on how they contribute to the practice and about what they need to learn in order to do their jobs more effectively.

Next, poll your patients for their views on how well your office seems to be running. *Ask them* how your office could be more efficient and patient-friendly.

One great exercise would be to walk through a typical patient visit with your entire staff—starting with a hypothetical phone call to schedule an appointment, continuing up to the reception desk, sitting in the waiting room, being escorted past the nursing area to an exam room, then back to the check-out desk. Encourage open and honest comments on areas that pose challenges to your staff and that need improvement.

Now, if your budget allows, carefully select a consultant – a highly-recommended expert – to evaluate your current practice setup. The information from the consultant may prove invaluable. And then, it would be a great idea if you actually listen to *all* the advice your consultant gives you! Don't forget to get your staff's feedback on those recommendations, too.

After gathering information from your staff, your patients, and perhaps from a paid consultant, put your heads together as you ask the question: once the people processes are fixed, what areas would most benefit from a little techno-assistance?

If you have technology that isn't being fully utilized, determine if anyone on your staff has the skills to become your "technology guru." Ask this person to look for time-saving features in your equipment that may be under-utilized. Does the copy machine waste valuable employee time as it jams or tears up important documents? Maybe you should invest in or lease a machine that can scan, make copies, and send faxes in mere seconds.

Sometimes you may have equipment that is being improperly used, or inadequately maintained, or kept in service long beyond its life expectancy. Are staff members being too rough on equipment? Are you scrimping on preventive maintenance? Did you buy technology but forego the training? This is another area where penny wise may be pound foolish.

Remember, too, that people beyond the four walls of your practice will also have a profound effect on the success of your team. Let's explore some areas in which your team, working with outside experts, can make all the difference in the success of technology changes.

Notes on vendors

If you decide to take the plunge and invest in a phone system, copier, or computer system, you will probably work with a vendor. If so, consider these points:

- Take your time and shop around.
- Insist on references, and prepare questions that you will ask of each vendor. Consistency in the interview and reference processes may help you avoid an oversight that will be the difference between loving or hating the new equipment.
- Make yourself fully available when a vendor is in the office to talk with and train you.
- Set a good example for the rest of your team. If you try to avoid learning a new program, or if you delegate someone else to use it on your behalf, you will discourage the rest of the team.
- If you have employees who do not have the skills to learn these systems, invest in classes for them—particularly before the new phone system or computer software is installed. Make it clear that you expect some staffers may need extra help getting up to speed—but also make it clear that you do expect everyone will get up to speed.
- Require a written agreement regarding training, repairs, upgrades, and after-hours emergency assistance. The vendor should have technical support staff available whenever you need their help.
- Make sure the vendor is financially secure—you want them to be around in years to come.
- Be sure you understand a system's limitations, costs, and guarantees. Ask about installing a few components at a time, to save money.

Notes on Electronic Health Records (EHRs)

Before you even begin to look for an EHR system, get input and suggestions from your staff. They may be able to help you answer the question: how will this system make life easier for our team—and safer for our patients?

Do you want your EHR to:

- Gather information?
- Preserve information?
- Facilitate information access from home or hospital?
- Share information with patients' other healthcare providers?
- Facilitate your patients' access to their own health records?
- Customize specific tasks that are related to your specialty?

Notes on land-line phones, cell phones, PDAs, texting, emailing, websites, etc.

While the list may seem endless, your ability to pay for these resources is limited. So you need to pay attention to new developments in the techno-world – if for no other reason than to stay informed about sales and price reductions. Keep an open mind, even while you are assessing the potential challenges and benefits associated with bringing some new technology into your practice.

For example, emailing may be the next frontier in terms of patient communication and time savings. If you currently have email, do you use it with patients? Is it professional, with standardized responses and disclaimers, and is it being monitored on a regular basis? If used properly, computerized communication can pay for itself. Remember that you can't just delete email correspondence with patients. These interactions are usually relevant to ongoing patient care so you want to be sure that your system will allow you to transfer patients' messages, and your replies, into the patients' records.

Land-line phone systems often include features such as immediate computerized call routing. While this may free up staff time, the lack of a "real person" answering the phone can frustrate patients. A designated staff person ("Please press 0 if you would like to speak with a staff member,") who does call routing can buy a great deal of patient goodwill.

More and more Americans are opting for cell phones as their primary – or *only* – means of telephone contact. Be sure to ask for cell phone numbers routinely and make a note when the patient uses only a cell phone for personal communication. Also, document the patient's preference of communication methods, (i.e., "How would you like us to contact you to remind you about appointments or cancellations, etc ...?")

PDAs can be incredibly helpful to the busy practitioner who uses the device to juggle scheduling items, to store patient rounding lists and memos with medical protocols, and to keep track of to-do lists. Time taken to learn the functions of that PDA up front may save immeasurable time over the long haul.

Staying in the loop

The ever-changing nature of products and services will always present opportunities as well as challenges. A few suggestions for getting (and staying) informed:

- Consider subscribing to the American Health Information Management Association (AHIMA), a nonprofit organization dedicated to helping with the management of Protected Health Information (PHI);
- Set up a calendar for regular updates from the employee you have designated as your "technology guru;"
- Take advantage of technology education opportunities available through your local and state medical societies;
- Create a task force in your practice to analyze ways to improve the efficient and accurate management of clinical and business information;
- Consider bringing in an outside consultant to speak to a gathering of staff from both your practice and from other similar practices in your area;
- Consider, too, the benefits of sending one or two staff members to various regional or national educational programs – with the understanding that, upon their return, they will provide an in-service update for other members of the team.

Conclusion

Technology can be daunting, expensive, and complex. It can also be incredibly helpful in running a practice that caters to the needs of both staff and patients. There are many things you can do without spending money to best utilize your staff's talents and the functionality of the technology you already own. There are also ways you can wisely spend money to bring better processes and efficiencies to your practice – freeing you to spend more time with patients, be more efficient and make more income. ■

Beware! If You Make a Payment Directly You May Be Required to Report

Louise Hensleigh, Esq., Legal Counsel, Medical Protective

As you may already be aware, new federal laws[1] being administered by the Center for Medicare Services (CMS)[2] now require that liability insurers, non-group health plans, and self-insured businesses that make payments to Medicare recipients on or after January 1, 2010 must report such payments to CMS in an electronic format set by CMS. What is not commonly known is that CMS has defined self-insurance in such a way as to make the new law's reporting requirements applicable to physicians, hospitals and other healthcare providers (and even dentists, in some instances) when they make a payment to a patient in order to resolve complaints about services provided or in connection with claims not submitted to insurance carriers.

What difference does this make to the average practitioner? If you settle a patient's claims directly, without reporting the settlement to your insurer, you may be violating federal law. Any such settlement, whether for a pittance or merely for forgiveness of outstanding medical (and in some instance dental) bills, must be reported to CMS if the settlement is made to a Medicare recipient. Moreover, when healthcare providers make medical payments on behalf of patients on an ongoing basis, different rules apply, and reporting is required on payments made on or after July 1, 2009, not January 1, 2010.

Failure to timely report can result in civil penalties being assessed of up to $1000 per violation per day.

How did this happen? The relevant language is found in Appendix G of the CMS User Guide:[3]

> **LIABILITY SELF-INSURANCE:**
> 42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no fault insurance, or workers' compensation law or plan) for a business, trade or profession.

to a Medicare Patient, the Transaction to CMS

What is not commonly known is that CMS has defined self-insurance in such a way as to make the new law's reporting requirements applicable to physicians, hospitals, and other healthcare providers (and even dentists, in some instances) when they make a payment to a patient in order to resolve complaints about services provided or in connection with claims not submitted to insurance carriers.

Under this definition of "Liability Self-Insurance," a medical professional making any payment to satisfy a claim is deemed to carry "Liability Self-Insurance," and is thus subject to the federal reporting requirements. CMS has repeatedly confirmed this interpretation during its scheduled monthly teleconferences with industry representatives as well as during CMS seminars regarding Section 111 requirements.

Accordingly, exercise extreme caution when making any payment to or on behalf of a patient. Keep in mind too that a "payment" may include anything of value given to a patient, including: 1) a refund of previously paid medical bills; 2) forgiveness of outstanding medical bills; 3) free services; 4) gift cards; and 5) any sum of money. However, during a recent teleconference, CMS representatives indicated that it is considering whether writing off a medical bill constitutes a reportable incident–so stay tuned. Also note that when any self-insured payments are made, CMS requires the healthcare provider–not the insurer–to determine whether the claimant was Medicare-eligible[4] at the time of the payment, and if so, to make the required report to CMS via its existing electronic reporting system.

One additional caveat: Because CMS issues stand-alone "Alerts" clarifying reporting obligations and has also updated the Section 111 User Guide several times, reporting requirements remain in a state of flux. If and when the reporting obligations discussed herein change, Medical Protective will notify insureds in follow-up *Protector* articles.

Due to the complexity of the issues discussed here, it is recommended that you consult an attorney with specialized expertise in Medicare-related matters if you have additional questions or concerns. ■

1. Section 111, Medicare, Medicaid & SCHIP Extension Act
2. More information regarding CMS and reporting requirements can be found at www.cms.hhs.gov.
3. MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Worker's Compensation User Guide (Version 2.0)
4. To be "Medicare-eligible," a patient must be: (1) age 65 and over; (2) under age 65 with certain specified disabilities; or (3) any age with end-stage renal disease.

World Health Organization Raises Flu Alert to Pandemic Level

Is Your Practice in Sync with Changing Guidelines and Requirements?

The pandemic is now official

In June, the World Health Organization (WHO) warned that H1N1 Virus had reached pandemic levels. An influenza pandemic is classified as a new virus subtype – not previously contracted by humans – which "starts spreading as easily as normal influenza, by coughing and sneezing."[1] Cases of the virus have been reported in 74 countries and worldwide the evolving strains have accounted for 28,774 deaths.[2] In the U.S., the Centers for Disease Control and Prevention (CDC) has reported that over a million people have contracted the virus and at least 353 are known to have died from the disease. By the time readers see this report, the data will be obsolete.

The Southern Hemisphere is already in the middle of its flu season. According to the WHO, "Isolates sequenced at WHO and CDC suggest that circulating novel influence of (H1N1) viruses look similar to A/California/07/2009, the reference virus selected by WHO as a potential candidate for novel influenza A (H1N1)."[3] What does this mean?

It means that there is increasing prevalence of strains of this potent virus in the seasonal flu data forewarning the severity and types of flu strains likely to occur during the North American flu season. Strains identified in the Southern Hemisphere are used by the CDC to determine the "mix" of inoculations for the upcoming U.S. flu season.

Challenges

This year, children will be in school before any type of flu inoculations become available. Optimistic reports indicate that flu shots may be available by mid-October. This hampers one of the most effective means of prevention of the spread of any flu – reducing its ability to spread among children. In addition, this strain seems to be particularly virulent in young, healthy people. The elderly are more likely to have protection from previous exposures to similar viruses, according to the CDC.

Shortages of flu vaccine are another concern, according to several reports from both the WHO and the CDC. Most flu vaccine is manufactured outside the U.S. Should the winter strain prove as deadly as some fear, the demand for inoculation will soar. Countries where the vaccine is manufactured may fail to honor sales commitments and reserve all available vaccine for their own populations.

Serious shortages of qualified laboratory workers in the U.S. may also complicate the diagnosis of a wave of patients reporting flu-like symptoms. Without adequate diagnostic services, it may be difficult for doctors and hospitals to differentiate between those who merely have seasonal flu and those who have contracted a deadly virus strain. According to the American Society for Clinical Pathology (ASCP), the U.S. has a mere 300,000 workers to handle all laboratory diagnostic testing. Even without the need for a highly-trained body of skilled technicians to handle an onslaught of flu tests, the already-existing shortage means that many hospitals have job vacancies in their labs that can take more than a year to fill. Some states report job vacancy rates for lab technicians exceed the 50 percent level, ASCP reports.[4]

Inoculation refusal may pose yet another challenge as increasing public concern about the effects of medications and inoculations has been associated with a drop in the willingness of many in the U.S. to receive flu shots and other types of public health preventive treatments. The CDC warns that mass inoculation programs are effective only if high percentages of the population undergo treatment. Without this participation, the "herd protection" effect fails and a highly contagious and deadly virus such as H1N1 could endanger those who could not bear the risk of inoculation,

e.g., those with compromised immune systems. If most of the population were inoculated, these at-risk individuals might have a better chance of avoiding infection.

Worst-case scenario

Healthcare professionals are being warned by the CDC to stay apprised of reports about changes in various virus strains. According to the WHO, the current Pandemic Stage Rating is 6, meaning that public health officials need to be prepared to enact steps which, at some point, may include imposition of travel bans, school closures, etc. The WHO warns that outbreaks of a more serious strain could easily extend beyond two years and could sorely test the resources of health systems throughout the U.S. In this scenario, the CDC says that up to 40 percent of the workforce could be affected at some point and the likelihood that young working-age adults may be among the most vulnerable bodes ill for the provision of essential services and goods.

What can physicians and dentists do?

Have a plan. It would be dangerous if healthcare professionals ignore the potential risks associated with this virus. The number of reported cases of H1N1 continued to increase throughout the summer and the 2009-2010 flu season is expected to be severe, according to both U.S. and international public health monitoring agencies. According to the WHO, a new and even more deadly strain of virus would spread to all continents in less than three months. This rapid transmission is predicated on the number of international travelers and would necessitate medical care for "significant portions" of the world's population and cause shortages of vaccines, antiviral drugs, and medical supplies.[5]

Be accountable. Every medical and dental office should have an assigned infection prevention and control officer. Depending on the size of the practice it may be helpful to have a committee as well. This accountability should include the day-to-day aspects of clinical infection prevention and control as well as public health risks, including preparation for highly contagious or deadly diseases. Just a few resources that should be frequently monitored include:

- American Society for Professionals in Infection Control and Epidemiology (APIC)
- Centers for Disease Control (CDC)
- Healthcare Infection Control Practices Advisory Committee (HICPAC)
- Federal Emergency Management Agency (FEMA)
- Local health systems and hospital initiatives
- Professional association websites
- American Dental Association
- American Medical Association
- American Osteopathic Association
- Society for Healthcare Epidemiology of America (SHEA)
- State and local Departments of Public Health (all of which have their own websites)
- State and local professional dental and medical associations (Yes, dentists will play an important role in pandemic management.) It would be well if both professions work together in planning and local policy development.
- World Health Organization (WHO)

All of these resources are available through a variety of Internet search engines. Several of them, e.g., the CDC, FEMA, and WHO, have multiple site resources. Include key words like pandemic, H1N1, Swine Flu, or influenza preparedness in the search function to be directed to relevant areas of the websites.

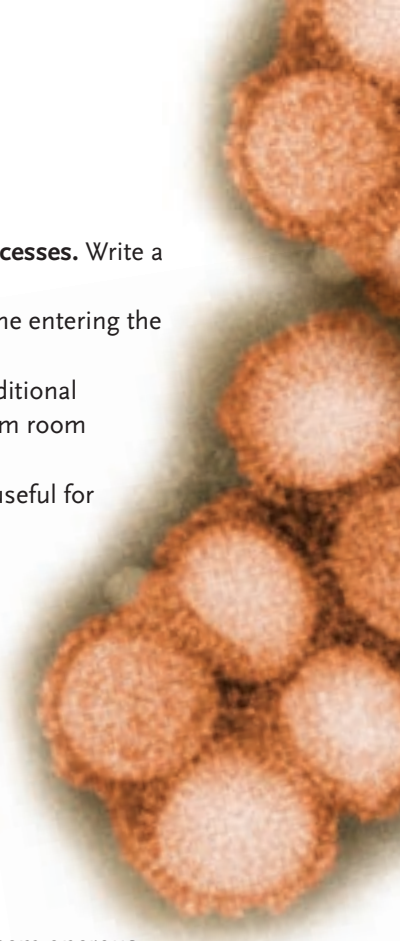
Don't reinvent the wheel. Develop a disease management section of the practice's infection prevention and control policies and procedures. Wherever possible, incorporate updates or changes into already-existing infection-control and/or patient safety processes. This is appropriate for the protection of the public, the practice's patients and their families, and the members of the medical or dental team themselves and their families.

Tune in to local resources. Become familiar with the local pandemic preparation plans. For example, if a patient has symptoms, to what resources or facilities should that person be referred? In many communities the triage area for flu patients is removed from the hospital itself and may be located in a completely different site. Don't send people on a goose chase. Physicians and dentists should be able to help reinforce the local community's emergency plan by providing accurate and current information to those who may need it. Remember that instructions may sometimes change with little notice; someone in the practice needs to stay current on these details and update other members of the team. Be prepared to discuss patients' fears and concerns; help them understand the local community's preparedness plan and, to the extent possible, obtain their commitment to follow the local protocol.

Start long before an emergency exists. The medical or dental team should discuss the possibility of time off for the care of family members or if daycare centers and schools are closed. Can the practice manage on reduced work hours? Walk through a hypothetical "flu day" during which at least half of the staff may be missing, elective procedures have been cancelled and needed supplies may not be available. Consider stockpiling materials and supplies that would be essential during a three-month period in which deliveries might be delayed or non-existent, depending on your office area of practice.

Incorporate a team approach to processes. Write a protocol for in-office prevention.

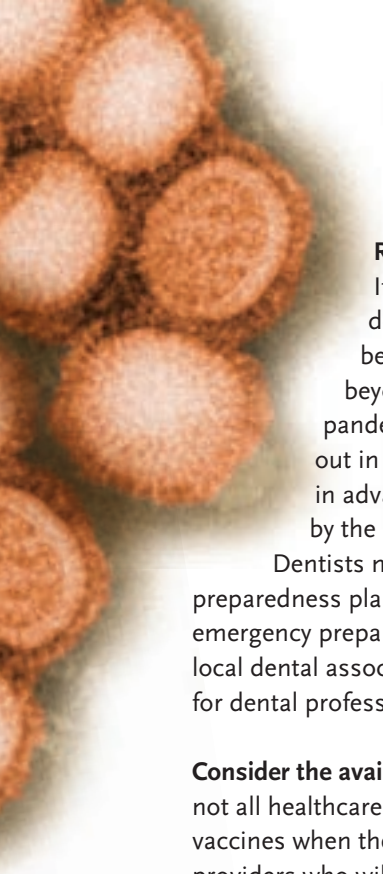
- Is it feasible to require that anyone entering the office use a hand cleanser?
- Would it be helpful to initiate additional cleaning procedures in every exam room between patients?
- Would the same procedures be useful for frequently-used work surfaces?
  - Light switches
  - Door knobs
  - Telephones
  - Computer keyboards
  - Fax machines and printers
  - Other equipment
  - Desk surfaces
  - Bathroom fixtures
  - Kitchen appliances and eating surfaces



While review of the activities may seem onerous, in fact, most medical and dental offices already have sound infection prevention and control practices in place if they've been paying attention to public health updates about the prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) in the U.S. A sound infection prevention and control plan can kill more than one pathogen at a time.

Educate. Remind. Reinforce. Introduce in-office staff education for behavior modification. If prevention training isn't already in place, consider it a priority. It can be challenging to change habits, especially in a busy office where everyone is wearing several hats. So it's important to insist on new behaviors *before* an emergency occurs.

Compliance is not optional. Put some teeth in prevention policies. Make it clear that the policies apply to everyone associated with the practice. The clinical, administrative, or business duties of a practice's employees are irrelevant to the "bugs." They're perfectly happy moving from one human to another. They don't care about job titles. Find ways to celebrate compliance but also implement helpful reminder systems. Monitor the acquisition of new habits and, if necessary, enforce penalties for failure to "get with the program."



Research clinicians' potential roles. It's important for physicians and dentists to understand how they may be asked to participate in clinical service beyond the walls of their own offices. In a pandemic, physicians may be asked to help out in a variety of ways. They need to know, in advance, what may be required of them by the hospitals where they have privileges. Dentists need to be plugged into the local preparedness planning for their profession as well. Local emergency preparedness leadership and state and/or local dental associations will be an important resource for dental professionals.

Consider the availability of supplies. Be aware that not all healthcare professionals may be able to access vaccines when they become available. In an emergency, providers who will be directly involved with caring for the infected population are typically first served, e.g., ED staff. The second group most likely to receive inoculations will be those who have joined a formal volunteer program in advance. Since the system can plan for their participation, their protection will also be factored into vaccine distribution. The availability of inoculation for the remaining clinical population – and for their staffs – will be determined by local prioritization of resources and availability of vaccine.

Beef up safety and security protocols. When businesses are closed, crime may increase. Protect your investment. Review office security. Notify police if the office will be closed for any period of time. Local law enforcement officials may be able to offer helpful suggestions. Consider placing certain materials, e.g., prescription pads, unused laptop computers, etc., under lock and key. Change passwords on in-office computer systems. Lock the system down. Better to be safe than sorry.

Remember HIPAA Privacy Rule requirements. This law assumes that healthcare providers make reasonable efforts to protect the security of patient health information. HIPAA requirements are unlikely to be suspended during a health emergency although HIPAA makes some provision for certain disclosures to disaster relief organizations. For instance, 45 CFR 164.510(b)(4) of the Privacy Rule allows covered entities to share patient information with the American Red Cross so it can notify family members of the patient's location.[6]

Stay tuned. Be mindful that regulations from other federal bodies may also come into play. Regulatory mandates or guidelines may be issued by the CDC, the U.S. Department of Agriculture (ASDA), or the Occupational Safety and Health Administration (OSHA). For example, in a pandemic, the OSHA bloodborne pathogen standard or respiratory protection standard[7] might be rigidly enforced – or new regulations might be imposed based on the seriousness of the threat. While the "general duty" clause of the Occupational Safety and Health Act[8] stipulates that employers must ensure a safe working environment for employees, new guidelines relative to pandemics were issued by OSHA in November 2006 and gave more specific instructions relative to the safety of individuals whose work environment might put them into contact with the virus, e.g., cleaning areas in which persons with the virus may have congregated.[9]

Summary

In light of the many day-to-day challenges inherent in busy healthcare practices, physicians and dentists may find it difficult to add one more major project to their to-do lists. However, the potential risks to the population, to their own patients and employees may be significant. Delay in development of epidemic-focused policies and procedures may have catastrophic results – and may potentially expose doctors to allegations of professional negligence. ■

1. World Health Organization. Ten things you need to know about pandemic influenza. 2005. www.who.int/csr/disease/influenza/pandemia10things/en/index/html
2. Hellerman, C. Swine flu 'not stoppable' World Health Organization says. June 11, 2009. CNN On Line. www.cnn.com/2009/HEALTH/06/11/swine.flu.who/index.html
3. Centers for Disease Control and Prevention. Flu Surveillance Report. www.cdc.gov/h1n1flu/surveillanceqa.htm
4. Landro, L. Staff shortages in labs may put patients at risk. *The Wall Street Journal.* May 13, 2000. D5-D6.
5. Ibid. World Health Organization.
6. Department of Health and Human Services. HHS.Gov. Is the HIPAA Privacy Rule Suspended During a National or Public Health Emergency:? www.hhs.gov/ocr/privacy/hipaa/faq/providers/hipaa-1068.html
7. 29 C. F. R. §1910.1030 (a)-(i) (2006).
8. 29 U.S.C. § 654, 5(a)1: Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." Each employee shall comply with occupational safety and health standards and all rules, regulations and orders issued pursuant to this Act which are applicable to his own actions and conduct.
   29 U.S.C. § 654, 5(a)2: Each employer shall comply with occupational safety and health standards promulgated under this act.
   29 U.S.C. § 654, 5(b): Each employee shall comply with occupational safety and health standards, and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct.
9. U.S. Dept. of Labor, Occupational Safety & Health Administration. OSHA guidance Update on protecting employees from avian flu (Avian Influenza) Viruses (2006).

It's easy being green.

Small changes create a big effect. We'd like to thank those of you who have chosen to receive your copy of *Protector* via email. You're helping us do our part to reduce paper waste and protect the environment.

To also receive your copy of *Protector* via email, you can sign up one of two ways:

- Go to protector.medpro.com/register
  and complete the online registration form.
- Email us at customerservice@medpro.com.
  Type "Email Protector" in the subject line.
  Provide your email, name, address and policy number.

Don't forget: Articles from this and previous issues of *Protector* are available online at medpro.com in the Risk Academy for registered users.

In addition, we'd like to remind you of our extensive online services and resources available at medpro.com. Find industry news, obtain certificates of insurance, access risk management tools and educational materials for CMEs/CDEs, obtain coverage verification through online credentialing, and sign a HIPPA Business Associate's Agreement with Medical Protective. All at your fingertips!

Thank you for helping us to conserve energy and natural resources.

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.
a Berkshire Hathaway Company

5814 Reed Road
Fort Wayne, IN 46835-3568

Visit us at medpro.com or call 800-4MEDPRO.

STANDARD-CLASS
PRESORTED
U.S. POSTAGE
Permit #4550
Milwaukee WI