Inside Medical Liability

New Tactics for Lowering Readmissions

A PIAA Publication for the Medical Professional Liability Community

2017 Third Quarter

MPL under MACRA
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In the U.S., and around the world as well, both citizens and their governments are facing a difficult new reality: quality healthcare simply costs more than the capacity to pay for it. Various countries have developed different approaches in their attempt to rein in costs. Here in the U.S., while Congress has struggled to find an acceptable replacement to the Affordable Care Act, within healthcare itself, there is a fundamental shift underway in how care is approached and delivered.

No longer can a healthcare professional simply undertake numerous tests and procedures, followed by an open-ended series of treatments. That way of thinking is being replaced by value-based care, which is grounded in the findings of evidence-based medicine. An important component of this transformation is the astonishing volume of data that is now available to us. Researchers and practicing clinicians alike are discovering new ways to utilize this data, to optimize, and, when possible, streamline the processes involved in good care.

The cover story of this issue of Inside Medical Liability outlines two new data-based approaches to reducing patient readmissions. While general in concept, these are in fact tailor-made for each patient, based on (in one program) a Web-based personalized risk assessment. The assessment uses an app to assess variables such as overall health and age-independent patient frailty.

Other factors are playing into this sea change in healthcare as well. MACRA, the Medicare Access and CHIP Reauthorization Act, specifies new metrics for the quality of care. A feature article in this quarter’s issue examines, through the lens of today’s environment, the problems and shortcomings of clinical practice guidelines (CPGs), particularly when it comes to their use in medical professional liability litigation. It also provides analysis on how CPGs can be properly interpreted by a defense team and medical experts.

And, of course, technological advances continue to be ubiquitous in healthcare. The digitization of healthcare could prove to be the biggest trend in the next 10 to 15 years. This point is illuminated in our coverage of the 2017 PIAA Medical Liability Conference and the keynote address by renowned healthcare expert Dr. Robert Wachter. Dr. Wachter’s guidance on 21st century medicine and the ramifications for medical and healthcare professional liability insurers and indemnifiers, as well as the key points from some of the other enlightening conference sessions, are captured in the bonus coverage of this event. Watch for information coming soon on the 2018 Medical Liability Conference in Orlando.

So all of these are in play at this point: data analytics, technology, metrics, and measurements of all sorts, used to check on, and then evaluate, virtually every aspect of diagnosis and care. Will the new initiatives that utilize these quantitative analyses prove instrumental in improving the quality of care, and perhaps equally important, stabilize or maybe even lower the costs of healthcare?

This current stage of healthcare is comparable to what is seen in an emerging market for a new technology, with multiple experiments in applications of metrics and data being tested at the same time. Here at PIAA, we will closely monitor those trends and metrics that are most likely to impact and advance the delivery of quality healthcare.
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“The general goal is to help patients better endure, or more quickly recover from,
the physical trauma of major surgical procedures.”
—Cover story
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Events & Calendar

Technology, Human Resources, and Finance Workshop

Information Technology Track

Business Value Alignment—What Your Company Can Gain by a Structured Business and IT Health Check

The IT function is constantly challenged to incorporate new innovations and generate real business value. Bill McGarry, Principal Essentialist, Trissential, will discuss how it is useful to have a framework that business and IT leaders can use to assess their alignment with strategic objectives and help them determine where to focus their limited resources. Utilizing an industry-standardized IT-Capability Maturity Framework (IT-CMF) can help organizations devise more robust strategies, make better-informed decisions, and perform more effectively, efficiently, and consistently.

Human Resources Track

The Importance of Succession Strategy

PIAA members, and in fact, most insurance companies, will soon experience a great demographic shift in staffing. With the baby boomer generation retiring, and millennials moving into the workplace, human resources professionals will face significant changes in the way they recruit and train for strategic business continuity and succession. Gregory P. Jacobson, Co-Chief Executive Officer, The Jacobson Group, will provide strategies to manage the evolving workforce brought on by the exodus of the baby boom generation and prepare for the succession to fill the related experience and knowledge gap.

Finance Track

A.M. Best: New BCAR Update

A PIAA member company’s underwriting, financial, and asset leverage are subjected to an evaluation by A.M. Best’s Capital Adequacy Ratio (BCAR). In this session, Kurt Johnson, FCAS, MAAA, Executive Vice President, BMS Re U.S., will outline the most recent changes to A.M. Best’s calculation of balance sheet strength and the amount of capital needed to support the risks on that balance sheet. He will provide an overview of A.M. Best’s updated capital adequacy calculation, provide analysis on how the new calculation will impact PIAA companies, and highlight the components of A.M. Best’s “Building Block Approach” to the rating process.

2017 Introduction to Medical Professional Liability Insurance Workshop

Designed for Professionals Who Want to Learn the Fundamentals of the MPL/HPL Business!

The operations of a medical and/or healthcare professional liability insurer are inherently complex. For industry newcomers, longer-term employees who need to broaden their understanding of this sector, and everyone new to governance in PIAA member companies, this event will expand their knowledge of the foundational concepts, and what’s involved in the day-to-day operation, of MPL/HPL insurance entities. Key areas examined at this meeting include the various elements of healthcare risks, rate-making and reserves, claims and underwriting administration, risk management and patient safety, and much more! Note: This event is open to both PIAA members and non-members.

Insider Medical Liability

Third Quarter 2017
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A Helpful Word of Warning, from a ‘Caring’ Personal Injury Attorney

Are personal injury attorneys really concerned for their clients? Or are they simply focused on the bottom line? The following text from one firm’s website casts doubt as to their true motive. For example, this is the first cautionary sentence for potential clients: “The first factor that we need to know about is damages. Prosecuting a medical malpractice case is exceptionally expensive.”

Okay, then: please tell us, just how expensive? “A typical malpractice case against the hospital or doctor can cost anywhere between $75,000 and $300,000; sometimes more!”

So, in addition to the money, which is substantial, you may be wondering what, as a patient, you should focus on when considering presenting this firm with your case—the medical misadventure, or what it’s potentially worth. Here is their answer: “Before you begin to worry about whether or not there is medical malpractice in your treatment, know that without the damages being pretty large, without your life being very changed, without the addition of significant unnecessary medical treatment, you may have a negligence case but you won’t have a case worth pursuing, because you don’t have enough damages.”

What’s the bottom line, then, at least according to this firm? “You may have a case, but as a consumer, you should not be looking for a medical malpractice lawyer unless you have significant damages.”

Source: Lobovick and Diaz law firm, www.lobovitz.com

Well, that didn’t take long. The same week that the Florida Supreme Court struck down the 2003 cap on MPL awards ($500,000; $1 million for catastrophic injuries), the law firm of Haliczer, Pettis & Schwamm announced its intention to represent plaintiffs, instead of defendant healthcare professionals they’d represented before, in MPL suits.

The genesis of the switch was (of course) humanitarian. “Given the tumultuous state of healthcare in America, we have collectively decided to switch sides to help those who need it most,” said founding partner Eugene Pettis.

There are benefits all around for the firm. Already, the switch has allowed Pettis to jettison four of its associates, based on the premise that plaintiff clients usually require fewer attorneys than defendants. Another of the partners, James Haliczer, points out that the switch wasn’t completely driven by money, but he does concede that “the partners don’t expect it to be a losing proposition.”

Source: Daily Business Review, June 6, 2017
Here’s an interesting statistic: With the amount of money that the National Health Service (NHS) is spending on legal costs for unanticipated outcomes, the organization has realized that the training of more than 6,000 doctors could have been funded with the same amount of money.

Commenting on the issue, a Department of Health (DOH) spokesman noted, “We agree that clinical negligence costs are too high. So, we’re taking action to drive these down. We have consulted on proposals to cap exorbitant payments going to lawyers, and NHS Resolution will give hospitals incentives to learn from mistakes so that costs are reduced just as patient care improves.”

A significant driver in the explosive growth in lawsuits, says NHS, is increasing expectations on the part of patients. In 2015–2016, this resulted in a 27% increase in the number of claims and a 72% increase in legal costs, which amounted to £1.5 billion.

Observer suggests that perhaps the U.K.’s MPL counterparts in the U.S. could help out in this regard. H.R. 1215, the “Protecting Access to Care Act of 2017,” has been getting excellent reviews, though admittedly we do not yet know its eventual fate. But its text can no doubt be quoted, with due credit to the source.

Sutter Health, a hospital chain in Northern California, thought it had found a simple solution to the problem of “defensive medicine.” The Sacramento-based health system deleted the button physicians used to order daily blood tests. “We took it out, and couldn’t wait to see the data,” said Ann Marie Giusto, a Sutter Health executive.

Unfortunately, the number of orders hardly changed. That’s because the hospital’s medical-records software “has this cool ability to let you save your favorites,” Giusto said at a recent presentation to other hospital executives and physicians. “It had become a habit.”

Trimming waste in America’s $3.4 trillion healthcare system, as the Sutter example illustrates, is often not as easy as it seems. Some experts estimate that at least $200 billion is spent annually on excessive testing and treatment.

“There is still a continued financial incentive to do that test, do that procedure, and do something more,” says Dr. Harry C. Sax, Executive Vice Chair, Administration Department of Surgery Surgical Physician Adviser, Cedars-Sinai Medicine. In addition to financial motives, Sax notes, many physicians still practice defensive medicine out of fear of medical professional liability litigation. Also, some patients and their families have come to expect a CT scan, every time they have bump on the head.

To cut down on needless care, Cedars-Sinai arranged for doctors to be alerted electronically when they ordered tests or drugs that ran contrary to 18 recommendations in the Choosing Wisely program promulgated by the ABIM Foundation. The hospital analyzed alerts from 26,424 patient encounters from 2013 to 2016. All of the guidelines were followed in just 6% of those cases, or 1,591 encounters.

Well, with so many incentives in play, it’s really not surprising that effecting change in “defensive medicine” wasn’t going to be easy. Are there any more buttons like the blood-test one that we can delete?


Source: Daily Mail (London), February 27, 2017
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PIAA Data Sharing Project

Postoperative Infection

- Cardiovascular and Thoracic Surgery
- General Surgery
- Neurosurgery
- Ob/Gyn Surgery
- Ophthalmology
- Orthopedic Surgery
- Otorhinolaryngology
- Plastic Surgery
- Urology

4% of 40,559 claims closed between 2006 and 2015 for surgical medical specialties showed postoperative infection as the most prevalent outcome.

More than 22% of 1,550 closed claims paid $111 million in total indemnity and an average indemnity payment of $325,781.

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<th>Specialty</th>
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The majority of the 1,550 closed claims reporting postoperative infection outcomes were among general surgeons and orthopedics. Of the general surgery claims, 26% of closed claims paid $42 million in total indemnity and an average indemnity payment of $350,125. Of the orthopedic claims, 19% of closed claims paid $27 million in total indemnity and an average indemnity payment of $337,331.

For more detailed information, see the PIAA MPL Specialty Specific Series reports or contact P. Divya Parikh at dparikh@piaa.us. © 2017 PIAA. All rights reserved. This page may not be reproduced or distributed without express written consent from PIAA.
Billing and collection events may well be the most frequent point of contact between an insurance company and an insured. Think about this: If you insure a doctor for 10 years, and he has no claims but pays his premium quarterly, you will have had 40 billing and collection encounters during that 10-year period.

Yet, billing and collection has usually been regarded as a non-core, back-office function.

More than 50% of premium is still collected by mailing out a bill and receiving a check—just as it was done in 1960. But now that it’s 2017, that seems like an incredibly inefficient and outdated way to do things. Electronic practices are widely used in every kind of commerce today, so agents and insureds should be familiar with—and indeed, expect—the same kinds of easy transactions from their insurance company.

Using best (electronic) practices for billing and collection can have the following benefits:

- **Reduced transactional costs**—less time spent on handling, mailing, filing, data entry, investigation of discrepancies, etc.
- **Improvements in working capital**—with more timely collection and fewer discrepancies, premiums are collected more quickly, and there should be fewer overdue payments and bad debts to manage.
- **Improved efficiency and service**—the process can work more smoothly, for the insured as well as the company.
- **Better communication with the insured**—if you have his attention for billing, you can combine this with sales messaging, like highlighting the premium credits he is receiving, or cross-selling a new kind of coverage, for example.

How the changes to billing and collection are made will depend on the capabilities of the software in place. Most policy administration system vendors bundle billing and collection with their product, but there are some standalone solutions in the market if what you currently have installed isn’t able to meet the requirements. In addition to the right software to support changes to the process, management needs to view this function in a different light: as a vehicle for better service and communication. Overhauling the software, just to get rid of some problems in the legacy system, is not sufficient.

It’s said that many people still want to do business the old way. But really, is that true, or is it just an excuse for avoiding change? E-commerce has been around long enough now that almost everyone has had some exposure to a better way of doing business. The other excuse is that e-mail addresses are not available. Well, a one-time exercise can take care of that, and these days, people tend to keep the same e-mail address longer than keep their physical address, so once set up, a system based on e-mail should require little maintenance.

And then, consider: With the old system, there are the fees for lockbox processing, merchant fees for credit cards, and so on. After the full direct and indirect costs of the current paper-based methods are calculated, including the cost of the higher volume of time-consuming queries and delinquencies, there will likely be a cost savings. And remember, that isn’t the only benefit.

**Improvements to consider**

Here are some ways to improve billing and collection:

- If there is a Web portal, the billing documents could be accessed from there, with an e-mail reminder sent to the insured when it is time to do so. A Web portal also gives you a
place to add information targeted to the insured, for example, his billing history, the amount of the next payment, any new coverages you’re offering, or to highlight his premium discounts. Alternatively, if a Web portal is not available, the billing documents could be sent to the insured or his agent as an e-mail attachment. An opt-out should be available for those who prefer to stick with a hard-copy bill, but the default should be electronic, and the opt-out preserved for those few who just seem to love paper. (And you can use the “go-green” environmental appeal to promote e-billing.)

- Encourage the use of EFT or ACH—electronic funds transfer and automated clearinghouse; these terms can be used interchangeably. With this arrangement, the company sends a notice to the insured that a payment will be “drawn” from his checking account on the appointed date. The funds are processed electronically and arrive at the company’s bank account without any need for data entry. There are obvious savings in time, but most of all, this method cuts down on discrepancies and late payments, situations that frequently require significant man-hours to resolve. If the company offers a monthly pay plan, one idea would be to make it dependent on the use of EFT; monthly payments using paper are hard to manage and become confusing if there are delinquencies.

- For mailed-in payments, use a lockbox to process the cash. This saves time and data entry, and it’s been around forever. Also, it does not require any special action on the part of the insured.

- An IBM study done in 2016 found that 76% of people paid their monthly bills using more than one method. In the name of good service, insurers should offer this, too. If there is a Web portal, the insured should be able to manage his preferences, for example, in selecting or changing the method or frequency of payment. Credit card payments are not offered by many MPL companies, but in a world where almost everything can be bought using one, maybe it’s time to change. Credit cards can work like an EFT, with a regular payment schedule set up for a given day of the month. Obviously, there are merchant fees involved that need to be factored in, but even with those in the calculation, the savings in timeliness and labor could easily offset the cost. To address the question of security, the collection can be done via companies that specialize in credit card processing.

- Prevent or cut back on exceptions. There is a temptation—usually in the name of service—to make exceptions in the billing and collections process, for example, offering a non-standard commission rate or commission payment accommodation, setting up a non-standard pay plan, or a “magic” method of applying cash to the receivables. But these generally add up to inefficiencies, errors, and problems down the road.

When everything works as intended—the premium is paid on time and in full—these measures can make billing and collection a hands-off and highly automated process. Then, most of the work of the accounting staff will be spent on dealing with queries, errors, and exceptions. But there should be fewer of them, because timeliness and accuracy are built into the methods discussed here.

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Last quarter, I told you how the PIAA biannual Government Relations Survey helps us develop an advocacy agenda, and corresponding strategies, to ensure that our lobbying efforts are providing the maximum possible benefit to our members: the medical and healthcare professional liability (MPL/HPL) insurance community. Now, I would like to review some of the other ways our interactions with PIAA members enhance our advocacy efforts, and how your interactions with us may also serve to enhance your own.

Advisory committees
Working through its committees, PIAA members and staff interact in ways that enhance the services we provide to you. For advocacy issues, there are two dedicated committees: the Government Relations Committee (GRC) and the Regulatory Affairs Committee (RAC). Each committee is comprised of six to 14 individuals who represent the broad spectrum of PIAA membership, covering the full span of differences in geographic reach, size, and company structure. Members of each committee are individually chosen, based on their interest in, and knowledge of, the overarching topics under the committee’s jurisdiction.

The GRC meets quarterly to oversee our state and federal legislative, as well as our federal regulatory, advocacy. It is, among other things, responsible for guiding PIAA in its federal legislative priorities, overseeing the development of state model legislation, and reviewing proposed regulations to determine what, if any, response from PIAA is appropriate. The GRC has played a crucial role in the development of recent federal tort reform legislation (Protecting Access to Care Act, H.R. 1215), in shaping PIAA’s response to federal regulatory issues like the Medicare Mandatory Reporting Requirement, and in determining how PIAA can best support our members working on state legislative issues like patient compensation system proposals.

The RAC has a more narrow, but equally vital, focus: the National Association of Insurance Commissioners (NAIC) and state regulations. It holds regular conference calls before each NAIC meeting, and additional calls as needed to address pending issues. In recent months it has focused heavily on the activities of the Medical Professional Liability Working Group, as well as the model legislation that NAIC is developing to address...
LEGISLATIVE UPDATE

Mutual did just that. In only a few days, they equipped legislators with just a few clicks. able to send a personal message to their state representatives. and those individuals will be able to receive (if the company wants that). Then, all the company has to do is e-mail the link to its employees, insureds, and anyone else it would like to contact, and those individuals will be able to send a personal message to their state legislators with just a few clicks.

Earlier this year, our colleagues at MAG Mutual did just that. In only a few days, they were able to generate 150 messages that were sent to state representatives and senators, helping to kill legislation that would have been detrimental to the company. PIAA stands ready to assist all our member companies in creating state-level grassroots advocacy campaigns at no cost to you. To learn more, just contact us at governmentrelations@piaa.us.

Grassroots advocacy
As some of you know, PIAA recently launched a new grassroots initiative to allow its members to contact their members of Congress directly to express their views on crucial issues. While the use of paid lobbyists, like me, is an essential element of any advocacy effort, equally important, if not more so, are communications from the constituents of the members of Congress. Elected officials need to hear from the people they represent so they know how the voters actually feel (yes, it does make a difference!).

PIAA has made it easier than ever for anyone affiliated with a PIAA member company to e-mail his Congressman about the day’s most pressing issues. Our recent campaign to promote H.R. 1215 generated more than 360 e-mails to congressional offices expressing support for the new federal tort reform bill. The bill eventually passed with only four votes to spare, so it is impossible to calculate how critical those communications were to ensuring that a majority in Congress would vote in favor of the bill. To learn about the latest legislative campaigns supported by PIAA, just go to www.piaa.us and click on “Advocacy.”

But grassroots activity isn’t about federal legislation alone. Using our new advocacy tool, you can contact your state’s elected officials to express your views on the issues they are considering. When a PIAA company tells us that they need to address a pending state bill, for instance, our Government Relations team can develop the grassroots campaign for them from scratch, right down to the wording of the message(s) that the state legislators will receive (if the company wants that). Then, all the company has to do is e-mail the link to its employees, insureds, and anyone else it would like to contact, and those individuals will be able to send a personal message to their state legislators with just a few clicks.

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Elected officials need to hear from the people they represent, so they know how the voters actually feel (yes, it does make a difference!).

State bill tracking
Another feature now in the final stages of development is our 50-state bill tracking service. Utilizing the latest technologies, PIAA will make available online information on every state’s legislative activity on a wide variety of issues of importance to the MPL/HPL community. Whether your company operates in multiple states, or you just want to know what other states are doing that might impact the industry, this service will provide you with invaluable information to help shape your advocacy efforts. You’ll be able to observe the latest trends in MPL/HPL-related legislation, and find out which of your PIAA member colleagues are facing legislative initiatives similar to ones you’re facing. This will allow you (in some cases) to develop legislative strategies well before bills get too far along in the legislative process. We look forward to rolling this out in the near future, so stay tuned for the upcoming announcement.

Website
In recent months, PIAA has completed a substantial overhaul of the Government Relations section of its website. A new “State Legislation” page has been added to address the NAIC and its myriad committees, working groups, and task forces. We’ve updated the “Federal Legislation” and “Regulation” pages, as well as the “State Legislation” page, to provide the latest information on what’s happening in each of those arenas. As mentioned before, we’ve also added a page on grassroots advocacy. The Government Relations section of our website is now the one-stop shop for everything you need to know about MPL/HPL advocacy.

Conclusion
It’s 2017; advocacy is no longer about smoke-filled rooms and political payoffs. It takes a coordinated effort by government relations professionals, working in coordination with local constituents, to achieve success in influencing an elected official. It takes modern communication technologies, comprehensive information, and innovative strategies.

We hope you will find the recent enhancements in our advocacy activities useful, not just in helping to achieve the federal priorities that you’ve entrusted to us, but also in realizing your own advocacy goals in the state(s) where you do business. If you think there’s something you need that’s still missing, though, just let us know. PIAA
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Bug Fixes Coming for the Federal Rules of Evidence: Click ‘Like’ to Install

Ready for download on December 1, 2017 will be two amendments to Federal Rule of Evidence 902, allowing for the self-authentication of electronic information. The changes may facilitate more efficient and focused forensic e-discovery and case preparation. They should also make it easier to admit at trial powerful evidence from electronically stored information (ESI) gathered from “publicly facing” social media, digital environments, and electronic hardware.

In the “old days…”

In the recent past, courts confronting whether and how to admit forensically-captured ESI under Rule of Evidence 902(11) often analogized such evidence to business or telephone records. For example, in February 2015, the Colorado Court of Appeals considered a case involving a murder in which the 36-year-old leader of a “street family” of homeless and runaway teens was convicted of orchestrating the killing of a victim by way of conversations memorialized on the defendant’s Facebook account.1 To establish the authenticity of evidence gleaned from Facebook, the prosecutor produced an affidavit from a Facebook records custodian to show that the records in fact were those of Facebook. The affidavit from the Facebook records custodian stated that the records included basic subscriber information, IP logs, messages, photos, and expanded content for the profile pages linked to the defendant; the custodian also stated that the records provided were made and kept by the automated systems of Facebook in the course of its regularly conducted activity, as a regular practice of Facebook.2

To link the substance of the postings to the defendant, the prosecutor presented testimony from several percipient witnesses. The witnesses were necessary to establish the defendant’s name as it was registered to his account; to identify photos of the defendant on his profile; to identify communications with the defendant via the account; and to confirm the defendant’s nickname as it was used in the various posts in his account. The prosecution’s diligent efforts in establishing the authenticity of the defendant’s Facebook profile paid off—the information posted to the defendant’s account was incriminating, and the jury entered a guilty verdict that was later upheld on appeal.

The forthcoming updates to Federal Rule of Evidence 902, if they had been in place and adopted when Glover was prepared and tried, would likely have streamlined not just the prosecutor’s presentation of evidence in the courtroom, but also the legal team’s workup and preparation for trial.

Self-authentication and the amendments to Rule 902

Pursuant to Rule of Evidence 902, various items of evidence are self-authenticating; they require no extrinsic evidence to estab-

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lish that they are what they purport to be. Examples of self-authenticating evidence include newspapers, certain government documents, and certified copies of public or business records. With the proposed amendments in place, electronic evidence will attain a status similar to that of more traditional self-authenticating documents.

Rule 902(13) will cover records “generated by an electronic process or system that produces an accurate result,” such as a metadata report showing forensically verifiable details of information downloaded from a computer; or showing time, date, and location details obtained from GPS software on a smartphone.

Rule 902(14) would allow a copy of data to be considered self-authenticating when taken from “an electronic device, storage medium, or file, if authenticated by a process of digital identification”—for example, a comparison of a series of alphanumeric characters called MD5 Hash values that serve as a document’s proverbial “DNA.” For both items of evidence, the proponent of the evidence must still meet the requirements of Rule 902(11), which include certification of a custodian or other qualified person to certify the records of regulated-conducted activity.

Importantly, because these amendments to Rule 902(13) and (14) focus on the electronic processes and devices from which ESI is captured, these amendments should allow trial counsel to present his or her forensic e-discovery professional as the proponent of electronic evidence. This avoids, for example, involving a records custodian from the latest social media outlet from which the records were obtained. And it may obviate the need to track down ephemeral witnesses indifferent—or hostile—to the parties and events at issue. In the case of People v. Glover, these amendments would likely have simplified the prosecution’s efforts to authenticate the statements recorded in Facebook postings. That may have kept more focus on the actual content of those postings—the stuff of which good competitive storytelling is made.

**Significance of the amendments**

As with other rules of evidence, the arcane language of these new provisions gives way, with careful thought, to a practical framework to help tell your client’s story to the jurors in the jury box, using language and common experience we can all understand. Although it remains to be seen how courts will apply the amendments to FRE 902—and whether individual states’ rules committees will adopt similar language across the country—lawyers can keep in mind these principles to inform their allocation of discovery resources, their retention of forensic e-discovery consultants, and their deposition and trial preparation. Just as with our ubiquitous electronic devices, an appropriate update of the Rules of Evidence keeps us humming along, bug-free.

**Footnotes**

2. Id. at 740.
3. See, e.g., FRE 902(1) – (9).

Acknowledgment: The author would like to thank Joe Buccholz, Head Trial Consultant at Summit Litigation Support, for his input in preparing this article.
Pressure on hospitals from third-party payers to reduce surgical readmissions—and their attendant costs—is likely to grow in the years ahead. In response, hospitals increasingly are looking to interventions in the presurgical environment as another means to help improve surgical outcomes. By better preparing patients for surgery, clinicians may be able to lower patients’ risk of a readmission needed to address surgery-related issues, such as infections.

Presurgical Preparation in a New Light

New approaches to improve surgical outcomes and reduce readmissions

Within the past decade, estimated rates of hospital readmission within 30 days of major surgery (predominantly abdominal or thoracic procedures) have varied widely. Merkow and colleagues (2015) calculated an average 5.7% readmission rate among almost 500,000 major surgeries, including bariatric procedures, colectomy, hysterectomy, and hernia repair, at 346 U.S. hospitals participating in the American College of Surgeons National Surgical Quality Improvement Program. The first and second most common reasons for unplanned hospital readmission were surgical site infection and gastrointestinal obstruction. Tsai and colleagues (2013) found a 13.1% readmission rate among 479,471 Medicare discharges for major sur-
surgery, including coronary artery bypass grafting, pulmonary lobectomy, repair of abdominal aortic aneurysms, and colectomy, at 3,004 hospitals in the two-year period, 2009–2010. Hospitals with higher surgical volumes and lower surgical mortality rates had lower rates of readmission after surgery than other hospitals.7

To help address this issue, several researchers in recent years have examined whether efforts to upgrade patients’ general health before surgery might improve surgical outcomes and thereby reduce hospital readmission rates. These efforts, commonly termed “prehabilitation” (as opposed to postsurgical rehabilitation), address areas such as lifestyle changes (e.g., diet, exercise, smoking cessation) and improved management of chronic disease. The general goal is to help patients better endure, or more quickly recover from, the physical trauma of major surgical procedures. A search of ClinicalTrials.gov found about 40 ongoing trials of various prehabilitation strategies targeting primarily major abdominal or thoracic surgery (nine U.S. trials; 26 outside the U.S.), with a few addressing hip and knee arthroplasty or peripheral vessel revascularization.

ECRI Institute, an independent nonprofit health research organization, included presurgery programs on its 2017 Top 10 Hospital C-Suite Watch List.14 In the U.S., a few groups have implemented successful prehabilitation programs. Some have attempted to branch out from single centers or regional health systems to help other institutions replicate their efforts.

MSHOP

A team at the University of Michigan developed the Michigan Surgical and Health Optimization Program (MSHOP) to help healthcare professionals assess patient-specific risks before surgery, to improve subsequent outcomes for patients who had been referred for major abdominal surgery. With MSHOP, a surgeon adds a Web-based, risk-assessment app, available on smartphones and tablets, to his standard evaluation of surgical candidates.15 The application employs analytic morphomics to predict surgical risk, characterize overall health, and objectively measure age-independent patient frailty. Analytic morphomics uses diagnostic imaging scans to quantitatively measure patient-specific biomarkers including organ size and condition, muscle volume, fat density and distribution, bone structure and density, and vascular anatomy and condition.15 The application links to a central database and generates a composite score that encompasses risk for complications, extended length of stay, and mortality on a 0- to 100-point scale, and this individual risk score is presented in a format resembling a format resembling a typical automobile speedometer to enhance patient comprehension.6 The application employs analytic morphomics to predict surgical risk, characterize overall health, and objectively measure age-independent patient frailty. Analytic morphomics uses diagnostic imaging scans to quantitatively measure patient-specific biomarkers including organ size and condition, muscle volume, fat density and distribution, bone structure and density, and vascular anatomy and condition.15 The application links to a central database and generates a composite score that encompasses risk for complications, extended length of stay, and mortality on a 0- to 100-point scale, and this individual risk score is presented in a format resembling a typical automobile speedometer to enhance patient comprehension.6

After their risk assessment has been completed, patients who have been identified as having a remediable risk profile are invited to participate in a four-step preoperative training program intended to improve surgical outcomes. The four components include a walking and physical activity program, a respiratory exercise program to increase lung function, with smoking cessation aids if indicated, nutritional counseling, and stress reduction techniques to reduce pain and promote healing.6,15 An MSHOP coordinator initiates the patient training program and periodically contacts patients by phone, text message, or e-mail to track and encourage progress using both personal and automated messages. As part of the patient tracker component, the patient updates daily walking and lung-exercise logs to a secure website, with reminders sent via automated text message or e-mail to update his logs. A Web portal provides patient access to updated logs and various resource links (e.g., recipes, free exercise classes, smoking-cessation tips). The training and monitoring program lasts about one month before surgery.18,19

In published data from a pilot study (Englesbe et al., 2015), the MSHOP team reported that the program reduced average hospital stays from six to four days and average hospital costs by about $2,300 per major abdominal surgery patient.20 Based on the pilot’s success, the U.S. Centers for Medicare & Medicaid Services awarded the program developers a $6.4 million grant in late 2016 to determine whether MSHOP’s initial results could be replicated at 40 other Michigan hospitals. Results are expected by 2018.21 Further, the startup company Prenovo was formed to offer the MSHOP approach to hospitals outside Michigan.22 Prenovo claims to deliver scientifically validated solutions that reduce costs by 25% and improve patient outcomes. Its Web-based solution, Prenovo Prepare™, is intended to engage patients preparing for surgery and recovery beyond the clinical setting. The company states on its website that 80% of patients enrolled in the program stick with it. According to the company, the platform seeks to enhance “the patient-provider relationship with evidence-based teaching tools for shared decision-making.”24

POET

At Duke University Health System, the Department of Anesthesiology has championed the cause of improving outcomes of major elective surgeries through its Perioperative Enhancement Team (POET), launched in 2012. POET is dedicated to identifying high-risk patients before surgery and managing modifiable risk factors to reduce the incidence, or downstream impact, of adverse outcomes.19,20 When specific new goals to improve surgical outcomes are identified, POET works with other clinical departments and hospital administration to develop strategies and workflow changes designed to achieve those goals “to enhance the value proposition of perioperative care.”25 To date, POET has been instrumental in creating a preoperative anemia clinic to reduce the need for intra- or postoperative transfusions and a presurgical diabetes screening program for spinal surgery candidates to reduce postoperative infection risk. Other POET-led collaborations have addressed several areas related to improving surgical outcomes, including complex pain management; reductions in anticoagulation-
PRESURGICAL PREPARATION

Prehabilitation

Efforts to upgrade patients’ general health before surgery.

Associated bleeding and blood-clotting risk in obstetric, cardiothoracic, and trauma surgery; physical conditioning and exercise tolerance; and counseling on proper nutrition and smoking cessation.18-20

Strong for Surgery program

Researchers in Washington State’s Comparative Effectiveness Research Translation Network and Surgical Care and Outcomes Assessment Program developed the Strong for Surgery quality improvement initiative and launched it in facilities across the state in 2012. In 2016, the American College of Surgeons announced that it would gradually assume administration of the program, with the goal of broadening its exposure and reach to surgeons and hospitals across the U.S.

Outlook

As developers of these and other surgical prehabilitation programs accumulate more data and disseminate their findings, other health care stakeholders could take notice and champion their wider use. However, broader use of prehabilitation approaches is unlikely to occur in isolation, as demonstrated by the emergence of groups such as the ERAS® (Enhanced Recovery After Surgery) Society, whose stated mission is to improve perioperative care and recovery of surgery patients worldwide through research, education, audit, and implementation of evidence-based practice. Going forward, the most likely scenario is greater integration of prehabilitation programs, in tandem with efforts to reduce acute surgical complications as well as enhance postsurgical recovery, thus addressing the full continuum of surgical care.

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Market Softening Continues in 2016—Signs of Pressure Emerge

BY STEVE UNDERDAL, GREG BLISS, MATT WALTER, AND BLAKE BERMAN

Since the last hard market in the early 2000s, medical professional liability (MPL) insurers have faced a combination of both cyclical and secular pressures that have driven down rates and the number of insured exposures.

Since 2010, the MPL industry has been navigating a soft market, with declining profitability, diminished investment gains, and rising accident year operating ratios. Yet, reserve redundancies have kept calendar year combined ratios below 100%, allowing carriers to pay dividends to policyholders while maintaining favorable returns on equity. Recent trends in the MPL insurance industry, including more aggressive competition among carriers and a leveling off of frequency trends, are driving accident year combined ratios higher. Without the continued tailwind of favorable reserve development, current market rates could prove unsustainable, driving market hardening in the coming years.

In a broader context, over the last 30 years the MPL industry's loss ratios have been strongly
correlated with those of the general liability and commercial auto liability lines. As a result of economic, technological, and market factors, these lines began to show significant moderation in favorable reserve development and increases in accident year loss ratios in recent years, particularly in commercial auto liability, where both frequency and severity have trended unfavorably. Each line of business is different, but historical data points to a strong relationship in performance across casualty lines, which would indicate that future reserve releases in MPL will be materially less than what was reported over the past decade. Key trends in the MPL market are depicted in Figures 1 through 4.

**Trends in premium**

MPL direct written premiums have fallen every year since 2007: a cumulative decline of 23%. Healthcare reform has exacerbated this trend, by driving the acquisition of physician practices by hospitals, healthcare systems, and other self-insuring entities. During the same period, MPL rates fell by 8.4%, implying a reduction in exposure of 16% in the last decade. Favorable prior period reserve development as a percent of net earned premium (NEP) peaked at 27% in calendar year 2010, but has also deteriorated since, falling to 11% in 2016. The calendar year direct loss and loss adjustment expense ratio bottomed out at 50% in 2010, but higher claim defense costs and loss costs increased it to 73% by 2016. A reduction in favorable prior period development accounts for 16 points of the calendar year increase (27% in 2010 versus 11% in 2016), while the remaining 8 points result from higher accident year losses and loss adjustment expense. Concurrently, the industry’s accident year combined ratio increased from 76% to 113% over the last 10 years, at the year-end 2016 evaluation.

These trends in the MPL market have affected companies differently depending upon their capital structure. While the average size of an MPL writer (by NEP) has declined from $56.5 million in 2007 to $39.8 million in 2016, this is largely driven by the increase in numbers of smaller carriers and risk retention groups (RRGs). In terms of percentage of the total market, these companies have expanded from 4% to 7% in the last decade, while mutuals slipped from 30% to 26%, stock companies grew from 49% to 51%, and reciprocal exchanges stayed flat, at 16%.

**Underwriting, investments**

Stock companies have led the way in underwriting performance, with a combined ratio of 94% from 2007 to 2016, while RRGs (110%) and reciprocals (107%) have trailed the industry average of 99%. Mutuals have performed in line with the overall industry, at 100%. All of the companies have seen a slight decrease in operating leverage over the past 10 years, but stock companies have seen their leverage decline the least, because they can distribute excess capital to shareholders. In the last three years, stock companies have also reported the lowest loss adjustment expense ratio, 25%, while reciprocals have reported the highest (37%), and RRGs (28%) and mutuals (31%) have performed in line with the industry.

All of the companies have seen their return on invested assets fall in a declining interest rate environment, but RRGs have been hit the hardest, decreasing 2.1 points in the last 10 years. With loss frequency and severity stabilized, industry hardening of the market will depend
most critically on the level of redundancy in current booked loss reserves. Negative loss cost trends have held the 2016 industry rate change to -0.14%, compared with an estimated frequency trend of 3% and a severity trend of 0.6%.

Current accident year reserves are being booked at a nominal combined ratio of 119%, after the policyholder dividend. Based on current rates, this level of loss and expense is unsustainable, absent the expectation of continued favorable development on accident years 2016 and prior. While MPL writers tend to release redundant reserves over a longer time period than they realize adverse development (more than six years versus three to four years), favorable calendar year reserve development has historically continued two to three years past the point when reserves were subsequently found to be adequate. These recent development trends indicate that the industry is nearing a break-even point in reserve levels.

MPL booked loss ratios for the most recent accident years are highly uncertain and dependent on a variety of drivers that might impact future loss cost trends. If reserves on accident years 2011 to 2016 develop similarly to that of years 2008 to 2010, there will be approximately $6.9 billion of additional favorable development, proving today’s booked reserves are 25% redundant. If they follow the pattern of the period 2004 to 2007, they are $10.2 billion redundant, or 37% of booked reserves. Conversely, if these years behave like years 1997 to 2001, they are currently $6.9 billion deficient, and the industry will need to strengthen reserves by 25%. Though the true answer likely lies somewhere between the numbers in these scenarios, most signs suggest that reinsurers are currently living off past profitability, and a market hardening may be on the horizon.

Authors’ note: Guy Carpenter’s Insurance Risk Benchmarks Research Annual Statistical Review, which has provided the basis for this analysis, is a comprehensive research project in the industry, representing more than 30 years of property/casualty insurance statutory financial data from more than 1,000 companies. The study’s purpose is to provide a unique source of unbiased financial data, to help industry leaders better understand the sector’s changes and evolution, including reserve volatility, expense management, and pricing cycles, to help them grow, profitably.

Footnotes
1. Stock companies have decreased 1.4 points; reciprocals, 1.6 points; and mutuals, 1.3 points.

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The adoption of clinical practice guidelines (CPGs) into medical practice is creating a new concern for medical professional liability (MPL) that has not yet been widely recognized.

This is the second of a two-part article discussing the role of CPGs and need for understanding them as they affect MPL litigation in the ever-changing healthcare delivery system. Part One reviewed the legislation that has redefined the reimbursement of healthcare services based on quality and value. It also established a foundation for some of the problems created by using CPGs in patient care delivery.

This article, Part Two, will discuss the problems and shortcomings of CPGs and how this creates a problem when they are used in MPL litigation, since they are now going to be used to define “quality” care. The article will explain how CPGs will be used in the context of MPL litigation, so they can be properly interpreted by a defense team and medical experts.

**CPGs: a new role**

The Quality Payment Program (QPP) is intended to reward the delivery of high-quality healthcare, rather than basing reimbursement on the volume of healthcare services provided. The Merit-based Incentive Payment System (MIPS), one of the two options of the QPP that most independent practice physicians will choose, is based on the fee-for-service (FFS) model. It ties FFS directly to quality performance. Beginning January 1, 2019, MIPS becomes the default payment system; however, data collection started with a number of options on January 1, 2017. Physicians and other Eligible Providers (EPs) will be assessed in the MIPS under four categories: Quality, Resource Use, Clinical Practice Improvement Activities, and Advancing Care Information (ACI).

The Quality Category of MIPS is currently the major concern in the MPL arena, because it will likely involve CPGs for documenting that the...
defined “quality” parameters have been met. That is, quality now becomes one element in a complicated reimbursement formula used to reward or penalize an EP if a certain score is not achieved. Essentially, CPGs will assume a more prominent role than previously as they become enmeshed in patient care in the course of defining quality for the healthcare services formula used in calculating the EP payment. Quality will be assigned a weight of 60% of the total reimbursement formula under MIPS in 2017.

CPGs and grading: the devil is in the details

A reputable CPG needs to provide an assessment of the strength of each clinical recommendation. The common approach is to grade the strength of the medical evidence and the strength of the clinical recommendation independently. There is no uniform standard grading system that is utilized in developing a CPG. Determining the strength and trustworthiness of a CPG is crucial, especially in light of the new issues at stake. The grading of Recommendations, Assessment, Development, and Evaluation System (GRADE) is now used more frequently to develop CPGs, although there are other grading systems that are also widely accepted. By way of example, we will look at GRADE.

GRADE has two options for the assigned strength of the recommendation, strong or weak, and a four-level representation for the quality of evidence: high (A), moderate (B), low (C), and very low (D). Quality strength for low/very low evidence is sometimes consolidated and graded as “C.” High-quality evidence comes from well-performed, randomized controlled trials or other strong evidence, while moderate-quality evidence comes from randomized trials with limitations or from other study designs with special strengths. Low-quality evidence comes from observational studies or from controlled trials with serious limitations. Very-low-quality evidence comes from non-systemic observations, biologic reasoning, or observational studies with serious limitations.

Physician opinion leaders and authors of published articles, reviews and otherwise, exert a strong influence on practice decisions and CPG development. Although the scientific strength of a study is rated by experts in a particular medical field, expert opinion and usual practice not supported by research evidence may be included in a CPG, especially in instances where research is lacking, as can be seen by looking at the components of GRADE.

Once a guideline is published, the grade of the CPG recommendation is frequently overlooked by physicians. For example, a strong 2C recommendation and weak 1B can both be part of the same or overall guideline. Whether the CPG recommendation was followed is what is scrutinized. There are other issues in regard to CPG development, including the nature of the sponsoring society, conflicts of interest, and disagreement among the rating experts that are not apparent when reviewing the text of the finalized CPG. In other words, a CPG may not be what it seems.

A CPG with a lower strength and/or quality rating and other behind-the-scenes issues is still a published guideline and will be used for clinical practice, reimbursement, and possibly as a standard against which litigation is assessed. Even more problematic, physicians historically do not routinely check CPGs, necessarily agree with them, or follow them to the letter. Expert witness testimony is required to establish the current SOC. The link plausible between CPGs and quality has sparked new discussions as to whether CPGs have in fact become the new SOC. This is indeed a very slippery slope.

CPGs have been allowed into testimony as relevant to medical decision-making, but not for defining the SOC, to date. The relevance and validity of a CPG must still be corroborated by a medical expert. Opposing experts will then disagree on the importance of the CPG in a particular case, which makes understanding how a CPG was developed and graded all the more important in defending an MPL case.

Conclusions

Healthcare reimbursement will be undergoing drastic changes over the next decade. This will affect all EPs. It is imperative that physicians understand the system, if they are going to survive in the fluid healthcare environment of the future. As we have seen historically, private insurers quickly follow the government’s example when it comes to reimbursement for healthcare services. So the QPP will likely become the model for reimbursement by private health insurance companies.

A significant portion of the reimbursement formula that will be part of MIPS for 2019 will involve achieving quality goals. These quality goals are being defined by CPGs. This scenario creates MPL liability and exposure beyond what has previously been recognized. CPGs have the potential to play a role in MPL litigation. Plaintiff’s attorneys and experts could make the argument that the CPGs are the SOC, since they need to be followed for, and have been adopted for, reimbursement. Financial penalty for not achieving a quality goal under MIPS could appear to represent care that is below the SOC, when these are in fact mutually exclusive.

Therefore, it is imperative that medical experts review and understand any relevant CPGs in an MPL claim, whether or not the CPGs are actually part of litigation or allegations in that particular case. 

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The first major roadblock Dr. Berwick sees is displacement of a focus on safety by other concerns. “Money,” he said, “has become more important than safety” for some CEOs. He cites the 2017 annual survey of healthcare CEOs done by The Advisory Board Company. In that survey, safety was not on the list of the top five concerns of these executives. Instead, they mentioned items like changing reimbursement systems and the threat of repeal of the ACA. But many who work in patient safety are convinced that adverse events do impact the bottom line.

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Another roadblock, Berwick suggests, is thinking that incentives per se will improve quality. Healthcare professionals are working as hard as they can, he says, in a system that seems to set them up for failure. Because of these system failures, they develop work-arounds to get their job done. They deliver care in a system of isolation and fragmentation, a system lacking transparency in communication, a system fraught with sensory overload—more than the human mind’s capacity to handle. It’s not surprising, then, that adverse events are occurring. Dr. Berwick pointed out that the idea of using incentives to promote safety ignores these realities.

The third roadblock is “the illusion of completeness.” There may be a sense that a facility has made great progress on patient safety once a project on “X” problem (sepsis, for example) has been successfully finished; the participants then declare victory, with an upbeat, generalizing comment such as, “We do safety.”

But that is in fact an illusion, Dr. Berwick points out. Achieving safety is in fact a long journey that requires constant vigilance and action. “The concept of safety as a box-checking exercise is lethal to patients,” Dr. Berwick says.

Yet another roadblock, Berwick points out, “is the metrics glut.” As the healthcare industry has pursued incentives, and ever more regulation has been introduced, healthcare systems have been chasing metrics to the point where “the metrics outweigh the clinical realities.” Doctors may tend to provide a treatment, but from that point, see the metrics—not the patient.

Separation of safety from quality is a major roadblock, according to Dr. Berwick. People need to remind themselves of that, he says, by looking at the full spectrum of factors that define quality in healthcare. The challenge is to find ways to replicate the achievement in the aviation industry, and “engineer safety into our healthcare.”

System literacy is the final roadblock that Berwick discerns. Spending time educating all staff members on what is required to achieve patient safety is key to success. To truly advance in this effort, systems need to create a system of learning—an approach that simultaneously addresses culture, process, and technology. Caregivers need to abandon their checklists and fragmented approach to quality and safety, which denies that safety and quality are inextricably linked.

What is needed is a data-driven system that will promote safety and ensure quality.

The concept of culture is essential too. It captures all of the situations in which patient care is delivered. Culture, considered as a social phenomenon, has a powerful influence on the way we act and behave. And our behavior is driven by the social cues and norms we have been surrounded by, defined by the culture.

Basic elements for safety surveillance

There are in fact solutions to the challenges Dr. Berwick cites. Active automated surveillance and decision support can be done, using the breadth and depth of data that is available today, by applying a system that (for example) uses a combination of algorithms, text analytics, and machine learning to provide a comprehensive safety surveillance network.

“Text analytics,” or text mining, is the process of determining and collecting high-quality information from unstructured text. A dataset could include a mass of tweets or even a collection of scientific papers.

And “machine learning” comes about when a computer has been taught to recognize patterns by providing it with data and an algorithm to help understand that data. We call the process of learning “training” and the output that this process produces is called a “model.”

The sponsoring company for the webinar on which this article is based is offering a collection of machine learning algorithms for free, via its open-source website, www.healthcare.ai. Using the site, both MPL/HPL organizations and healthcare professionals can (for example) create and compare models based on their own data, perform risk-adjusted comparisons, and deploy a model to produce daily predictions.

In general, though, healthcare systems seeking to improve safety can use data in three different ways:

- **Reactive capabilities.** With automated triggers, the safety tool reacts to potential harm by identifying risk and notifying frontline caregivers. This adds a layer of critical thinking to the tool—the frontline user clicks on a patient name, sees his individual risk, and can follow up with appropriate interventions.

- **Proactive capabilities.** Once the safety tool determines risk within a patient set, predictive analytics identifies interventions to reduce or prevent harm. This proactive capability makes the information from risk triggers actionable—by suggesting interventions—and accessible—by putting otherwise hard-to-find procedures and protocols at the user’s fingertips. For example, the application might show that a patient is at risk for pressure ulcers and remind the caregiver to rotate him regularly and follow safe skincare practices to reduce risk.

- **Full integration capability.** Because the safety tool is integrated across workflow tools and across the health system, it enables improvement across the continuum of care. This allows improvement efforts to not be isolated and fragmented within departments—potentially impacting only a few patients—but implemented across an organization to impact many. In the long-term vision for patient safety, patients will have access to safety applications on their mobile devices, making them true partners in their care.
Using data: two examples

Even obtaining the data to be used in safety improvement can be a challenge. Automation of data collection and integration of data into improvement plans is often where systems need to begin in applying data to inform improvement opportunities. The efficiencies gained from automation allow patient safety staff to use their time for more in-depth analysis, rather than just data collection. For too long, we have been "hunters and gatherers of data," rather than data consumers.

Here are two examples of these applications:

Even though health systems widely use intravenous (IV) heparin (an anticoagulant) to prevent thrombosis, the medication carries a high risk for dosing errors. When an organization determined that its hospitals used several different IV heparin protocols (high variation), it saw a need for standard practices targeted at patients’ clinical needs. The health system developed an anticoagulation safety analytics application to monitor and better understand IV heparin outcomes. As a result, the organization immediately improved the percentage of patients with accurate therapeutic doses by 7%. It also made essential progress by reducing variation, and thereby risk of error, by establishing one system-wide guideline and four system-wide protocols.

In another healthcare system, a risk assessment was used to decrease both length of stay (LOS) and costs for patients undergoing percutaneous cardiac intervention (PCI). PCI is a minimally invasive alternative to open heart surgery that is suitable for some patients, but it still carries risk. A health system that performs the highest volume of PCIs per year sought to lower the risk of bleeding—the most common non-cardiac complication associated with the procedure. The organization found that bleeding events were increasing LOS and costs for patients undergoing PCI. To lower bleeding risk, the system leveraged its analytics platform to generate a bleeding-risk-assessment tool that allowed clinicians to focus interventions based on risk and to reduce complications. The organization has seen a 5.3% reduction in bleeding-complication rate with PCI and $1.8 million in cost savings.

Conclusion

Patient safety won’t be achieved without quality improvement measures that include integrated clinical, cost, and operational data; automation; actionable insight; and full integration across the continuum of care. Happily, if organizations leverage predictive analytics and machine learning to make safety an overarching cultural goal, then other factors that define a successful health system will fall into place—including reimbursement and patient satisfaction scores.

Everyone stands to gain with improved patient safety. As American physician and educator Arthur L. Bloomfield (1888–1962) explained, safety is an industry imperative: “There are some patients whom we cannot help; there are none whom we cannot harm.” 

This article is based on a presentation by Health Catalyst, June 14, 2017.
The 2017 Medical Liability Conference in Colorado Springs, Colorado, brought together more than 450 professionals who work in insurance and alternative risk transfer, all looking to gain key insights into the global—and day-to-day—issues facing the medical and healthcare professional liability (MPL/HPL) community. The meeting addressed the most important issues these professionals needed to learn about and discuss.

Topics covered included new theories of liability, leveraging data to reduce risk, a global look at patient compensation systems, the pros and cons of employment versus independent practice for physicians, and more.

Attendees left the meeting with a clearer perspective on the present and the future, and with specific strategies for meeting the challenges of the evolving healthcare system, both in the U.S. and around the world.

Keynote address: “21st Century Medicine: IT, New Practice Methods, and More”

“Healthcare,” said Robert M. Wachter, MD, “has become a computerized industry, and we’ve only done it in the last five years. And I think that is pretty remarkable.” As recently as nine years ago, he noted, fewer than one in 10 American hospitals had electronic health records. Now, more than 90% of hospitals have them. “That is an enormous, enormous, consequential change,” Dr. Wachter said. “It took the government incentive to achieve
this. It took $30 million to make it happen.”

Robert M. Wachter is Chair of the Department of Medicine; Chief, Division of Hospital Medicine, Marc and Lynne Benioff Endowed Chair, University of California, San Francisco.

In fact, he said, healthcare is in the midst or two hugely transformational trends. “The first is the pressure to provide high-value care. The second, as I mentioned before, is the digitization of the U.S. healthcare system.” He believes that it is in the interaction between these two where “the most action will be” in healthcare.

In 10 to 15 years, he said, the digitization will prove to be the bigger trend. Why? “Because I can’t think of an industry where after widespread digitization, that industry hadn’t been turned completely upside down. If you don’t believe that, ask your friend who used to work at Sears, ask your friend who used to work at Borders. In every industry, five to 10 years after digitization, the incumbent leaders are no longer the leaders.”

But in medicine, he pointed out, this level of disruption has not yet happened: “I think that’s because we’re still in the early stages.”

He illustrated the scope of the change in our midst with a story about a Philadelphia physician who converted everything in his office to a digital format. Before the go-live day, everyone was thoroughly trained in how to use the new equipment. But then came the actual day when everything was turned on, and when the staff came to work, “Nobody knew how to do their job.”

No one could have anticipated the full scope of the impact of digital change, Wachter said: “So that was one of the things we got wrong.”

With medicine overall, Dr. Wachter said, as medical records are becoming digital, in five years, every patient will have full access to his complete medical record. “Physicians will have to learn to be a little more careful about documentation,” Dr. Wachter advised.

And now, in hospitals, Dr. Wachter said, “the minute the physicians have stopped seeing patients, they leave the floor to go to some other place. Is that a problem? It is; if you believe that collaboration between doctors and nurses is a good thing, you’ve now thrown a monkey wrench into it.”

In MPL, he said, many lawsuits stem from poor communications and poor relationships, “and I think the computer has created a new threat to those relationships,” as healthcare professionals focus on filling in the EMR during a patient visit. Also, burnout has increased dramatically in the last few years, and computer entry is a big part of that problem.

To get the most from the digital revolution, two things are needed, Wachter said: The technology itself will need to get better, and the second (probably more important requirement) is that people will have to reimagine the work, and be willing to try things in a brand-new way.

Where will we end up? Wachter envisions that in sufficient time, every element of significance in healthcare will be connected. He foresees some limitations in the digitization of care, though. There will likely be tech-enabled care, rather than wholesale replacement of doctors by technology.
Focus on a Session

“Storm on the Horizon: Determining the Next Claims Hurricane”

“My takeaway from this is that insurers really need to manage the big claims. It doesn’t mean you ignore the small ones. It’s an industry adage that ‘10% of your claims drive 90% of your losses.’ You need to make sure that the increase in severity we’ve seen isn’t something that impacts the bottom line.”

These are some words of advice for insurers in the presentation by Matthew Neilson, Esq., Vice President, Claims, OMS National Insurance Company, RRG.

He surveyed the current landscape to predict some of the newer risks that may impact the future success of the MPL/HPL sector. One example: “As medicine becomes more institutionalized,” Neilson said, “is this improving risk—or is it going in the other direction? Are institutions really managing the risk better? Or are they creating a system where it is more difficult for healthcare providers to actually do their jobs and do their jobs well? In my experience, this is a legitimate question.”

Neilson also discussed the emerging issues linked with 3-D printing. “This is one that absolutely fascinates me,” he said. “It gives providers the ability to design and create actual physical devices—orthopedic implants, cranial implants, surgical tools, and devices. Providers are actually creating these in-house.”

But now, he said, a provider could face a claim for strict liability, under the doctrines of product liability law. There is a very different legal system, he explained, which sets out the rules and parameters for liability stemming from products.

Neilson asked, “So if you have a doctor, who’s actually making
that product, is he subject to strict liability if something goes wrong? Or is he still a healthcare provider, who is subject to a negligence claim? Or, is it potentially both?"

Also, in this session, Barbara Glogiewicz, BSN, Esq., Director, Fenemore Craig, P.C., discussed the impact of the shortage of physicians, including new issues related to the expanded use of physician extenders, and the loosening of regulations governing how extenders practice. In 22 states, these professionals can practice on their own. For doctors supervising these providers, there may be issues related to vicarious liability. In addition, she said, there are looming issues inherent in telehealth, arising in part from the different regulation on telehealth in the various states.

Joel C. Hopkins, Esq., Partner, Saul Ewing, considered, among other topics, the potential for mass tort in MPL. In general, he said, MPL cases are not subject to consolidation, because each is considered unique. But plaintiff’s lawyers have found a way to get around this, by linking the cases via common elements or themes. In diverse lawsuits, you will see the same claims, expressed in the same language.

Sarah E. Pacini, JD, CEO of Cooperative of American Physicians, served as moderator of the session.

▶ Focus on a Session

"Unexpected Medical Outcomes: Myth vs. Reality"  

Why are unexpected outcomes a popular topic in the U.S. now? The first reason is because we’re so often told that “the U.S. is a significant outlier,” said session moderator Jaan Sidorov, MD, and informed us that this is “the result of a healthcare system that is out of control, and not doing a very good job of delivering health, arising in part from the different regulation on telehealth in the various states.

Joel C. Hopkins, Esq., Partner, Saul Ewing, considered, among other topics, the potential for mass tort in MPL. In general, he said, MPL cases are not subject to consolidation, because each is considered unique. But plaintiff’s lawyers have found a way to get around this, by linking the cases via common elements or themes. In diverse lawsuits, you will see the same claims, expressed in the same language.

Sarah E. Pacini, JD, CEO of Cooperative of American Physicians, served as moderator of the session.

PIAA Award of Excellence in Honor of Peter Sweetland

PIAA recognized Sultan “Sully” Ahamed, MD, MBA, as the recipient of the 2017 PIAA Award of Excellence in Honor of Peter Sweetland. Dr. Ahamed was honored for his singular contributions and longtime dedication to the MPL/HPL insurance community, PIAA, and healthcare professionals.

Dr. Ahamed, a surgeon and a vascular specialist in Connecticut, has represented the interests of the medical community through his work in the MPL/HPL industry for decades. He is the President and Chairman of the Connecticut Mutual Insurance Company (CMIC).

Dr. Ahamed has dedicated many years of service to PIAA. He served a full, nine-year term on the PIAA Board of Directors, as a member and also as its Chair. He has also served on many PIAA Committees, including Membership and Bylaws, Continuing Education, Nominating, Activities, and Audit. He was also a member of the PIAA International Section, Chief Physician Executive Section, and Medical Executive Section.

"Sully has served the needs of hundreds of patients through his distinguished career as a physician and surgeon while at the same time making significant contributions to the establishment, growth, and success of PIAA," said Richard E. Anderson, MD, Chair of the PIAA Board and Chairman and Chief Executive Officer of The Doctors Company. "We are honored to present him with our highest award in recognition of his dedication and commitment to PIAA and those who provide healthcare."

The PIAA Award of Excellence in Honor of Peter Sweetland, established in 1993 by PIAA’s Board of Directors, was created in honor of the late Peter Sweetland, one of PIAA’s chief architects and most fervent supporters. The award recognizes an individual who has provided exemplary service to the industry and to PIAA, and who epitomizes the high ideals and ethics for which Peter Sweetland stood.

PIAA Chair Richard E. Anderson, MD (left) presents the 2017 PIAA Award of Excellence in Honor of Peter Sweetland to Sultan “Sully” Ahamed, MD.
ourselves to perfect patient safety?” Dr. Sidorov asked. To learn more, he reviewed the actual data on patient safety, worldwide. He discovered that every healthcare system in the world is in fact struggling with tradeoffs in regard to three aspects of healthcare: cost, quality, and access. What is often forgotten are the other factors at work in determining a person’s health: the so-called “social determinants of health.”

Three-fifths of excess mortality for persons under 50 arises from factors outside the healthcare system. “We’re being told that the jumbo jet is the result of issues with medical care,” said Sidorov, when in fact, he pointed out, much of what happens in terms of outcomes is determined by how the patient lives and also by the zip code where he lives.

From this comes the surprising conclusion: Some substantial portion of every indemnity payment is made for factors other than “healthcare.”

Mary Jane Osmick, MD, Vice President/Medical Director, Medical Services Department, American Specialty Health noted that for the first time, in 2016, statistics indicate that the U.S. really is losing ground: The life expectancy for an American citizen fell. This could be a blip in the curve, or a true change in direction.

Although 51% of healthcare costs are spent on chronic disease, “We don’t stop them—stop them in their tracks,” said Dr. Osmick. Reiterating what Dr. Sidorov had said, she pointed out that of the factors that are driving premature death, 21% to 50% have nothing to do with healthcare per se.

Doctors can help in countering the impact of SDH, first, by being aware of them, and then, by educating their staffs about them. She concluded: It takes multiple stakeholders, in multiple sites throughout the community, all focusing on SDH, to make progress on their impact.

Gordon Wallace, MD, FRCPC, Managing Director, Safe Medical Care, Canadian Medical Protective Association, underscored the importance of “providing cultural safety”—understanding how a patient’s culture interacts with his health. “Every patient encounter,” he said, “is a potential cross-cultural lesson. We come to understand ourselves better, including our biases.”

He echoed the prior presentation in noting that “Your zip code is a better predictor of your health than your genetic code.”

To attain compliance with chronic conditions like high blood pressure takes a real commitment to shared decision-making, and that means understanding “their values, beliefs, and wishes,” Dr. Wallace said.

Left to right: Gordon Wallace, MD, Managing Director, Safe Medical Care, Canadian Medical Protective Association; Mary Jane Osmick, MD, Vice President/Medical Director, Medical Services Department, American Specialty Health.

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The Importance of the Referral

More often than not, a person’s healthcare has a team focus. For this reason, communication within the team is pivotal to its high performance, all for the benefit of the patient.

BY CHERYL MCDONALD

The referral is an important part of this communication loop, but often it is given little thought other than to satisfy a legal requirement. In fact, the referral

Cheryl McDonald is National Manager—Claims and Legal Services, MIGA.

document is a crucial element in the coordination of a patient’s healthcare and carries with it a number of responsibilities, including:

- Accuracy of the information contained in the document
- An obligation to explain to the patient why the referral is being made and clear communication about the timeliness associated with making an appointment with the referral recipient
- Documenting the fact of the referral, with a copy retained in the patient’s medical record
- Ensuring there is a system for follow-up on the referral including:

- whether the patient attended
- the outcome of the referral
- Confidence that the patient’s medical welfare is in hand and that the clinicians are clear on the treatment plan for the future, including the name of the individual who has primary responsibility in the team for management of care.

In Australia, the New South Wales Civil and Administrative Tribunal recently commented on the duty of a general practitioner in referring to, and working with, a specialist. The observations provide helpful guidance on the requisite standard expected of a practitioner when referring to a specialist. In its decision, the Tribunal stated:

Referral to a specialist goes beyond the administrative task of writing a letter. The appropriate and expected standard involves obtaining the opinion sought, considering the advice and taking appropriate and considered action. In cases of chronic conditions where patients are on medication, constant periodic reassess-
Risk management

Here are some risk management tips for clinicians:

- Approach your patient’s care in a collegial way and engage with your patient’s specialist, reviewing his recommendations regularly.
- Seek peer support, with a practitioner within your own group, or a specialist. Ensure that any discussions (including telephone conversations) are documented in the patient’s medical record.
- A second opinion may be appropriate if you have reached an impasse with your patient. This is particularly important for patients who may be having difficulties with addiction.
- Take the time to review previous entries/attendances to ensure results have been followed up. Document that this review has taken place.
- Don’t assume that a colleague is following up or managing the patient for you. Confirm this with the patient and other treating doctors who are responsible for various aspects of the patient’s care.
- Ensure that your practice has a thorough follow-up and recall system.

Issues for insurers

For medical and healthcare professional liability insurers and indemnifiers, the risks associated with a referral can be traced back to the risk management tips:

- Poor communication between team members (that is, referrer and referral recipient) creates a medico-legal risk.
- Poor follow-up systems and recall systems also create a medico-legal risk.
- The importance of documentation cannot be overstated.
- Poor communication with the patient about the urgency associated with the need to act on the referral is a risk for insurers: A patient may argue that he was not told/did not appreciate the urgency associated with the referral.
- One of the greatest exposures between clinicians is a lack of understanding about who is managing the patient’s healthcare. Clarity around this issue is vital.
- Blaming the patient for a lack of understanding is not usually an option when it comes to defending a claim.

A high-performing medical team can provide enormous support to the individuals within the team and produce excellent patient outcomes. High-performing teams understand the importance of the referral process in the patient’s healthcare, and they ensure that strategies are in place to minimize the risks identified in this article.

Reference

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INTERVIEW WITH.... SARAH E. PACINI, JD

At the 40th Anniversary of the Cooperative of American Physicians’ Mutual Protection Trust: A Conversation with Its CEO, Sarah E. Pacini, JD

This year, the Cooperative of American Physicians’ (CAP’s) Mutual Protection Trust (MPT) is celebrating a major milestone: its 40th anniversary. To explore some of the unique history of CAP and its MPT, Inside Medical Liability spoke with its CEO, Sarah E. Pacini, JD. We wanted to learn, for example, how the concept of a cooperative arrangement and mutual protection trust structure for medical professional liability (MPL) originated, and the evolution of the role of reinsurance in CAP. Pacini offered numerous insights and illuminating facts about CAP, its MPT, and the organization’s vision for the future.

This interview is one in an occasional series of talks with the leaders of PIAA’s members, both in the U.S. and around the world, to gain from them their personal insights into the current status of the MPL/HPL sector, and find out how their organization is evolving to manage current and emerging risks and to deal with other new realities of the evolving healthcare environment.

Membership in PIAA gave CAP and MPT recognition within the MPL community and enabled us to participate in PIAA’s Data Sharing Project and its public policy initiatives.

California Insurance Code to allow for inter-indemnity arrangements for physicians. According to the statute, the participants in the risk-sharing inter-indemnity arrangement must be members of a California cooperative corporation whose members consist only of California-licensed physicians. Following this prescription, MPT began operating in 1977.

**IML:** How did California’s MICRA law make CAP possible?

**Pacini:** MICRA provides the same benefits for CAP physicians and their patients as it does for the other MPL providers in California: It enhances access to medical care by setting reasonable limits on non-economic damages, while providing unlimited remedies for economic damages. MICRA helps keep millions of dollars within the medical care system; these savings benefit patients statewide. We keep our members well informed about the benefits of MICRA, and we provided weekly member updates when MICRA’s opponents attempted to upend the law in 2014. That voter initiative, Prop. 46, failed at the ballot box by a 2-1 margin. CAP is a longtime partner in the efforts of PIAA and other national groups to enact federal MICRA-like legislation.

**IML:** How was the original amount needed to fund MPT determined, in the absence of loss data?

**Pacini:** The legislative threshold for the initial trust corpus, $10 million...
INTERVIEW

Pacini: Marketing was carried out by the original members, who presented the idea to their colleagues. It was almost entirely word-of-mouth for the first few years. The underwriters were also the service personnel, and they were the ones who answered questions for prospective members. A formal membership development (sales) department was not created until the late 1980s. CAP has since established a full-time Membership Development department staffed by 12 sales and support professionals, and a Marketing and Corporate Communications department staffed by six professionals. Today, CAP, MPT, and the other CAP business lines are presented to the market through the full spectrum of traditional and online sales and marketing channels.

IML: How has the role played by reinsurance in CAP’s financial stability changed over time?

Pacini: As it does for many MPL providers, reinsurance has played a role for CAP in managing the inherent volatility in loss development, and CAP, like them, has to make decisions about how to balance the cost of reinsurance versus the benefits provided.

CAP established a captive insurance subsidiary in 2002 to provide certain reinsurance coverage to MPT at more economical terms than was currently available in the marketplace. This has turned out to be a successful strategy, as this captive insurance subsidiary has evolved to provide insurance coverage to CAP, reinsurance support to the insurance carrier in the CAPAssurance Risk Purchasing Group program, and key reinsurance support to MPT. It also carries an A- (Excellent) rating from A.M. Best. In addition to the captive insurer, MPT maintains a robust reinsurance program with a diversified slate of reinsurers, rated A and above in the U.S. and European markets.

Collectively, the total reinsurance structure has over time proven successful in making it possible for the organization to manage loss volatility and maintain stability in its operating results.

IML: In what ways was gaining membership in PIAA in 1997 a milestone for CAP?

Pacini: As alternative-funding vehicles became more common within healthcare, and as it became obvious that MPT was a highly viable and successful physician-owned and -governed MPL option, an invitation to membership just seemed natural. Soon after that, the company joined, and several of our senior staff chaired PIAA sections; and ultimately, our former CEO, Jim Weidner, was invited onto the Board, which he chaired from 2009 to 2013. Membership in PIAA gave CAP and MPT recognition within the MPL community and enabled us to participate in PIAA’s Data Sharing Project and its public policy initiatives.

IML: What is your hope for CAP for the next 10 years—and maybe even, stretching your imagination a good bit—for the next 30 years?

Pacini: Successful organizations know the importance of maintaining core values while simultaneously responding to changing circumstances. It is imperative to adapt to changes and capitalize on the opportunities they present. One new paradigm that is every day, Americans now participate vigorously in the debate over how healthcare is best delivered. CAP believes that physicians should welcome the public’s involvement in this dialogue. We work together with our physician members to ensure access to quality medical care.

The MPL business is rapidly evolving through a period of more intense competition and consolidation. We expect that to continue for the foreseeable future. To confront these challenges, CAP has diversified its products and services to meet the ever-changing MPL protection needs of solo and small group physicians,mid-sized and large medical groups, and hospitals, clinics, and surgery centers— and to help increase their success.

At the same time, CAP continues its substantial commitment to its core comprehensive risk management education and services, including a 24/7 risk management hotline, the availability of an on-site risk analysis conducted by a highly trained risk management specialist, and online CME courses tailored according to medical specialty.

It is this ability to adapt to change, to diversify while at the same time strengthening core services and promoting access to quality healthcare, that will keep CAP a leading provider of MPL protection, risk management, practice management, and financial management services for a long time to come. Put another way, our 40 years of serving California’s finest physicians provides a solid platform for looking at the future through fresh eyes.

Footnote
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The age-old concept of the patient experience merits some fresh thinking. One aspect of this new focus is patient engagement, the importance of which has been recognized for decades, or longer, as a critical concept, from the perspective of liability and also for patient care and safety.

An argument could be made that the concept of patient engagement, in the context of today’s rapidly evolving healthcare environment, is more important than ever. It is the cornerstone of population health. It is a well-documented principle that it improves outcomes, reduces costs, enhances the patient and family experience and yes, reduces frequency and severity of medical professional liability claims as well. Quite a combination!

But it may also be harder than ever to accomplish. Relationships between physicians and patients have so many distractions now. If we are not careful, the so-called “patient engagement aids” could become just another one of these distractions. The distractions that are frequently mentioned include additional levels of caregivers, telehealth, group visits, electronic visits—all, if done correctly, and with the right foundation, are very positive and further the goal of engagement.

However, it is easy to see how they could actually distract from the creation of the solid physician-patient relationship that is so important to our core goals for the impact of healthcare. Instead of simply seeing one’s doctor, a patient must first visit a website to arrange a visit; then he is sent to another web-
site for an educational tutorial on his health condition and then, at the actual visit, an advanced practice professional provides the care, in place of the doctor.

All of these are perfectly appropriate, and potentially very helpful, but they can distract from the development of that all-important physician-patient relationship. It does not have to be so. The information that the patient or family gains outside the exam room needs to be an extension of the relationship created in the room. All of these learning aids need context. Why is the information important? How does it fit in with diagnosis and treatment? What are the implications? The patient needs to understand that the advanced practice professional is on the same team as the physician. It is the physician who helps in connecting these important dots. Therefore, it is essential to strengthen the physician-patient relationship and make the patient, to the extent possible, a true member of the healthcare team. The result will be a satisfied patient, and not just that, but also, one who is engaged. For that to happen, the patient and healthcare professional will need to focus on understanding this patient’s particular plan for health and full well-being, the ultimate goal. This was essential to the Co-active Solution Dr. Lehman described, and it is a critical element for all the various innovative new relationships we are attempting to create today.

**Building trust**

So, the first foundational step is the important work of establishing trust and confidence between the physician and the entire provider team with the patient and his family. We know that establishing and excelling in creating a positive patient experience is the “gateway” to patient engagement. It is extraordinarily difficult to accomplish the goals noted above, and truly engage patients, partnering with them in their care, arriving at joint decision-making, and involving them in a positive way in their health, if they do not trust or feel that a solid relationship with the physician exists. This is why the new two-sided engagement measurement tools are so important—so a healthcare professional can know whether or not this area in his practice, genuine engagement, requires further efforts. Some type of measurement of this process is critical. Engagement can be improved, but, like so many aspects of healthcare, you cannot improve what you do not measure.

Again, it is what we do not know that will hinder our efforts. Engagement, to a certain extent, is misunderstood and underrated. As one physician recently informed me, after a talk on the importance of...
“patient engagement,” “I always have several jokes that patients really seem to get a charge out of. More of my partners need to be engaging like this, for sure.” A good point, but that’s not really patient engagement, is it?

There is much written, and a lot of solid science, behind the concept of patient engagement—whether we call it patient activation, patient responsibility, patient partnership, the core is developing this trusting relationship between the patient and you and your practice and then, in a systematic and meaningful fashion, truly involving the patient in his own health and actual care.4 What is done may be different, depending on the specialty, but the core is always the same. It all starts with providing a true five-star experience, which can only be accomplished through measurement and accountability. After establishing five-star care, true engagement is accomplished through a laser focus on certain specific trigger points, also subject to both measurement and verification, and then improvement.

A brief comment about the descriptor, “five star.” This is the consistent and pervasive pursuit of a truly excellent patient experience. In 2018 and thereafter, it will be absolutely necessary, for reimbursement; it will drive markets and, as mentioned, will be the gateway to engagement. So, one’s first step must be to strive to improve the patient experience and make measurement a critical part of that. It is no longer too cumbersome or expensive to omit. This concept will never be abandoned; it will in fact become more important, and will simply be considered as one cost of doing business in healthcare in the future. It should be carefully created, scientifically based (with predictive value) and developed separately for each specialty; that is the key. This is an area where psychometrics can really help out, and where home-grown paper questionnaires have definitely gone by the wayside.

The next steps
Next, start to incorporate the classic engagement documents, which are fairly standard and easy to apply in creating a valid engagement process. But that’s just a start. Healthcare professionals also need specialty-specific informed consent/engagement documentation, patient compliance/at-risk documentation, patient commitment/partnership documentation, patient education/engagement confirmation modules, and engagement tests documented too. Each will be written differently, depending on the specialty, but each must focus on the trigger points where, in the particular specialty, the outcome is uniquely dependent on patient involvement.

It is interesting that these trigger points are typically in the same areas where we also find liability claims. So, these same documents can both enhance engagement and everything positive that goes along with it, but at the same time, they can reduce the potential of an initial adverse event, alter patient expectations, make cases less attractive to plaintiff’s counsel, and make cases more easily explainable to the jury in the event of full-blown litigation. In some circumstances, these documents have actually been used in legal arguments, to establish comparative or contributory negligence.

Importantly, at their core, these are not “gotcha” documents, but rather, tools and aids that have, when used appropriately, helped in optimizing patient outcomes and improving the patient experience. But we have to be certain about this, which is why continuous concurrent measurement (of both satisfaction and engagement) is necessary. If your engagement tools are missing the mark or not striking the right balance, it will show up in your “real time” patient experience measurement tool, and you can alter what you’re doing accordingly. This is why it all fits together.

This is an important concept. Dr. Lehman was right, Eric Anderson was right, hundreds of other professionals who teach, coach, and write about this issue are right. However, it hasn’t been completely embraced. At present, measurement is minimal. Physicians and healthcare organizations need to challenge themselves. The time has come to take this concept seriously, and compile additional scientific evidence to support it. Measure the patient experience. There will be opportunities for improvement. Measure patient engagement. The results may be surprising.

Footnotes
3. See generally, “Innovation Center” news at www.saxtonstump.com
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As we discussed in our last article (Inside Medical Liability, Second Quarter 2017, page 61), an analysis of relative value across sectors should include not just a comparison of OAS (option-adjusted spread) but also of risk-adjusted spreads. To provide an example of how this type of analysis is done, we will focus here on two sectors of the fixed-income market, both of which offer 75 basis points (bps) of OAS: collateralized mortgage-back securities (CMBS) and Intermediate A-rated Credit. Since the OAS of both sectors is the same, we can make more of an apples-to-apples comparison between the two by focusing on how they’re different.

It’s also important to compare these two sectors because they represent two of the main schools of thought for investment-grade bond portfolio managers: those who look to outperform by adding structured products (CMBS, non-agency RMBS, etc.) versus those who look to outperform by adding credit products (corporate bonds, municipal bonds, etc.). Since both strategies have proved successful over time, comparing the key underlying sectors of each is an important exercise when selecting a manager.

The analysis
To begin our analysis, we start with a comparison of the duration of both sectors. The Intermediate A-rated Credit index has a duration of 4.5 years, whereas the CMBS index has a duration of 5.5 years. With both indices having an OAS of 75 bps, the duration-adjusted spread of the Intermediate A-rated Credit index is 16.7 bps per year of duration, whereas the CMBS index is 13.6 bps.

Next, we turn to the historical OAS, to get a sense of how today’s spread compares to prior levels. As you can see from Figure 1, these two sectors have had very similar levels of OAS for most of the past five years. Going further back, to capture the events of 2008,
however, reveals a very different picture. You can see a much higher level of volatility in CMBS spreads, driven by the underlying exposure to the real estate market during the housing crash.

This elevated level of volatility also appears in Table 1, which shows that the volatility of CMBS spreads has been approximately double that of Intermediate A-rated Credit spreads over the past five-, seven-, and 10-year time periods. Even when using the more recent (and lower) one-year volatility numbers, on a volatility-adjusted basis, the Intermediate A-rated Credit index offers 13.2 bps, while the CMBS index offers 8.3 bps.

The size of a sector within the broader fixed-income market can also serve as a helpful data point when assessing its liquidity and volatility. The CMBS index has a market value of $345 billion of index-eligible debt, representing 1.8% of the Bloomberg Barclays Aggregate Index. The Intermediate A-rated Credit market has just over $2 trillion in market value of index eligible debt, good for 11% of the same aggregate index. The larger size of the market provides a broader and deeper pool of investors, which in turn provides greater liquidity and helps mitigate violent spread movements.

It is also important to consider the underlying fundamentals of the sectors in question when making relative-value decisions. Within the CMBS market, while there are many fundamental factors to analyze, the three most common are commercial real estate prices, underwriting standards, and loan structuring. Starting with prices, commercial property pricing has recovered significantly from its lows, and is now approximately 25% above its pre-crisis peak. However, there are signs that considerable stress is building in certain segments of the market, such as retail. As for underwriting standards, the market pendulum has swung, once again, back from the
conservative underwriting seen in the immediate post-crisis years, and toward more lax practices, such as a higher concentration of interest-only (IO) loans, versus fully amortizing loans, in recent vintages.

Another impact of the ebb and flow of underwriting standards is the upcoming “maturity wall” of loans that need to be refinanced in the next year. Because commercial real estate loans are typically structured to include a large balloon payment after 10 years, many loans that were originated at peak property prices and using very loose underwriting standards in late 2006 and 2007 are now coming due.

And finally, turning to loan structuring, there has been a steady increase in the percentage of retail and office properties backing recent vintages, two areas that have been under pressure lately. The concentration of the loans backing deals has also continued to rise, with the average number of loans per deal falling to 48, down from 65 in 2015 (a decrease of 23%). This dynamic reduces the diversification benefits of the underlying pool of loans.

**Investment-grade credit**
Turning now to the investment-grade credit market, we consider the underlying strength of corporate balance sheets as an aid in our analysis. When thinking about the strength of a company as a debt investor, the two main areas of concern are earnings and debt load. Put simply, the aim is to assess how much money a company is earning, how sustainable those earnings are, and how much debt the earnings have to support.

To evaluate earnings, we look to the metric, earnings before interest, taxes, depreciation, and amortization (EBITDA) and sales, both of which are finally showing signs of growth after a weak 2016. Profitability continues to recover, and the possibilities of tax cuts, infrastructure spending, and a less restrictive regulatory environment all loom on the horizon. Leverage, which is the ratio of a company’s debt to its earnings, has been a concern for the past few years due to its rapid increase. However, more recently this metric appears to have peaked, with aggregate leverage moving modestly lower over the past few quarters. With rates still relatively low, the higher levels of debt have not had a dramatic impact on interest coverage, which is the ratio of earnings to interest payments. This measure remains high by historical standards, indicating an elevated capacity to service the debt load. Like the CMBS market, there are pockets of concern in the credit market, most notably the retail and energy sectors; however, in aggregate, the fundamentals remain encouraging.

This analysis was meant to provide an example of how to compare the relative risks and returns of different segments of the fixed-income market. The key lesson to remember is that yields alone are not sufficient for making allocation decisions; a more nuanced approach is required to uncover the true value.

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Hospital readmission is a topic perpetually near the top of the list in global conversations about the quality of healthcare. In the U.S., according to the CDC’s National Center for Health Statistics, health expenditures in 2015 topped $3.2 trillion—and 32.3% of that was spent on hospital care. You do the math—that’s a big number.

Within that, estimates vary on how much is spent on readmissions. According to Medicare data, each year, roughly 2 million patients are readmitted, for a total cost of $27 billion. Of that, $17 billion is spent on readmissions that could be classified as potentially avoidable.

Do the current penalties for readmissions treat hospitals equitably? Is readmission rate a fair measure of quality? These are legitimate questions. But regardless of the specific answers, it seems that one essential fact may be overlooked: With the renewed focus on readmissions, the quality of care is improving, with the result that fewer patients are returning to the hospital.

Hospitals and the dedicated healthcare professionals who work in them strive diligently to reduce readmission rates. They are well aware that re-hospitalizations are costly, potentially harmful, and at times avoidable. But the challenge is formidable. As a result of today’s splintered healthcare system, discharged patients may be unable to follow instructions they are given and get outpatient follow-up care when they need it, or they may be unsure about how to care for themselves at home.

Fortunately, there are trendsetters like the nurses at California Hospital Medical Center in Los Angeles. They have developed a new way to reduce patient readmission, “said Gladys Castro, RN, nurse manager on the med/surgical unit at California Hospital Medical Center. In just two weeks, they’d come up with a high-risk readmission form, to be completed when a patient is admitted to the hospital.

The form has been in use for only a year, but Castro has said it’s shown promising results. “We haven’t eliminated readmissions entirely, but we have shown a significant decrease,” she said.

And there are plenty of other examples as well. Mercy Health (Cincinnati) employs nurses specifically in charge of care transitions to meet with patients from the time they are admitted through their discharge. And Cullman Medical Center (Alabama) now uses iPod Touches to document discharge instructions for patients at high risk for readmission and then makes the recording available online.

But what about the ultimate impact on the patient? A study done at Yale University found that recent advances in reducing hospital readmission rates for three key medical conditions were achieved without a concomitant increase in death rates. According to lead author Kumar Dharmarajan, MD, the correlation between reduction in rates for readmissions and mortality may be a consequence of the processes that hospitals have put in place to improve hospital and post-hospital care. Those strategies include: better preparation of both patients and families prior to discharge; timelier follow-up; and improved communication with outpatient providers.

So the healthcare community, as it always does, is searching for new approaches to care that lead to continuous improvements. In the instance of readmissions, we may well be seeing a win-win, a notable payoff.

RATES: A SYMBIOTIC RELATIONSHIP?
QUALITY CARE AND LOWER READMISSION RATES: A SYMBIOTIC RELATIONSHIP?

BY ERIC R. ANDERSON

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