Inside Medical Liability

2014 FOURTH QUARTER

WWW.PIAA.US

Keep your eyes open:

Untapped opportunities in the current market

AND

Understanding Predictive Modeling

PIAA
Huggins Actuarial Services, Inc. is a full service, independent actuarial consulting firm. We have fourteen credentialed actuaries on staff with an average of over 25 years of experience.

Our Services Include:
- Serving as Appointed Actuary
- Loss Reserve Analysis
- Ratemaking, Rate Filing Preparation & Product Management
- ORSA Preparation Assistance
- Economic Capital Modeling
- Actuarial Forensic Litigation & Valuation Services

www.hugginsactuarial.com
111 Veterans Square
Media, PA 19063
phone: 610.892.1824
We are all aware that the delivery of healthcare is going through a period of unprecedented upheaval. You probably hear this every day from everyone you interact with: your policyholders, the professionals on your staff, the directors on your board, and thought leaders throughout the medical professional liability (MPL) and healthcare industries.

Today, we don't know how profound these changes will ultimately be. Nor do we yet know the impact of these changes on your business and the scope and extent of the liability assumed. Although no one can predict with certainty the answers at this point, it is our responsibility to do everything we can to prepare for what may lie ahead.

A trend that is virtually impossible to miss is the consolidation among physicians and hospitals. There has been a corresponding proliferation in new MPL policies that integrate both physician and hospital coverage, which are specifically designed to reduce costs. In the wake of trends like this, MPL coverage has become inexorably linked to the overall financial success of the healthcare system. So continued efforts to optimize risk management and patient safety are critical—particularly in light of today’s emerging culture of accountability and transparency.

A wave of new federal laws and regulations over the past decade will continue to impact the MPL environment. PIAA is keeping a close eye on the many changes and developments. Guidelines for value-based medicine and the thorny issue of financial incentives may set the stage for new standards of care for hospitals, physicians, and all medical professionals. Over time, some problems in our healthcare system may benefit from the greater availability of wellness and preemptive care, but the path ahead will be uncertain and take many years to assess objectively. This period of uncertainty presents a significant challenge for the MPL community.

In this issue of Inside Medical Liability, various experts take on some of these issues, in an attempt to help you navigate through the twists and turns of the healthcare environment. Our cover story provides a revealing look at the many new pressures from multiple stakeholders—including payers, patients, and employers—to reduce expensive and inefficient care. Helpfully, the article identifies some of the new opportunities that MPL professionals can take advantage of, new markets that are opening up precisely because of these dynamic changes.

We have all witnessed the birth and subsequent growth of the “accountable care” era. Many authors have written about the potential for new liability risks as a result of the potential weakness and uncertainty associated with accountable care organizations. But in this issue, we include a story on MPL exposure in the ACO environment that paints a rosier picture. In fact, since adverse outcomes may well be reduced by easier access to a common set of patient data, liability exposure may be diminished for physicians working in ACOs.

Among the changes occurring in our healthcare system has been the availability of care in locations not previously associated with the delivery of care. Primary care is being offered by corporations like Walmart via clinics that are available 24/7, and nurse practitioners have gained more independence in providing care. For this reason, we include an article about the potential ramifications of the expanded scope of practice, and roster of patient care responsibilities, assumed by nurse practitioners. Inevitably, as they come to assume this new role, nurse practitioners are confronting many of the same risk exposures and MPL claims as primary care physicians.

So, the lesson here: those in MPL must be diligent in monitoring the environment they work in, stay nimble in adapting to that environment, and look beyond the potential downsides of change to envision new ways of doing business. Over the years, PIAA members have shown that they have a singular talent for reinvention, can deploy their capital in ways that are optimally beneficial to their policyholders, and are agile in responding to new challenges. They are clearly here for the long haul.

To support your work as the bedrock of the MPL community, and a key component of the healthcare system, PIAA is here for you. We will do everything in our power to assist you as, together, we navigate through this constantly evolving environment.
Features
22  Cover Story: Hospitals + Physicians = Opportunity
By Paul Greve

25  Feature: MPL Exposure in the Accountable Care Era
By Julian D. Bobbitt, Jr.

28  Feature: Small-Scale Grant Awards Programs: Professional Liability Insurance Partnerships with Providers Aim to Reduce Claims and Improve Patient Safety
By Jan Rebstock, Phillip M. Cox, Esq., Randall C. Jenkins, Esq., Marvin A. Dewar, MD, JD, Laura Gruber, and Linda Le-Wendling, MD

31  Feature: Predictive Modeling: The Essentials
Q&A With Dave Otto and Brett Nunes

“At the same time, hospital staff responsible for legal services, claims, risk management, patient safety, and insurance stand to benefit from knowing the executives of their local PIAA companies.”
—Cover story
Make claims reduction more than wishful thinking.

Join the many medical professional liability insurance carriers, captives, and risk retention groups who rely on ECRI Institute for unbiased advice and proven risk reduction strategies. Healthcare professionals across the continuum of care refer to ECRI Institute as the “gold standard” for risk management and patient safety resources. Partner with a trusted healthcare research agency whose sole mission is to improve patient care.

Let ECRI Institute be your source for:

► Online guidance and tools
► Evidence-based best practices
► Patient Safety Organization reporting and federal protection
► Risk assessment services
► Online CME and webinars
► Healthcare technology decision support
► Access to our 450-person interdisciplinary staff

Jump start your risk management and patient safety initiatives today.
Visit www.ecri.org/insurance, e-mail smurphy@ecri.org, or call (610) 825-6000, ext. 5145.
“Conversations that Win the Complex Sale”
Given the widespread competition and commoditization in MPL, it is difficult for sales, marketing, and communications professionals to differentiate their offerings effectively. Often, companies resort to severe price cuts, the ultimate self-defeating tactic in differentiating a product. Tim Riesterer, Chief Marketing Officer and Senior Vice President of Products and Consulting, Corporate Visions, will discuss how to engage prospects in compelling, profitable sales conversations, by teaching participants how to challenge the customer’s status quo—one of the most powerful forces in resistance to change. His program can offer a potent advantage to MPL professionals looking to stand out from the competition, and thereby win their prospects’ attention and agreement.

“Creating a Customized Mobile App”
Building mobile apps is all about engagement and “youtility” value. Delivering on user satisfaction requires more than just guessing at needs. A successful application must encompass meaningful value, leading-edge technology, and performance monitoring. Matt McKenzie, Vice President of Digital Strategy, Intermark Group, Inc., will provide key insights for launching effective apps that garner high levels of adoption and loyalty through user-focused strategies.

“Cyber Liability and Other Cyber Risks in Dentistry”
Cyber liability and the related exposures that vary from state to state present challenges for all dentists, regardless of group size. Anita Bryant, Assistant Vice President, NAS Insurance Services and Desiree Khoury, AVP Specialty Reinsurance, NAS Insurance Services, will provide a broad view of various exposures to dentists, practice characteristics that an underwriter, claims, or risk manager should be able to identify, and will then suggest some real-world solutions for protecting the insured dentist practice.

“Marketing Dental Professional Liability Insurance to Young Dentists”
Yesterday’s marketing strategies and tactics may not be relevant for young dentists in today’s environment. To successfully attract young dentists, it is critical to know and understand what makes them tick—and how they differ from the older generation of dentists. This session will examine the key issues involved in marketing to young dentists. It will feature an agent who works with young dentists, a representative of the American Dental Association who will provide important perspective on what young dentists are looking for in a dental liability carrier, and a dentist who is in residency.

EVENTS & CALENDAR

2015 PIAA Marketing Workshop
Sessions on sales techniques to separate your company from the crowd; and designing and launching a mobile app.

2015 PIAA Dental Workshop
Sessions on cyber liability; and selling dental professional liability insurance to young dentists.

March 11–14, 2015
CEO/COO Meeting
The Westin Kierland Resort & Spa
Scottsdale, AZ

March 12–15, 2015
Board Governance Roundtable
The Westin Kierland Resort & Spa
Scottsdale, AZ

April 8–10, 2015
Marketing Workshop
The Ritz Carlton
Charlotte, NC

April 8–10, 2015
Dental Workshop
The Ritz Carlton
Charlotte, NC

May 13, 2015
Leadership Camp
Caesars Palace
Las Vegas, NV

May 13–15, 2015
Medical Liability Conference
Caesars Palace
Las Vegas, NV

September 16–18, 2015
Technology, Human Resources, and Finance Workshop
Omni Providence Hotel
Providence, RI

October 6–7, 2015
Introduction to Medical Professional Liability Insurance Workshop
The Mayflower Renaissance
Washington, D.C.

October 7–9, 2015
Underwriting Workshop
The Mayflower Renaissance
Washington, D.C.

October 22–23, 2015
Corporate Counsel Workshop
Casa Monica Hotel
St. Augustine, FL

November 4–6, 2015
Claims and Patient Safety/Risk Management Workshop
The Roosevelt
New Orleans, LA

Future PIAA Medical Liability Conferences:
May 11–13, 2016
Washington, D.C.

May 17–19, 2017
Colorado Springs, CO
CREATE A WIN WHEN YOU CHOOSE THE IMPERIAL PFS INSTALLMENT SOLUTIONS PROGRAM

1. INSTALLMENT PLAN FLEXIBILITY/OPTIONS
   - When a consumer finances a purchase, the focus is on the amount down and the monthly payment.
   - Offering more down payment and monthly installment options correlates to higher sales success for carriers.
   - Add significant value to your product offerings by dramatically improving your billing options.

2. REDUCE BILLING & CUSTOMER SERVICE EXPENSES
   - Collect premium payments UP FRONT.
   - Eliminate the cost of billing and servicing deferred installments.
   - Imperial PFS handles customer service calls.

3. FINANCIAL BENEFITS
   - Cash flow, liquidity and investment income all grow when full premium is collected UP FRONT.
   - No deferred installments means reduced operating expenses and credit risk.

THE NATURAL CHOICE.

To find out more about the advantages of the Imperial PFS Installment Solutions Program, call:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>JACK MERRIMAN</td>
<td>312.205.4838</td>
</tr>
<tr>
<td>DICK CRNKOVICH</td>
<td>253.466.3583</td>
</tr>
<tr>
<td>JASON SANDERS</td>
<td>312.205.4821</td>
</tr>
</tbody>
</table>

For information on all other Imperial PFS programs, visit: ipfs.com

HAPPIER CUSTOMERS. MORE PROFITS. LESS RISK. THAT’S A WIN.
NHS Whistleblowers Threatened for Speaking Out against Failing Patient Care Standards

So much for the bountiful advantages of a single-payer healthcare system. Apparently, whistleblowers in the NHS have been bullied and threatened so badly that many suffer from post-traumatic stress disorder. There are also claims that NHS managers fabricated evidence to smear staff identified as whistleblowers who raised concerns over poor patient care.

An investigation into what’s happening to whistleblowers was spearheaded by Patients First, established to promote transparency and accountability in the NHS. They compiled a dossier of 70 cases of badly treated whistleblowers from all over the U.K., which described their treatment as “shocking,” noting that there is a “culture of fear” in the NHS and “bullying is an almost universal feature.”

Patients First concluded there was a “real and continuing problem over the treatment of those who raise concerns.” All this has happened despite a range of measures introduced in an attempt to encourage whistleblowing.

One NHS manager, trying very hard to stay positive, noted that, “We have communicated widely on whistleblowing and tried to ensure all staff are aware of the mechanisms available to them in the event that they have concerns.” But then, another worker painted a rather darker picture: “Horrendous bullying started which involved me being sworn at, shouted at and threatened, and having my head slapped.”

Source: Property Casualty 360, August 29, 2014

Probably Inevitable? Medical Marijuana Liability Insurance

We’ll skip the cheap pot jokes—at least for now. Creative Edge Nutrition Inc. has announced that the company will be offering medical marijuana liability insurance, via Lloyd’s of London and through The Wellness Medical Protection Group. The policies will cover the growing and harvesting of marijuana, the facilities, landlords, dispensaries, and medical prescribers in America.

The apparent envy of its peers, Creative Edge Nutrition has stated that it is the first truly diversified marijuana company based in the United States, with four major divisions including insurance, marijuana, hemp, and vitamin nutritional supplements.

The marijuana production division can produce up to 1.3 million pounds, with facilities ready for government inspection. Through its subsidiary, Hemp Technology, Creative Edge Nutrition supplements will strive to meet the current $1 trillion global hemp market.

The management team at Creative Edge Nutrition includes attorneys (of course), representatives from an auditing firm, and a chairman who worked as a global markets securities fraud official with the SEC, IRS, and FBI. It sounds like they’re ready, for just about anything.

Source: Property Casualty 360, August 29, 2014
Medical Cyber-Crime Is On the Rise. Why?

Cyber-criminals are increasingly targeting the $3 trillion U.S. healthcare industry. Unfortunately, many companies still rely on aging computer systems that do not use the latest security features. But at the same time, many have switched to electronic health records, thus offering a rich compilation of data to anyone with a talent for hacking.

The percentage of healthcare organizations that have reported a criminal cyber-attack rose to 40% in 2013 from 20% in 2009, according to an annual survey by the Ponemon Institute think tank on data protection policy.

But what, in particular, are they looking for? Credit card and checking account numbers? No. Something worth a lot more: medical data. The data that the hackers are peddling includes names, birth dates, policy numbers, diagnosis codes, and billing information. Fraudsters use this data to create fake IDs, which they then use to buy medical equipment or drugs that can be resold. Or, they combine a patient number with a false provider number and file made-up claims with insurers.

Criminals have the luxury of time in making use of these data. And that makes medical data more valuable than credit cards, which tend to be quickly canceled by banks once fraud is detected.

Stolen health credentials can go for $10 each, about 10 or 20 times the value of a U.S. credit card number, according to Don Jackson, director of threat intelligence at PhishLabs, a cyber-crime protection company. He obtained the data by monitoring underground exchanges where hackers sell the information.

Source: JAMA Internal Medicine, September 15, 2014

‘Defensive Medicine’: Not Easy to Quantify

One recent estimate pegged the cost of defensive medicine at some $46 billion annually in the U.S. But in the past, these costs have been measured only indirectly. Now, a new study attempted to put a price tag on defensive medicine for three hospital medicine services in a health system—by having the physicians assess the defensiveness of their own orders.

Michael B. Rothberg, MD, MPH, from the Cleveland Clinic’s Medicine Institute Center for Value-Based Care Research, and colleagues investigated the hospital medicine services at three Massachusetts institutions: one tertiary care and two community hospitals. Physicians (n=39) rated the defensiveness of their orders from the previous day on a scale from 0 to 4, with 4 being completely defensive (ordered because of fears about MPL).

The authors hypothesized that if physicians feared being sued, they would practice more defensively and have higher costs. However, the researchers found that while fully 28% of orders and 13% of costs from the 39 participating hospitalists were rated at least partially defensive, only 2.9% of costs were completely defensive. Most had resulted from potentially unnecessary hospitalization.

“Those who wrote the most defensive orders spent less than those who wrote fewer such orders, highlighting the disconnect between physician beliefs about defensive medicine and their contribution to costs,” the authors point out.

Commenting on the study, Howard Brody, MD, PhD, director of the Institute for the Medical Humanities at the University of Texas Medical Branch Galveston, notes that there may be other reasons involved, for example, a belief that one patient is sicker than another.

He is skeptical that defensive medicine can ever be precisely quantified. “I’ve frankly come to the conclusion that you can’t measure defensive medicine,” because you just cannot sort clearly the reasons you did something, he said. “It’s typical for a doctor to do something, and one reason would fall under defensive medicine and the other two or three reasons wouldn’t, and whether you say that’s defensive medicine or not depends more on your political agenda than on the pure description of the case.”

Source: JAMA Internal Medicine, September 15, 2014

On Defensive Medicine. Part Two, the Comments

Sometimes, the “Comments” section can offer insights that are at least as good as the material that prompted them. Some examples for the JAMA Internal Medicine article:

• “This is a worthless study but can tell you I estimate my personal use of defensive medicine is 20% to 30% of what I would do without the specter of malpractice. It ranges from unnecessary antibiotic use and over-testing, to increased tree-killing to document everything I think could possibly be wrong and why I choose to think it is not so. So much time wasted and that is the biggest cost!” (plastic surgeon)

• “All this study proves is how insidiously defensive medicine has become the standard of care. I would use Cesarean section as the classic example, having risen from 3% to 5% in the 1960s to a rate closing in on 40% in many centers. While there is no way of quantifying thought processes in decision-making, the specter of the courtroom looms large over the labor suite.” (Ob/Gyn specialist)
MPL Data—Advanced Practice Professionals

Claims closed between 2009 and 2013

Using PIAA closed claims data from 2009 to 2013, approximately 408 claims were reviewed identifying Advanced Practice Professionals (APPs) (includes certified registered nurse anesthetist, nurse practitioner, surgical/physician assistant, or certified midwife) as the insured.

70% of claims were closed without an indemnity payment. Among the paid claims (30%), diagnostic errors (26%), improper performance (22%), and medication errors (12%) topped the list as the chief medical factors.

The PIAA Data Sharing Project provides information on claim trends for the most recent five-year period and other timeframes. For more information, please visit the PIAA website at www.piaa.us.
The delivery of healthcare is undergoing profound change. New regulations, shifting business models and evolving client needs require timely market and industry intelligence to maintain competitive advantage.

Guy Carpenter’s Healthcare & Life Specialty Practice is uniquely focused on this transformation. We invite you to learn how our dedicated team of specialists leverages our industry experience, market insights and analytical expertise to customize solutions that meet the unique needs of Medical Professional Liability insurers.

Let us put our intellectual capital to work for you. Please contact Steve Underdal at (952) 820.1030 or steve.underdal@guycarp.com for more information.

Learn more at guycarp.com
Exhibiting Strategy Increases ROI

For decades, organized medicine has hosted conferences and exhibitions, and for good reason: The revenues from these events have historically generated a good portion of an organization’s annual budget. And, for savvy MPL companies, a good trade show can be an equally valuable goldmine for generating leads and revenue. But finding the right conference to sponsor or participate in as an exhibitor can be extremely time-consuming and expensive for today’s insurance professional. So having a good strategy for making these purchases is crucial for maximizing the return on investment (ROI).

For certain, there’s no shortage of opportunities. There are the national medical societies; national, state, and county specialty societies; state and county medical societies; national, state, and even city-level management societies; risk management associations; claims/legal groups; and dozens of local events outside the scope of healthcare that physicians, hospital administrators, and medical group managers are likely to attend.

But, despite all these opportunities, insurers seem to be realizing diminishing returns from exhibiting and sponsoring of late. And rightly so; about a decade ago, it was estimated that 82% of all exhibit and trade show attendees came to see new products. But today, it feels like the opposite is true, and that 82% of physicians and clinic managers avoid the exhibit hall, despite the best efforts of the conference planners in using creative approaches for driving attendees into the room. It’s not uncommon for wary physicians who have to walk to the back of the exhibit hall, to get breakfast or coffee, to avoid looking anyone in the eye, for fear of being sucked into a sales pitch.

But conference exhibits don’t have to be unpleasant experiences, or a waste of marketing dollars. In fact, these trade shows can still be powerful media for increasing awareness, making it possible for smaller companies to compete right alongside their larger peers. They can also be strategically valuable, in creating opportunities for brand engagement, client interaction, and the social word-of-mouth marketing that drives business. And, for organizations already established in the marketplace, a trade show is an excellent venue for conducting research to find out what new services might be of value to various target audiences.

Separating the wheat from the chaff
Start off by doing some research and making a list of all the shows that will put you in front

David Kinard, MEd, PCM, is Vice President of Business Development at Physicians Insurance A Mutual Company, Seattle, Washington.
Call it reinsurance. Call it a coverage enhancement. Call it a program supplement. But no matter what you call it, call on NAS to develop and deliver innovative insurance products and services that complement your core business.

NAS provides essential products like Cyber and EPL with a complete array of support services to help you differentiate. And while we enable you to provide state-of-the-art benefits to your policyholders, you also avoid the costs of R&D, operations overhead, and assumption of risk on the new program.

From underwriting to agent training to claims services, NAS is purpose-built to help you meet the unique needs of your policyholders and put your innovative ideas into practice.
of the right audience. Just because a show has a lengthy history doesn’t mean it still attracts the right type of attendee for you. Figuring out who usually attends the show is just as important as figuring out where your company should exhibit. You want to ensure that the average attendee is someone who can make a decision about your valuable offers, or can serve as a key influencer who can advocate on your behalf. Once you know what your ideal show looks like, it’s time to see which ones fit into your overall strategy and budget.

But before you invest any time in planning or money in developing materials, it is critically important to determine your target return on investment (ROI) and how you plan to measure the show’s relative success or failure. Too many exhibitors cannot demonstrate a return on their investment, because they don’t start out with a plan. Consider: What is the purpose of even attending the show? What do you need in terms of results to justify your expenditure? Is this show supposed to create awareness, leads, or sales? How many leads are needed? How many sales? Are the objectives for the show realistic, in light of your abilities and resources?

Once you have a solid set of objectives, you can determine if a particular show is the right one to help you; the clear objectives also help you focus your efforts and control your expenses. Trade shows will typically yield results proportionate to the amount of effort put into them. It is not uncommon to see exhibit booths that are understaffed (not enough people), poorly staffed (the wrong people), or not staffed at all. Just letting a show “happen to you” is a surefire route to expensive failure. To get the most out of a trade show, you need to put energy, time, and effort into planning, promotion, staffing, and follow-up.

**Identify costs and exhibit needs**

Participating as an exhibitor can make a major contribution to your company’s customer-acquisition and marketing campaigns. But before you register for an event, make sure you have a solid, measurable plan for it. This plan will help to preclude any unexpected and unwanted outcomes, and thereby ensure that your trade show experience is a positive one.

Why do all this planning? One simple answer: Trade shows are not cheap. While they can produce excellent results for your organization, they can also be a black hole, draining off critical resources, if not carefully considered and planned for.

The expenses typically involved in exhibiting at a trade show will vary greatly according to the type of booth you expect to have. Obviously, larger booth spaces and more complex displays will significantly raise costs.

- Travel and lodging for the individuals staffing the booth, if the show is out of town
- Employee time for those who are staffing the exhibit (if you don’t have volunteers)
- Shipping of materials, display, etc.
- Booth rental with supplies (tables, carpet, electricity, chairs, plants, etc.)
- Display rental or purchase
- Promotional materials
- Pre-show promotion or advertising
- Post-show promotion or advertising.

Depending on the particular show and how popular it is, renting booth space can...
cost anywhere from a few hundred dollars to several thousand. And if you’re sponsoring the event, plan to pay as much as tens of thousands of dollars, for big shows. It is important to note that not all of the “popular” shows are necessarily the best. Many exhibitors show up at these because they feel they have to, not because they get a lot of business from them. Sometimes the smaller shows can produce great sales results.

In most instances, the booth rental fee covers only the exhibit-floor space. You’ll also need to budget for chairs, tables, plants, carpet, electricity, video or sound equipment, extra lighting, trashcans, and more. Basically, plan to pay for absolutely anything and everything you don’t bring yourself. And if you wait until the setup day just prior to the show to order an item from the exhibition management company, expect to pay a sizable markup for the on-site order (if they can accommodate your request at all).

The display itself does not have to be a major expense. Yes, you can likely rent one, but for a few hundred dollars you can purchase a really nice, lightweight, and portable display. Larger displays with attachments and gadgets will dramatically raise the price. If you want to purchase your own 10'x10' floor display with custom photos, plan on spending a few thousand dollars. Today’s displays are quite flexible: if you need to update the images in it at some later point, you should be able to do that for a modest cost.

But the display isn’t the only element that determines whether your exhibit is a success or not. Successful exhibitors also plan pre- and post-show promotions. They send out invitation-style announcements to their current database of customers or prospects; they may buy a targeted list from a list broker or rent the show’s attendee list from the prior year. These promotions can be done as direct mail, advertising, telemarketing, e-marketing, or some mix of other formats. Your goal is to let people know you’ll be at the show and to get them to your booth. It’s often helpful to have a game or promotion which requires that the attendees visit your booth to get the prize or a free gift.

In determining your costs, you’ll also need to account for the promotional materials you bring with you to the show, such as samples of your product or company literature. Make sure you have enough to cover your needs during the show and some left over for your regular business afterwards. Creating specialized materials just for a show is a good idea because it can help you track leads or sales afterward. With the advent of quick digital printing, these materials can be simple and inexpensive to produce, yet professional-looking and attractive. Some quick-print chains may even be able to print your order in the city hosting the show and deliver the materials to your booth, thereby saving you shipping costs.

Measuring success

To quantify the success of your exhibits and sponsorships, you have to determine in advance what you’re trying to measure. Figuring this out after the fact is nearly impossible. If you’re trying to generate prospects, then you’re going to need some type of promotion beforehand inviting qualified prospects to your booth. Once they arrive, you can qualify them further by asking questions and collecting their contact information.

If you’re trying to generate awareness, create a pre-show promotion that drives people to your booth. There, you’ll have demonstrations, free samples, and other literature that is coded so you know where it came from. Then, do some post-show measurement, by calling and surveying attendees to see if they remember you, and what they thought of your product or service.

And at the end of it all, be sure to keep a diary or log with details about how well the show performed for your company, what the results were, what you learned about the event, what other exhibitors did, what your competition did, and what kind of floor traffic there was. This way, you’ll have all that information available for the next year when the request to exhibit or sponsor comes your way. Then, you can make a strategic decision based on solid results.

For related information, see www.phyns.com.
The federalist system of government in the U.S. has made it possible for the individual states to serve as laboratories for democracy. They have served as the setting where many new policy ideas are developed and tested before, potentially, becoming the underpinning of reform in other states or even nationally. While California’s MICRA reforms are one example of this concept in regard to medical professional liability (MPL) insurers, another may be emerging now: communication and resolution programs (CRPs).

For many years, CRPs have been tested within specifically defined parameters. Notable examples include COPIC Insurance Company’s 3 Rs program, the University of Illinois Medical Center at Chicago’s Seven Pillars Program, and Stanford’s PEARL program. Observers have concluded that the results have been largely positive, noting that CRPs have reduced the number of lawsuits, lowered the costs of resolving potential claims, and improved the provider-patient relationship. As a result, both Oregon and Massachusetts have recently adopted their own early disclosure programs, prompting discussion about whether a national model might now be appropriate.

When President Obama announced federal funding for patient safety and MPL demonstration projects in September 2009, it wasn’t surprising that several of the programs funded were based on the communication and resolution process. When the period of funding for the demonstrations had ended, the sponsoring entity, the Agency for Healthcare Research and Quality (AHRQ), determined that the initial results from them justified additional efforts to make CRPs more widely utilized across the U.S. This decision has spurred efforts from both the federal government and the private sector.

**Toolkit from AHRQ**

For its part, AHRQ is pursuing what it calls a Communication and Optimal Resolution (CandOR) program. Over 24 months, an AHRQ contractor will “develop a comprehensive communication and resolution toolkit for a set of 14 hospitals to use in the pilot implementation of such a program in their institutions.” The toolkit will comprise six modules:

- Gap analysis—a formal assessment of the hospital’s current implementation of early resolution principles
- Incident reporting—the development of a process for prompt and easy reporting of adverse events and a structure for tracking subsequent follow-up to the report
- Event analysis and process improvement—introduction of principles for effective event analysis and process improvement, building on the hospital’s existing systems
- Communication (apology and disclosure)—identification of the institution’s best communicators and training of those individuals in effective disclosure
- Care for the caregiver—development of effective support strategies for health professionals involved in an adverse outcome
Resolution—training in best practices for resolving the concerns of patients and families after an adverse event.

While this project is underway, PIAA will be maintaining close contact with AHRQ, to monitor progress on the program. In particular, PIAA is concerned about ensuring that the crucial perspective of MPL insurers is not overlooked as the federal government moves ahead with its plans.

Already, PIAA leadership has informed AHRQ that CRPs must maintain the extent of flexibility necessary for meeting the unique sorts of situations faced by different types of hospitals. Furthermore, PIAA has underscored why it is so important that hospitals work in collaboration with MPL insurers in the development of CRPs, to gain the benefit of insurers’ expertise in both risk management and claims resolution.

Private sector initiative

At the same time that AHRQ is moving ahead with its toolkit, leaders from the demonstration projects have been working on their own initiative for CRPs. A group, currently calling itself the Collaborative for Accountability After Medical Injury (the Collaborative), features experts on early disclosure programs from all across North America. While these authorities in CRPs bring to the table vast experience in the issue, they haven’t as yet rallied around a proposal that would be promoted as the centerpiece of their efforts. There appears to be some support within the Collaborative, however, for using many of the features in the disclosure, apology, and offer (DA&O) process first implemented by the University of Michigan Health System more than a decade ago. Like similar programs, this system includes prompt communication with the patient; a review of the incident to see if the care provided was appropriate; an apology, explanation, and offer of resolution if the care was deemed “unreasonable”; and an explanation (and vigorous defense when necessary) if the care fell within appropriate standards.

PIAA sits on the Executive Board of the Collaborative and, as in its monitoring of the AHRQ toolkit, is using this opportunity to ensure that no proposal moves forward without the full input of MPL insurers. Thus far, PIAA has participated in numerous conference calls with Collaborative leaders. The Association is also hosting the group’s first in-person meeting, in mid-November, at PIAA headquarters in Rockville, Maryland.

While much remains to be done, it is clear that significant momentum is building for more widespread implementation of early disclosure programs. The details behind such efforts, however, must still be worked out. It is not clear if these programs can work as well when they are introduced outside of the closed systems in which many currently operate. In addition, there have been questions about whether these programs will work as well in jurisdictions that do not have the necessary legal safeguards in place (such as an apology protection law).

As these efforts move forward, however, PIAA will continue to engage with advocates of CRPs to make sure that the viewpoint of MPL insurers is prominent in their minds, and to encourage outreach to insurers as part of any state or local efforts that may develop. Whether it’s in the conceptual development of CRPs, or in their actual implementation, PIAA is committed to ensuring that the thought leaders behind it are fully aware of the important role MPL insurers play in all liability-related issues.
Is it reasonable for a patient to believe that her health insurer is the employer of its in-network physicians? If so, can the insurer be held liable for the actions of in-network physicians? Just how much should an insurer assume that patients know about healthcare finance? A recent case in Maryland addressed these very questions. The answers may change the way healthcare providers do business.

**Bradford v. Jai Medical Systems**

In Maryland, a hospital may be liable for the negligence of a non-employee physician under the doctrine of apparent agency. Only recently, though, has the state’s highest court held that this doctrine extends to managed care organizations (MCOs) as well.

In *Bradford v. Jai Medical Systems*, the Maryland Court of Appeals considered whether an MCO could be held liable for the negligence of an in-network provider. The plaintiff, a member of an MCO, sought a referral from her primary care physician for a specific podiatrist for treating her bunion. As a result of the podiatrist’s negligent care, the plaintiff underwent partial amputation of her foot. The plaintiff then sued, naming her MCO as one of the defendants. Though the negligent podiatrist was not an employee of the MCO, the plaintiff claimed that the MCO was liable under the doctrine of apparent agency.

At trial, a jury found for the plaintiff, and the MCO appealed. The Maryland Court of Special Appeals reversed, finding that the plaintiff did not fulfill the criteria of apparent agency and faulting the lower court for not applying the “common knowledge” test. The Maryland Court of Appeals, the state’s highest court, affirmed, but disagreed, in part, with the intermediate court’s reasoning.

**Susan Preston** is a Partner, and **Ryan Sullivan** is an Associate, with Goodell, DeVries, Leech & Dann, LLP.
MCOs may be liable under apparent agency

MCOs encompass a variety of organizational structures formed to reduce healthcare costs. They include preferred provider organizations (PPOs), which generally cover both in-network and out-of-network physicians and charge more for the latter, and health maintenance organizations (HMOs), which generally restrict coverage to in-network physicians and require members to select a primary care physician. The defendant MCO in Bradford operated like an HMO and did not directly employ any healthcare providers.

Maryland has adopted the doctrine of apparent agency as set forth in the Restatement (Second) of Agency § 267. The doctrine, as applied by Maryland courts, holds a person or entity (“the principal”) liable for the actions of a non-employee (the apparent agent) when three criteria are met. First, the principal must have created, or allowed creation of, an appearance of agency, i.e., that the principal employed the apparent agent. Second, the plaintiff must have subjectively believed an agency relationship existed and relied on her belief. Finally, the plaintiff’s belief and reliance on that belief must be objectively reasonable.

In prior cases, Maryland courts have held that hospitals may be liable for the actions of independent-contractor physicians, in the capacity of apparent agents of the hospital. For example, if an emergency room is operated by a hospital’s independent contractors, but the emergency room is within the same physical structure as the hospital and there are no signs indicating that the hospital does not directly run the emergency room, the hospital is liable for the negligence of the emergency room physicians. The Court of Appeals in Bradford reasoned that an MCO, like a hospital, may lead members to believe that in-network physicians are employed by the MCO. Explaining that “there is no reason to preclude application of the theory of apparent agency in the context of an MCO and a network physician,” the court thus joined the courts of Illinois, Florida, and Pennsylvania in holding that MCOs may be liable under the doctrine of apparent agency.

The Bradford court ultimately found that the plaintiff failed to establish apparent agency. Though the plaintiff claimed that the text of the MCO’s directory of in-network physicians suggested that the physicians were employees of the MCO, the court found no such suggestion, especially considering that the directory listed the names of 4,000 providers, including numerous hospitals and nationally known retailers and pharmacies like Walmart and Rite Aid. The plaintiff showed that she subjectively believed the podiatrist was employed by the MCO, but the court held that her belief was not reasonable—the MCO did not hold out its providers as employees, and the plaintiff did not receive treatment on or near the MCO’s premises. Had the podiatrist been located in the same building as the MCO’s offices, there might have been a different result—or at least a question of fact created. Then, it would have been left to a jury to determine whether the MCO had implied that the physician was its employee.

The “common knowledge” test is inapplicable to MCOs

The Court of Appeals affirmed the intermediate court’s decision, but it disagreed in regard to the application of the “common knowledge” test. Under this test, a plaintiff cannot prevail on a claim of apparent agency if his belief contradicts matters of common knowledge. For example, it is common knowledge that an oil company’s signs and emblems at a gas station indicate only that the company’s products are sold at the station, not that the oil company owns and manages the station. Therefore, a plaintiff may not successfully claim that an oil company’s signs led him to believe that a gas station attendant was an employee of the oil company.

The intermediate court in Bradford ruled in favor of the defendant MCO, based in part on the common knowledge test. Here, the plaintiff’s belief that the MCO employed the podiatrist was not objectively reasonable, because “it is common knowledge that MCOs are the equivalent of insurance providers and not the provider of actual medical services.”

The Court of Appeals pointedly disagreed and instead held that the common knowledge test is inapplicable to healthcare finance. First, the Court noted that MCOs, due to their diversity, may be very different from traditional insurers. MCOs may finance healthcare services directly and may even employ healthcare providers. Thus, an assertion that MCOs do not provide medical services is not necessarily accurate and therefore not common knowledge.

Second, when a court finds that a decisive fact is a matter of common knowledge, it is taking judicial notice that no person of ordinary intelligence could possibly have a belief contradicting that fact. Citing research showing that only a small percentage of Americans understand fundamental insurance terms like “deductible” and “copay,” the court explained that “it is not clear that details of health care finance are ‘common knowledge’ even to well-educated members of our society.”

Conclusion

Apparent agency is not a new concept in the health sector. Hospitals in Maryland know, or should know, that an independent-contractor physician can create liability if the hospital does not clearly communicate to patients the actual status of the physician as an independent-contractor. But MCOs may be surprised to learn that they are subject to the same test in regard to professional liability.

Based upon the recent decision in Bradford, MCOs should clearly state in their directories that in-network physicians are not employees of the organization. Also, if the in-network physicians are located in the same
building as an MCO, that MCO should require that the physicians post signs clearly stating that the physicians are not employed by the MCO.

Finally, MCOs should consider requiring that their members sign a form containing an express acknowledgement that healthcare providers in the MCO’s network are not the employees or agents of the MCO. Such documentation would establish unequivocally that the MCO is not representing the providers in its network as its agents, rather than leaving it up to the courts to decide that such a presumption could not be inferred from the actions they did take. An express acknowledgement, signed by an MCO’s members, would also serve to contradict a plaintiff’s claim that he subjectively believed that there was an agency relationship between the MCO and the provider, and that his belief was reasonable.

This case shows that MCOs cannot rely on claims of “common knowledge” in asserting that patients realize that in-network physicians are not agents of the MCO. When it comes to healthcare finance, MCOs, hospitals, and physicians should not assume that patients understand basic terms and concepts.

References

For related information, see www.gdldlaw.com.

New Venue in 2015!

PIAA Board Governance Roundtable
March 12-15, 2015 • The Westin Kierland Resort & Spa • Scottsdale, Arizona

The PIAA Board Governance Roundtable is the preeminent educational and networking event for the Board members of PIAA regular and industry associate member companies.

This year’s roundtable will focus on fiduciary responsibilities for directors. Thought leaders from the fields of asset management, investment strategy, and reinsurance will help attendees understand the broad areas of corporate risk and how best to fulfill their roles and responsibilities as directors. Topics to be covered include understanding fixed-income investing, equity investing and its role in an insurer’s portfolio, tax implications and ramifications, and managing reinsurance risk.

Why Should You Attend the Board Governance Roundtable?
■ Created specifically for you: chairs, vice chairs, and directors
■ Provides a forum where board members can gain invaluable industry insights, and share ideas and concerns with their colleagues in other companies
■ Offers ample time for networking

To register, or for more information, visit www.piaa.us

Note: PIAA Affiliate Partner personnel are not eligible to attend this meeting.

Don’t Miss This Unique Educational Opportunity!
The Center for Quality Improvement in Radiology Interpretations offers two ways to improve outcomes in medical liability litigation.

**STRENGTHEN EXPERT TESTIMONY**

We provide your expert with the litigation study hidden among multiple control studies for interpretation.

**BLINDED CLAIMS ASSESSMENT**

Have your litigation study read and reported by 10 ABR certified radiologists in the course of their daily routine.

Visit our website, www.Veritas Reporting.com or contact us at info@Veritas Reporting.com
HERCULES
HIGH SOUTHERN SKY
Bulk up.

Gain capital and scale by becoming a mutual owner of Constellation.

If you're feeling a bit insignificant in the universe of physician-owned medical liability companies, you're not alone. Many are finding it increasingly tough to compete against large stock companies.

That's why we formed Constellation, a mutual holding company created for like-minded medical liability insurers and other types of health care organizations. As a joint owner of Constellation, you'll enjoy significant benefits, such as increased scale, efficiencies, capital and support.

With this kind of strength, you'll be protected from consolidation and more able to compete against commercial carriers. Most importantly, you'll remain independent and maintain your customary operations, allowing you to continue focusing on improving patient outcomes and serving the unique needs of your market.

Find out more about how your company can shine brighter as a part of Constellation. Contact us at 888.965.0503 or visit ConstellationMutual.com.
Healthcare reform, and the organizational response to it in the form of clinical integration, is dramatically changing the delivery of healthcare in the U.S.

But healthcare reform has not been driven solely by the passage of the Affordable Care Act. There was already great pressure from many stakeholders (payers, patients, employers) to reduce expensive and inefficient care.

Paul Greve, JD, RPLU, is Executive Vice President, Willis Health Care Practice.

Until the last four or five years, the medical professional liability (MPL) insurance industry, like many a healthcare-related industry, did not have to pay particularly close attention to change in the healthcare delivery system. This is certainly no longer true.

Strategic as well as tactical planning by PIAA companies must be premised on healthcare reform, in 2014 and beyond.
Healthcare in 2014: key observations for MPL

In 2014, and at least into 2015, we are seeing a healthcare delivery system still in transition from one that is volume-based to one that is value-based. Each local/regional market has its own unique characteristics that must be closely studied.

Here are some key observations about the healthcare industry in 2014 as it affects the MPL industry:

- Consolidation: mergers and acquisitions by hospitals/hospital systems continues unabated.
- A marked deceleration in the numbers of specialty practices being acquired by hospitals. Simply put: they are capital-intensive and may not achieve adequate productivity and financial returns.
- An exception to this is the ongoing purchase of primary care practices due to the pivotal role these physicians play in hospital and specialty referrals.
- A lot of structural/organizational creativity in the form of local/regional contractual networks: clinically integrated organizations (CIOs), joint ventures, partnerships, and a myriad of other contractual arrangements to respond to the demands of payers, especially CMS, and employers. These are less capital-intensive than acquisitions.
- Increasing use of allied healthcare professionals (nurse practitioners and physician assistants).
- Increasing migration in the delivery of care to outpatient and nontraditional settings.
- Organizations are beginning to accept financial risk to prepare for the future, but fee-for-service will still be the dominant reimbursement methodology, through 2015.

Change means opportunity

Dynamic change can mean new opportunities, and the PIAA companies have proven that they are well-managed, well-capitalized, and often nimble in responding to healthcare reform. The bywords for continuing success can and should be: creativity, communication, and collaboration.

Employing physicians markedly changes a hospital’s risk profile, in many ways. Now, the hospital’s entire limits of healthcare professional liability coverage are exposed in a claim, whereas each physician in private practice previously had his own separate policy. All of the allied healthcare professionals of the employed-physician practice now expose the hospital to claims as well. The hospital historically was not responsible for claims involving misdiagnoses and improper performance of a surgical or operative procedure, for example. That is no longer true.

Healthcare reform, new organizational structures, and employed physicians present challenges. But there are also opportunities to
NEW OPPORTUNITIES

Those relationships, as well as facilitate a broad understanding of theings and state hospital association meetings can help begin to foster local American Society for Healthcare Risk Management chapter meet-

Hospitals and hospital systems. Attending state conferences such as the world of captive insurance companies and their brokers, captive managers, domiciles, and reinsurers. Taking the time to meet regularly with both domestic and foreign reinsurers and excess insurers, using the appropriate retail and reinsurance brokers.

PIAA companies can participate in, or offer, alternative risk transfer (ART) structures. Many hospitals and physician-owned captives need back-room support for their physician insurance programs due to increased costs and insufficient staffing. Purchasing unbundled services often makes sense.

Hospitals may wish to purchase a layer of reinsurance from PIAA companies for their captive to address physician risk. Not all hospital excess insurers and reinsurers are comfortable with physician risk. Much creativity can come into play here, but it will not happen without the necessary focus and time allotted to building relationships with hospitals and independent physician groups that are captive owners, as well as excess insurers and reinsurers. This will mean initial, and then regular, meetings with both domestic and foreign reinsurers and excess insurers, using the appropriate retail and reinsurance brokers.

But maximizing ART opportunities means understanding the world of captive insurance companies and their brokers, captive managers, domiciles, and reinsurers. Taking the time to meet regularly with key individuals in the world of ART is essential, and that means attending the major conferences focused on ART.

Significant effort should be devoted to forging relationships with hospitals and hospital systems. Attending state conferences such as the local American Society for Healthcare Risk Management chapter meetings and state hospital association meetings can help begin to foster those relationships, as well as facilitate a broad understanding of the state's unique market environment in the face of reform.

PIAA company senior management can get to know the hospital association executives in their state through regular meetings and visi-

bility at the important state healthcare industry conferences. Contact with such centers of influence such as corporate healthcare law firms and consulting firms can be a big help in understanding the local market and it will facilitate introductions to key healthcare executives.

At the same time, hospital staff responsible for legal services, claims, risk management, patient safety, and insurance stand to benefit from knowing the executives of their local PIAA companies. Regular contact may reveal opportunities, although it may be necessary to work through their local broker or agent. Hospital staff would welcome an understanding in regard to defense collaboration when independent physicians are named in claims, for example.

Opportunities for PIAA companies cannot materialize if there is always, or more than very occasionally, conflict over the defense of claims. Hospitals will not turn to carriers for assistance with their insurance and risk management programs if carriers do not collaborate on claims. There may be inevitable conflict in some scenarios, but every effort must be made to collaborate upfront, and that alone engenders future good will. Time must be invested in having those discussions with staff from key regional hospitals and healthcare systems.

Underwriting physician and facility risk can no longer be done just by taking a standard application. The myriad of corporate structures utilized and unique contractual arrangements in force must be clearly understood as part of the underwriting process. Periodic updates may need to be made during the policy period, so that the insured’s true risk profile emerges.

Healthcare law firms and consulting firms are valuable sources of information about which new structures are being utilized locally, so that carriers can ask appropriate questions at renewal and come up with optimal approaches for minimizing risk. This is one more reason to stay connected to those types of legal and consulting professionals through regular communication.

Conclusion

Change means re-evaluating old assumptions. Healthcare reform requires creativity by PIAA members, in the form of new products, new services, new relationships, and new collaborations with hospitals and their centers of influence such as law firms, consulting firms, and state hospital associations. The same is true for understanding and working within the world of ART.

Change also means opportunity. Healthcare reform certainly has its challenges. For companies that have understood the perils of MPL and thrived, more success awaits if they can be creative, collaborative, and communicative.
Thoughtful opinions differ as to what the net impact of ACOs will be: increased medical professional liability (MPL) exposure for physicians—or reduced risk. Prior articles in *Inside Medical Liability* have explored emerging theories of new liability risk, so they will not be considered in detail here. This article touches on the emerging theories about risk, addresses areas of probable reduction in liability exposure, and suggests some strategies that ACOs and their physicians can use to mitigate the identified risks.

Yes, it is a legal minefield, and while creative theories of liability will surely be attempted in our litigious society, at the end of the day, I am happy to conclude that physicians providing better care, promoting better patient engagement, and utilizing the tools and clinical knowledge available through ACOs should feel confident that they will navigate that minefield successfully. In fact, since adverse outcomes stand to be reduced by following best practices and more easily accessing patient information, liability exposure may well be less for physicians within ACOs, relative to those working outside these structures. For those who are mindful of the new areas of potential exposure and adopt practical mitigation strategies, the outlook should be even brighter.

Potential new risks

Of course, these are new and untested waters. Potential new areas of risk include the following.

---

Julian D. Bobbitt, Jr., is a Senior Partner and Head of the Health Law Group at the Smith Anderson law firm in Raleigh, North Carolina, bbobbitt@smithlaw.com.
Joint, several, and vicarious liability. With multiple providers involved in caring for the patient, and more professionals providing their clinical input, there will be some novel challenges in sorting out who actually was responsible for the patient. If there was a failure in adhering to the standard of care, whose was it, and did it proximately cause the injury? Or, was it truly a joint-care event and all of the parties involved should be held jointly and severally liable? When two or more persons are “jointly and severally liable” for a tortious act, each party is independently liable for the full extent of injuries stemming from the tortious act. Vicarious liability is liability that a supervisory party, such as an employer, bears for the actionable conduct of a subordinate, based on the relationship of the parties.

It is foreseeable that there could even be a lawsuit against a physician who never saw the patient. The adverse event may have happened because of the acts of an employed or supervised provider or some other member of the ACO care team.

New duties to patients? Will “patient centeredness” create a heightened duty of informed consent? Will new duties (i.e., required individual-care plans) lead to new claims for breach of those duties?

Heightened standard of care? The Medicare Shared Savings Program (MSSP) requires ACOs to define the processes that they will put in place to promote evidence-based medicine. This could be considered as creating a heightened standard of care that is owed by the treating physician to the patient.

Conflict-of-interest allegations? Recalling the litigation during the capitation era when complaints against physicians and managed care organizations commonly alleged that appropriate care was withheld because the physician negligently prioritized his financial success over the health of the members of the plan, some predict a similar wave of claims because the ACO model includes shared savings incentives. However, since ACOs have mandatory and explicit quality standards and processes that are prerequisites for savings distributions, I believe the capitation litigation is clearly distinguishable and such claims will not be successful.

Defensive medicine no longer an option? What happens when that extra test, administered in pursuit of the added security of “defensive medicine,” is not in sync with the ACO’s best-practice guidelines?

Health liability risks. ACOs are encouraged to use digital technologies to gather, sort, and transmit patient data, including the use of electronic health records (EHRs). It is intended that these will be available at the point of care, along with best-practice decision support, to assist the physician in providing optimum patient treatment. These activities raise interesting MPL issues:

- The duty to consult medical records
- The duty to adopt new technology
- Negligence in EHR use.

As Sharona Hoffman, Co-director of Case University Law-Medicine Center has commented, “With EHR systems, clinicians may find it extremely difficult to process the plethora of information that floods their computer screens. Yet, those who miss a critical detail could be held liable for negligence because the fact in question was likely just a few clicks away when the physician was reviewing the patient’s EHR.” Another side of the same coin: the physician does review the information, but then opts to override the decision support best-practice guidelines in protest over “cookbook medicine.”

Other risks

Though beyond the scope of this article, other more predictable and settled potential MPL risks for physicians participating in ACOs include:

- Cyber liability
- Antitrust
- Contractual liability
- Officer and director liability
- Self-referral and anti-kickback regulatory compliance
- Civil monetary penalties law
- Tax exemption and inurement
- Corporate practice of medicine
- Insurance, business, and intellectual property laws.

Why risk may be lower—Two key elements of ACOs may translate to a reduction in risk

Following evidence-based best practices. Following evidence-based best practices will likely reduce risks in two ways. First, there should be fewer claims, since following best practices will result in fewer adverse events. Second, abiding by an aspirational nationally-recognized standard of excellent care can serve as a shield in the physician’s defense.

Here is an example of what happened to anesthesiologists in North Carolina who agreed to follow treatment guidelines. This policy was somewhat controversial at the time, as debate ensued concerning the fate of any physician who did not follow the guidelines. We asked the opinion of Dale Jenkins, CEO of Medical Mutual Insurance Company of North Carolina, who confirmed that, “No doubt this spe-
cially impacted their claims experience with guidelines, and their mal-practice insurance rates, which went down.”

Dr. Grace Terrell, President of Cornerstone ACO, put it another way. She said, “Despite the hoopla that ACOs would increase liability, I have seen no evidence of it. Doing the right thing for patients is never the wrong thing to do.”

The infant ACO movement is just now ushering in ubiquitous adherence to clinical guidelines. MPL statistics for physicians in ACOs are almost nonexistent, and the MPL benchmark for the community standard of care evolves slowly. Nonetheless, I believe that there is a solid basis for predicting that patient outcomes will improve, adverse outcomes will decline, juries will determine that a physician following guidelines has not been negligent, and thus the overall net exposure for physicians will be reduced.

Access to clinical knowledge. A physician in an ACO can call in specialty expertise as needed for a troublesome issue, virtually or actually. The previously overwhelmed physician, working in his or her silo, did not have the same access to a real-time clinical consult. One example is the change in risk exposure for emergency physicians. Often, they had no prior physician/patient relationship with the patient who was entering the emergency department (ED), had limited (or no) medical information on that patient, and in most cases, no follow-up appointment was arranged before discharge. It is understandable that the urge to practice defensive medicine is great in that setting.

Contrast that with the care of an ACO patient. The emergency medicine physician will likely have the relevant medical history available, and an opportunity for consult. And every ACO patient walking out of the ED should have a follow-up appointment to see the ACO’s primary care physician in his or her hand. That patient will be seen by a physician in a few days, greatly reducing the chance of a mishap. Some ACOs are posting cardiologists and other specialists in EDs, to provide real-time support. Quality goes up, costs go down, and the chances of an adverse outcome are reduced.

Strategies to manage MPL risk
There are several opportunities for reducing the MPL risks for ACO-participating physicians.

Best practices as shield. Obviously, in order to obtain the defense shield noted above, it is important for ACO physicians to establish, understand, and adhere to clinically-valid evidence-based best practices that meet or exceed the relevant standard of care. Jenkins cautioned that any physician who chooses not to follow the relevant guidelines should carefully document the clinical rationale for his decision.

Prudent system design. Prudent policies, data protection plans, systems, and training will go a long way to mitigate risks. The goal of this article is to target those risks, to make it possible to design a system that will be able to avoid them.

System-wide risk management. The ACO should consider employing real-time adverse event management, leveraging the ACO’s data collection capabilities. Some ACOs may have the critical mass needed to complement the risk management system by forming a captive insurance company and/or becoming a Patient Safety Organization (PSO). Pursuant to the Patient Safety and Quality Improvement Act of 2005, PSOs may receive medical information on a privileged and confidential basis, for the aggregation and analysis of a patient safety event.

Informed consent process. The concepts of patient engagement and patient centeredness imply an ongoing two-way relationship. The same can be said for the process whereby the patient becomes informed about his diagnosis and treatment. It is not a single-shot discussion, but rather, a process whereby the patient gains understanding over time. The entire process should be thoroughly documented, and an informed consent document should be signed by both parties.

Insurance. Insurance companies have been developing new products intended to address the uniquely different MPL risks for ACOs and their providers. These should probably include coverages that provide for the full range of exposure of ACOs and their participants, including healthcare professional liability, directors and officers liability, and business errors and omissions (E&O) that covers issues related to managed care, cyber liability, privacy, and social media.

Conclusion
In ACOs, the types of interactions between physicians and their patients, and between participating physicians, are dramatically different from every prior model for providing care. On the one hand, this innovation presents a legal minefield, one that is partially uncharted. On the other, as Dr. Terrell has said: “Doing the right thing for patients is never the wrong thing to do.” Physicians in ACOs who have identified the new risks and adopted prudent best practices, systems, and policies stand a fair chance to practice in an environment that is notable for better patient experiences and reduced exposure to MPL.
Small-Scale Grant Awards Programs:
Professional Liability Insurance Partnerships with Providers Aim to Reduce Claims and Improve Patient Safety

In growing numbers, medical professional liability (MPL) insurers are tapping into a wealth of expertise, innovation, and energy by awarding small grants to fund patient safety, claims reduction, and loss prevention initiatives that are developed by the healthcare providers they insure, with promising results.
The W. Martin Smith Award Program, established by the University of Florida’s Academic Medical Center Self-Insurance Program (SIP) and Continuing Medical Education office (CME), is a well-recognized example of just how much a small amount of funding, for projects designed by insured providers, can accomplish in improving patient safety and reducing the potential for claims and lawsuits.

Award program background and philosophy
The University of Florida Self-Insurance Program is the professional liability entity for the six colleges of the University of Florida Health Science Center and the health-related colleges at Florida State University, University of Central Florida, Florida International University, and Florida Atlantic University. In the latter part of 2011, SIP collaborated with the University of Florida’s Office of Continuing Medical Education (UF CME) to expand upon the existing UF CME clinical quality award program to form the W. Martin Smith Interdisciplinary Patient Quality and Safety Award Program (IPQSA).

Intrinsic to the Smith program philosophy is that by financing provider-resourced projects, the passion, vitality, and expertise of these healthcare professionals working directly in their local area of interest will have a high probability of directly advancing patient safety, reducing claims, providing a substantial impact in the short term, and then becoming self-sustaining in the long term.

By providing resources to several small, focused projects that complement claims reduction and patient safety objectives, as opposed to investing in large, long-term, multi-initiative projects, the program is seeing multiple simultaneous improvements over a short period.

Award framework
The Smith Awards are presented twice annually and do not exceed $25,000. The Smith Award selection process has been very competitive, with approximately three applications submitted for every grant awarded. Successful award applicants typically take a multi-disciplinary approach to their projects, and they have a strong implementation plan that includes a sound methodology for evaluating their project’s impact and sustainability.

To help ensure early compliance with award criteria, a “letter of interest” is required 30 days in advance of the project application due date. Following review of each letter of interest, feedback is provided to the applicant. An interdisciplinary selection committee, comprised of physicians, quality officers, patient safety and risk management professionals, nurses, administrators, and medical-legal attorneys, then reviews the accepted award applications against established criteria, to ensure objectivity in the selection process.

If an applicant’s project is selected for a Smith Award, the project’s principal investigator executes a grant agreement that specifies award criteria and grantee responsibilities, including the submission of quarterly progress reports and a brief mid-point presentation that is made to award administrators and the next cycle of awardees.

Smith Award recipients are required to complete their projects within 18 months. Projects must be approved by the University of Florida Institutional Review Board (IRB) prior to the release of award funds. Strict budget parameters prevent the use of award funds for offsetting what would more appropriately be categorized as a capital budget expense item, such as clinical equipment. Upon completion of their projects, award recipients must also create a CME approved program, a peer-review publication, or some other scholarly activity.

Award program participation
Since the initial Smith Awards, in January 2012, the partnership between the UF CME office and SIP has resulted in more than $441,750 awarded to fund 27 grants that address a wide variety of improvement initiatives (Table 1).

Because a large percentage of the Smith Award projects are still currently within their 18-month cycle of implementation, impact analyses and claims reduction efforts are of necessity pending on many projects. However, several funded projects are yielding very promising results.

One award was given to Dr. Linda Le-Wendling, MD, Assistant Professor, University of Florida, to develop a simulation model for the education in the physiology, detection, and management of venous air embolism. Venous air embolism is the introduction of atmospheric air into the bloodstream of a patient, which can result in hypoxemia, hypotension, electrocardiographic changes, altered mental status, stroke, unconsciousness, cardiac arrest, and death.
Air entering the bloodstream is usually iatrogenic, meaning it is introduced by a medical provider as a direct result of a medical intervention that in many cases is preventable. It can be introduced through any existing intravenous access (peripheral IV line, central line, PICC line), through surgical incision, through any procedure that might damage a vein or artery (endoscopy), or through traumatized vessels (trauma patient). Venous air embolism has resulted in significant morbidity and mortality in the modern medical era. A lack of awareness of the presence and complications of venous air embolism by providers has resulted in MPL actions for failure to diagnose, treat, and, most importantly, prevent their occurrence.

In her Smith Award project, Dr. Le-Wendling created an online educational module to teach medical staff preventive measures and improve an understanding of venous air embolism and why it is important to reduce its occurrence. Using a graph representation model in an animated video, the education module addresses possible scenarios and ways to detect and diagnose venous air embolism, as well as a management algorithm. Post-test development was designed to confirm knowledge retention and awarding of CME credit.

Upon completion of provider education, a review of patient records measures the incidence of venous air embolism before and after implementation. It is anticipated that the data analysis will reveal that this new CME has resulted in a lower incidence of air embolism and improved patient outcomes.

### Multiple stakeholder benefits

Although the Smith Awards were developed in an academic medical setting, the concept is being adapted for a variety of healthcare venues, such as long-term and ambulatory-care settings. Modest funding by MPL carriers provided to their insureds' locally focused projects represents a joint investment in patient safety and claim reduction initiatives. Collaboration among business partners who share similar goals and objectives, such as the University of Florida Self-Insurance Program and Continuing Medical Education Office, can exponentially increase the opportunities for provider projects.

Patients are crucial beneficiaries of these projects by way of safer, more effective care. Providers and facilities gain the benefits of higher patient satisfaction, fewer adverse events, and lower premiums for sustained loss prevention improvements. MPL insurers can realize reduced claims and improved loss results; they also demonstrate their ongoing trust in their insured providers: in their success, ingenuity, and commitment to excellent patient care.

### Table 1 Projects Funded

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Award Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Patient and Family Centered Care: A Family Partner for the Inpatient Unit at Shands Hospital for Children at the University of Florida</td>
<td>$23,050</td>
</tr>
<tr>
<td>Developing a Second Victim Staff Pilot Program for the Consequences of Unanticipated Clinical Events</td>
<td>$24,381</td>
</tr>
<tr>
<td>Implementation of a Hospital Based Discharge Intervention to Improve Heart Failure Readmissions</td>
<td>$24,540</td>
</tr>
<tr>
<td>Implementation of a Prospective Quality Assessment Program for the UF-Shands Breast Cancer Program</td>
<td>$27,318</td>
</tr>
<tr>
<td>Prehospital Sepsis Recognition</td>
<td>$24,974</td>
</tr>
<tr>
<td>Venous Air Embolism (VAE): A Widespread and Likely Fatal Complication and the Development of a Multidisciplinary Simulation Model for the Education of the Physiology, Detection and Management of VAE</td>
<td>$25,000</td>
</tr>
<tr>
<td>Management of the Traumatic Brain Injury Patient in Acute Care</td>
<td>$15,000</td>
</tr>
<tr>
<td>Impact of Structured Support Group on Quality of Life &amp; Disease Course in Teenagers with Inflammatory Bowel Disease</td>
<td>$11,096</td>
</tr>
<tr>
<td>Implementation of a Protocol, for Early Identification &amp; Management of Sepsis, Severe Sepsis/Septic Shock Patients—An Institution Wide Multidisciplinary Collaborative</td>
<td>$25,000</td>
</tr>
<tr>
<td>Improving Physician/Patient Communication with AIDET (Acknowledge, Introduce, Duration, Explanation, Thank)</td>
<td>$5,131</td>
</tr>
<tr>
<td>Medication Error by Hospitalized Patients and Analysis of Patient Satisfaction Using a Daily Medication List</td>
<td>$10,700</td>
</tr>
<tr>
<td>Best Fed Beginnings: A First Step</td>
<td>$15,000</td>
</tr>
<tr>
<td>The Effect of a Pain Management Protocol on Postoperative Neurosurgical Pain</td>
<td>$24,200</td>
</tr>
<tr>
<td>Impact of Collaborative Care Services for High-Risk Patients after Discharge from a Large Urban Academic Medical Center</td>
<td>$24,975</td>
</tr>
<tr>
<td>Building Infrastructure to Develop and Promote a Culture of Safety: A Pilot Program for General Surgery Patients</td>
<td>$24,100</td>
</tr>
<tr>
<td>Pressure Ulcers: Crisis of Prevention</td>
<td>$20,000</td>
</tr>
<tr>
<td>Implementation of Obstetric Emergency Simulation Drills</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

For related information, see [www.flbog.sip.ufl.edu/cqap/index.php](http://www.flbog.sip.ufl.edu/cqap/index.php).
Predictive Modeling: The Essentials

Inside Medical Liability: What is predictive modeling? Can you provide a precise definition?

Towers Watson: Predictive modeling (PM) is an area of statistical analysis that uses computer algorithms to extract information from historical data and utilizes that to predict future trends and behavior patterns. It relies on identifying relationships between characteristics and the extent to which these characteristics drive what is being analyzed, such as loss ratio, loss costs, claim frequency, and/or claim severity, to name a few. PM has been used for years in various industries such as financial, pharmaceutical, retail, and professional sports.

Inside Medical Liability: Where do you see MPL insurance companies using PM?

Towers Watson: In the insurance industry, PM is used in pricing, underwriting, marketing, and claims. Companies new to this technology usually focus first on an area with the greatest need for improvement, historically, pricing and underwriting, especially during soft markets. PM technology allows carriers to better understand how the true cost of insurance varies among its policyholders. Knowing the cost enables a company to determine the correct strategy for growth, profitability, and policy retention. For example, applying PM to pricing and underwriting on an unprofitable book of business often reveals the specific area responsible, so that an effective corrective strategy can be developed.

Inside Medical Liability: If a company is not driven by profit, what benefit does PM provide?

Towers Watson: The key to making good business decisions is having complete information, which PM helps accomplish. While companies may not be driven by overall profit, they should still want to treat their policyholders equitably. PM provides information on the true cost for each policyholder, which is important for a carrier to avoid pricing too competitively or losing business because a competitor prices too competitively. Likewise, the allocation of dividends among the policyholders can also be evaluated for appropriateness.

Inside Medical Liability: What types of information do you analyze when you build predictive models?

Towers Watson: It depends on the questions you are trying to answer with this
technology. In pricing and underwriting, we are interested in understanding the attributes that differentiate the cost of insurance among the policyholders. These attributes primarily consist of policyholder characteristics captured during the insurance application process. In addition, as insurance companies have become more sophisticated, they also use information obtained from external third party vendors, including education and certification history, affiliated hospital characteristics, prior claim experience, physician group characteristics, and information on the geographical location where the physician practices.

**IML:** Can predictive modeling be applied to groups of physicians? What type of group information is used?

**TW:** As groups of physicians are becoming more prevalent than individual practices, insurers using PM technology can leverage group characteristics in addition to the information about the individual physicians that make up a group. Group characteristics that might be used include average physician tenure and information on the mix of support staff.

**IML:** Which departments within the insurance company need to be involved in a PM initiative?

**TW:** PM leverages a company's historical data about its policyholders. In a pricing application, historical data includes exposure, claim, and policy information. As a result, the analysis team should include representatives from the underwriting, claims, and actuarial departments. Collaboration with these experts is important in order to (a) understand the company's unique attributes; (b) align the findings from the modeling with their experience; and (c) create an understanding of the results from PM throughout the process. In addition, IT needs to be involved in extracting historical data, responding to questions about the current system capabilities, and the integration of the results with the model into the business process. Because there are significant resources involved, an initiative of this type benefits greatly from the support and buy-in of senior management.

**IML:** How do you determine whether these models will actually work?

**TW:** PM utilizes historical data to build models. A common practice is to sub-divide the available historical data further into two groups, using one group as the basis for the PM analysis and the other to test how well the findings of the analysis are able to predict what is already known. This validation exercise can also be performed again, from time to time, as the model results are implemented, to help reinforce buy-in among the people using the model.

**IML:** Will the results from PM reconcile with the underwriter's intuition?

**TW:** Generally speaking, yes. Experienced underwriters have a good understanding of the characteristics that indicate better- or worse-than-average risk. Importantly, PM helps quantify the magnitude of the risk they already expect and, in rare circumstances, it may uncover relationships previously unknown by underwriters. Much more commonly, however, PM aligns very well with what an underwriter expects. That's why it's essential to emphasize that PM will usually reconcile with their intuition. Often times, we create this understanding in discussions that cover the characteristics that made it into the predictive model, and also those not found to be predictive. A common reason why certain characteristics were not found to be predictive is because they are redundant with other characteristics already in the model.

**IML:** But do you think that these models will eventually replace the underwriting function? Companies currently have in place?

**TW:** No, and commercial-lines underwriting may never become fully automated due to the vast number of qualitative characteristics that only an underwriter can know about the policyholder. Moreover, PM aims to assist the underwriter through a better understanding of the characteristics that can be objectively quantified, allowing the underwriter to focus more on the subjective elements used in pricing the business.

For example, many underwriters use PM analysis results successfully to enhance their clients’ policy renewal and acquisition process. Some policies may be identified as suitable for automated underwriting, while others may be flagged for more detailed underwriting review due to a combination of issues such as complexity of risk, unusual policy characteristics, and expected profitability. Their use of PM provides a more disciplined approach and helps direct limited resources to the applications where they are needed most. In addition, using PM has proven to be invaluable in helping a company maintain its business objectives during soft-market conditions.
KEEPING DOCTORS IN MALPRACTICE.

For nearly a century, Thuillez, Ford, Gold, Butler & Monroe, LLP has been the law firm doctors, hospitals and nursing homes have called to their defense.

We have a proven track record in complex, multimillion dollar lawsuits for negligence, medical malpractice and wrongful death. Our dedication to litigation is well known in the industry, and it's because of this that we're able to maintain a network of experts with outstanding credentials in every medical specialty.


Thuillez, Ford, Gold, Butler & Monroe, LLP.
Keeping the healthcare industry alive and well for 100 years.

Thuillez, Ford, Gold, Butler & Monroe, LLP
ATTORNEYS AT LAW

20 Corporate Woods Boulevard  o  Albany  o  NY 12211
P  518.455.9952  o  F  518.462.4031

Prior results do not guarantee a similar outcome.
Attorney Advertising.
Concerning loss reserves of captives (including risk retention groups) that are focused on liability for medical professions or health systems and hospitals:

Q: Are the variables considered, and the techniques used in calculations, materially different from what is done by traditional medical professional liability (MPL) companies?

A: In general, the methodologies and considerations used in estimating reserves for captives with an MPL focus are similar to those used by a traditional MPL company. One difference is the data used in the analysis. Traditional insurance companies may have access to large, complex datasets for their analyses. Frequently, this is not the case for a captive program, which may have a relatively short operating history and/or lower volume of annual claims. If we are doing an analysis for an existing captive, we try to use the captive’s own data. In addition, we use external data to supplement the captive’s own data in certain areas, including loss development and trend analysis.

Q: How is the “historical data” chosen? Are you using publicly available databases, or do you have other sources?

A: In addition to the captive’s own data, we use publicly available databases and also our own proprietary compilations of data. We try to find supplementary datasets that match the captive program as closely as possible, in terms of the types of risks insured, retention level, mix of states insured, etc. Over time, the captive will build up its own data history, and we can place more reliance on that.

Q: Is the time between the filing of a claim and its resolution shorter or longer for a captive, as compared to a traditional MPL company? And does this difference, if significant, affect reserving practices?

A: The time needed to resolve a claim depends mainly on the
complexity of the case and the jurisdiction, rather than whether or not a captive is involved. We do find that captives tend to have a shorter claim reporting pattern (i.e., there is less of a lag between the date of occurrence and the date when the claim is reported).

Regarding reserving practices, here again, captive involvement does not necessarily affect the adequacy of the case reserves. Captives that specialize in insuring a specific type of risk (such as those of anesthesiologists) may be able to value more accurately the types of claims those risks tend to incur (and even identify ways to reduce the frequency and severity of those claims).

From an actuarial perspective, the key issue is consistency of case reserving practices over time. If claim management practices are consistent, then the captive's historical loss development data may provide a good basis for estimating total reserves, and any shortfall in case reserves can be made up in the bulk reserves, i.e., the incurred but not reported (IBNR) reserves.

Q: Insuring only MPL, for a tightly defined group of insureds (such as anesthesiologists), may be linked with significant variability in the pattern of losses over the years. How do you establish reserves for this sort of highly volatile line of business—especially when there may be no spread of risk across regions, lines of business, underwriting groups, etc.?

A: In this type of situation, actuarial work becomes both science and art. You apply as much science as possible, and then draw on your experience and judgment to take you the rest of the way. Sometimes you have to customize a unique solution for the particular problem at hand, incorporating qualitative information gathered through discussions with underwriters, claim professionals, and defense attorneys—anyone whose expertise can give you a clearer picture and inform your quantitative analysis.

Q: With all of these factors in play, is there a much larger range of reasonable estimates for reserves?

A: Yes, these characteristics tend to increase the uncertainty and variability of reserves, leading to a wider range of reasonable estimates. In such situations, the actuary can also estimate probability levels that are associated with various values within the range of reasonable estimates, so that the captive has an idea of the risk associated with setting its reserves at any particular level within the range.

Q: Is there a bias toward lower premiums in a captive, and does this bias increase the probability that the captive will need a premium deficiency reserve?

A: Not necessarily. Some cap-
tives have a low risk tolerance and therefore include a healthy margin for contingencies in their premiums, especially those that are insulated to some extent from the competitive pressures of the commercial MPL market, where prices currently remain soft. These captives can maintain more discipline in their rates, while commercial insurers competing for business may have to offer deep discounts off their manual rates—to the point where current business may be unprofitable. Currently, though, reserve releases from older loss years serve to mask the problem, by producing profitable results on a calendar-year basis.

Also, although current rates may be inadequate (implying the need for a premium deficiency reserve), the inadequacy may go unrecognized for some time; the current year’s claim data is very immature, making it difficult to set loss reserves accurately.

The historical underwriting cycle in MPL tells us that, sooner or later, reserve releases will dry up and rate inadequacy will be exposed, leading to a hard market. If a captive has been able to maintain adequate rates through the soft phase of the cycle, it may not have to respond with steep rate increases during the hard phase. In fact, it is for this very reason—avoiding the amplified ups and downs of commercial market cycles—that many captives were formed in the first place.

**Q:** Do the lower minimum capital requirements for captives (and for the majority of RRGs), along with the volatility of the MPL line, make it more likely that an RMAD will have to be declared?

**A:** In determining whether there is in fact a “risk of material adverse deviation” (RMAD), the actuary must first select a materiality threshold. The threshold may be based on capital, so—yes—lower capital may increase the likelihood of an RMAD being present. However, it is important to remember that disclosure of an RMAD simply provides those who use the opinion (i.e., the captive and its insurance regulators) with additional information on the variability of the reserves being opined upon. For MPL specialty insurers—both captives and traditional carriers—it is not unusual to have an RMAD present, especially if a relatively low percentage of capital, such as 10%, is deemed to be material.

**The time needed to resolve a claim depends mainly on the complexity of the case and the jurisdiction.**

For related information, see [www.milliman.com](http://www.milliman.com).

**PIAA MPL Closed Claim Comparative**

The *MPL Closed Claim Comparative* provides unique data on nationwide payment trends for use by medical professional liability (MPL) insurance company staff and healthcare professionals. This information complements other data used to identify MPL trends. The *MPL Closed Claim Comparative* was recently updated, and it now includes many new enhancements, including:

- Claim trends for the most recent five- and ten-year intervals
- Data on the impact of damage caps
- Additional loss-causation data
- Enhanced graphs

Go to [www.piaa.us](http://www.piaa.us) to purchase this and other essential PIAA research publications!
One of the most difficult decisions for companies in deciding on their IT strategy is whether to adopt a single-vendor application suite or deploy a best-of-breed approach, using products from different vendors that best fill the bill for each business area. The question is—and always has been—will the functional benefits of best of breed be enough to offset the complexities with the initial integration and, then later, with maintaining that integration through diverse upgrade cycles? Which approach delivers the ideal balance of user features, return on investment, and business benefits?

Over the last 20 years, the use of a single package has generally been favored, and that may still be the best way to go for smaller organizations that lack strong IT skills. But recently, with the advent of more sophisticated software tools to support integration, and also cloud computing, the pendulum may be swinging back in the other direction.

For most PIAA companies, the installed software falls into two categories:

- **The core enterprise suite of software** for policy administration, billing and collections, and claims management
- **Specialty software** for reinsurance processing, customer relationship management, document management, financial (accounts payable and general ledger) packages, annual statement software, investment software, and more.

The specialty software is generally regarded as squarely in the best-of-breed camp. In fact, few core enterprise software vendors would offer these products. Ideally, though, these vendors will have some experience, and possibly a business arrangement, with a specialty software company, so that the integration will already be in place prior to purchase. If not, bear in mind that all of these specialized packages have come a long way in regard to their customer support for integration with other products.

So the decision actually comes down to three areas: policy administration, billing and collections, and claims. It involves these considerations:

- **Time, cost, and resources.** All modules of core enterprise software are generally implemented at the same time, because each module is so closely interconnected with the others. This is why the implementation of these packages requires considerable company resources, in both staff time and capital over a period of, typically, 12 to 18 months. In contrast, the implementation of best-of-breed packages can be spread out over a longer time period. Each package may only affect one department, so the implementation can be sched-
uled for that department’s convenience.

When negotiating for a suite, the customer has the advantage: the purchase is large, so it is more likely that you can cut a good deal, in terms of monetary cost. Buying modules from different vendors will likely not afford the same negotiating leverage.

Conclusion. If the resources are available for it, implementing an enterprise suite will generally be less expensive, in both cost and time, than implementing the equivalent best-of-breed packages. With best-of-breed packages, you can spread the implementation process over a longer period of time, but it will probably take more time, overall, and may actually cost more in the end.

Degree of fit. Best-of-breed packages are selected so as to be the best fit for a particular need—so, by definition, they should be!

The most mature versions of core enterprise software suites have addressed the issue of “degree of fit” by building in a huge amount of flexibility—a “rules and tools” approach that does indeed give flexibility, but also introduces a good deal of complexity. Complexity means lots of time spent in configuring the product to suit the company’s exact needs, which in turn means extra cost and time.

With an enterprise suite, you cannot have both simplicity and a good fit without doing some work. So it’s best to look for a vendor that has a “template” for the type of business that you do, so that the configuration effort does not have to start from square one.

Conclusion. Best of breed should, in theory, win this round—but only on points, if the enterprise suite comes with some template pre-configuration and the vendor has prior experience in working with the insurance products to be processed.

Simplicity of use. Best-of-breed software should be easy to use; otherwise, it wouldn’t be considered best of breed! However, its advantage over an enterprise system may not be that great. Each best-of-breed package will have its own internal logic and procedures. Anyone who has to work on more than one package has to learn different sets of instructions and conventions, so he may need to learn more new processes than with an enterprise system.

Note that integration of different products is not for the faint of heart. IT will probably underestimate the task; there are always some unknowns, and many IT staff haven’t had hands-on experience with

Has Your Reinsurance Program Evolved With You?

As your company matures, your reinsurance needs may have changed too. An updated program could allow you to focus on capital protection, growing your organization or achieving improved investment returns through more efficient cash flow.

We offer custom reinsurance solutions to help you meet these goals, while maintaining a level of risk that is comfortable for you.

It never hurts to have a second opinion. Talk to us today.

Gen Re.
A Berkshire Hathaway Company

the newer technologies. Even if two applications can be used to transfer data reliably fully 100% of the time, problems arise if one of the applications is modified or upgraded and the other isn’t updated for the change. Data can be lost or corrupted, with far-reaching consequences.

Conclusion. Simplicity of use is really a balancing act. For a particular function, best of breed generally scores highest, but from the perspective of the overall company, enterprise suites win out in most cases, particularly when it comes to deployment and ongoing maintenance.

Implementation management. When it comes to program/project management of the system implementation, an enterprise suite is a clear winner, because there is only one supplier to deal with. Also, there is just one company doing the training and support. With multiple packages that must work perfectly in sync, if there is a problem, the customer may find himself in difficulty when one vendor blames the other.

Upgrades are always a necessary evil. Enterprise software should be a lot simpler in this respect. One upgrade will include all of the modules, and it will have been tested in the state that it will be installed.

With best of breed, you’ll have to deal with a never-ending stream of upgrades. The more integration and data extraction your IT department has done for you, the more work you will need to do at every upgrade.

Conclusion. The best-of-breed products win in regard to degree of fit, but a fully integrated package wins on everything else: time, cost, resources, simplicity, and project management. The best-of-breed approach does allow you to spread out the cost and resources required for implementation, so it does offer one slight advantage: a short-term fix.

What’s the bottom line?

■ Support for software integration has progressed very rapidly in the last few years. Products offered via the cloud are designed from the ground up to work well with other software, offering software developer kits, application programming interfaces, Web services, and more, to help make the task of integration as easy as possible.

■ The medical professional liability community has followed the same trend in acquiring the specialty software products noted above—they’ve opted for best of breed—and the experience has generally been good, and getting better.

■ For the core enterprise software, there is a high degree of interdependence between modules, not just in the transfer of data, but also in online transaction processing, workflow processing, dependencies in business rules, and more. Most companies understand this, and on this basis have opted for the packaged-suite approach. Recently, though, there has been some movement in the other direction, typically because companies have made decisions promoted by their IT group, and have heard optimistic (over-optimistic?) assessments of what’s required for the integration task. Results, generally, haven’t been good. An enterprise software suite for policy, billing, and claims remains the better choice, especially if there is a template for processing all of the business.
THE COMMONWEALTH OF VIRGINIA DEPARTMENT OF THE TREASURY
HAS REAPPOINTED

THE
OPTIMAL
SERVICE GROUP
of Wells Fargo Advisors

TO PROVIDE INVESTMENT CONSULTING SERVICES TO THE
COMMONWEALTH OF VIRGINIA GENERAL ACCOUNT

To learn more about The Optimal Service Group’s investment consulting services, contact
Joseph W. Montgomery, CFP®, AIF®, Managing Director – Investments, or
Thomas C. Wilson, AIF®, Managing Director – Investments at 888-465-8422.
What Willful Neglect Might Mean for U.K. Doctors

By Dr. Nick Clements

A new criminal offense for doctors, of willful neglect, will likely become law soon in the U.K.; the Criminal Justice and Courts Bill has its final debate on it in October. If this proposed legislation passes into law, it will have significant consequences for all healthcare workers in England and Wales.

In its current form, the legislation will:
- Make it an offense for healthcare workers to “ill-treat or to willfully neglect” someone in their care
- Create an offense for the organizations that employ healthcare workers that ill-treat or neglect someone, if the organizations are not managed in such a way that could have prevented it
- Not require that there be harm to the patient for the treating healthcare worker to be judged guilty of an offense
- Create penalties for healthcare workers of up to five years in prison and a fine.

The Medical Protection Society (MPS) has been lobbying both government and parliamentarians to ensure that the law is clear and does not unreasonably affect the everyday decisions of healthcare professionals.

A climate of fear

Defensive medicine, amid a climate of fear, is a practice that MPS has frequently raised concerns about in the past. Typical examples of defensive medicine are ordering more tests than are medically necessary, avoiding treating certain conditions or performing particular procedures and over-treating “just in case.” Although it is right that unacceptable conduct by a medical professional should receive tough sanctions, adding a criminal element to these sanctions risks making healthcare professionals less willing to be open about genuine errors. This is in no one’s interest and would be in direct conflict with the government’s new “duty of candor”—the legal duty of organizations and employees to be open with patients about mistakes.

As the proposed legislation stands, there is a risk that normal, everyday decisions—whether they involve the allocation of resources, triaging of patients, or deciding on one course of treatment over another—could potentially be investigated for willful neglect. The government is relying on prosecutors to exercise their discretion not to investigate or prosecute reasonable clinical judgments, but this could create uncertainty and fear among healthcare professionals, unsure about whether their actions could be later deemed criminal.

There is also a concern that the new law could criminalize matters that would not succeed as a clinical negligence claim. A claim for negligence depends on three factors: a duty of care, a breach of that duty, and harm caused by the breach. Where there is no harm to the patient or any harm that did occur was not caused by a breach in the duty of care, a negligence case will fail. However, the doctor could then face a criminal investigation, because a doctor could be found guilty of the offense even in the absence of harm.

MPS believes that the current regulatory, disciplinary, and criminal framework is already effective for censuring unprofessional behavior. It is right that when a healthcare professional’s behavior is unacceptable, he faces tough sanctions for his actions; however, there is already a range of criminal laws under which a healthcare professional could be prosecuted. We have called for the legislation to be amended, so that the offense targeted by it clearly deals with only the most serious incidents, and does not spread fear about the potential for a police investigation of...
decisions about care.

This criminal sanction could have a significant impact on the professional lives of doctors in all sorts of ways that have not been adequately addressed by the government and need further consideration.

The government has been focusing on greater penalties and not enough on how to support doctors so that they can learn from the experience of a potential, or actual, adverse outcome. It is essential that there be an open and transparent learning culture where healthcare professionals feel able to report accidents and near misses, so they can learn from mistakes. The government’s focus should be on the development of mentoring, training, and leadership programs that create an open environment of learning.

Case Studies

The following are based on real cases and are designed to illustrate our concerns about how the sanctions for willful neglect—as they stand—may or may not be applied in practice.

1. Clinical decisions could be criminalized.
   A 12-month-old child presented to an accident and emergency (A&E) facility with severe chickenpox. He was eventually discharged, but returned later with cellulitis and swelling of the right ankle; he was seen by a pediatric consultant who was concerned about secondary bacterial infection, but—given unusual bruising on the child’s leg—he requested an x-ray to exclude a fracture first.

   No fracture was noted, and the child’s condition began to deteriorate. No observations were taken, as the consultant was busy with other patients, and there was a limited number of junior staff on the ward; when the consultant eventually attended the child, he was extremely unwell and required resuscitation. The child was then transferred to the pediatric intensive care unit with a diagnosis of necrotizing fasciitis; he survived after extensive debridement.

   Discussion. In this case, there were identifiable failings in care, involving inaction by healthcare professionals. However, it is unclear how a willful neglect offence would apply and how appropriate it would be. For example, would the clinical decision to delay antibiotics to rule out fracture first be classed as willful neglect? If so, is it only the consultant who is liable? Will the organization be liable as well, for the staffing issues?

2. The reality of multiple commitments
   An on-call consultant general surgeon was stationed in the outpatient clinic in the morning, and then performed a series of colonoscopy procedures in the afternoon. In the mid-morning, a patient was admitted with a possible leak after anterior resection. A registrar arranged a CT scan and informed the consultant that the results would be available by lunchtime.

   The consultant’s outpatient clinic session overran by an hour, and he went straight from there to the endoscopy unit, with no time to go by way of the ward. He was then in surgery most of the night with no time to go by way of the ward. He was in a lot of pain. He was not seen by the consultant until the next morning and was then taken to surgery for an emergency laparotomy. The patient fully recovered and was discharged some weeks later.

   Discussion. It was a deliberate act by the consultant to go straight to the endoscopy procedures and not stop by and see the patient. Will this constitute willful neglect? No harm came to the patient, but it seems possible that the criteria for an offence could apply, and there could therefore be a police investigation, potentially leading to a prosecution.

3. Deferring decisions to a “specialist”
   A GP saw a patient with shortness of breath, tachycardia and low blood pressure, and pyrexia, with slight elevations of C-reactive protein level and erythrocyte sedimentation rate. She was unsure of the diagnosis, as her examination of the chest and heart gave normal results, so she requested a second opinion from a respiratory physician. The physician advised antibiotics and an outpatient appointment the following day. The GP had reservations, but followed this advice and the patient went home. That night, the patient’s condition deteriorated, with septic shock developing. The case was subsequently referred to the General Medical Council.

   Discussion. It is not uncommon for GPs to seek the advice of specialists, and to rely upon it; in most instances, the advice is non-contentious. While this might seem to be an appropriate case for the General Medical Council to consider, it also raises questions about professional responsibility and whether following the advice of others could make a GP vulnerable to a charge of willful neglect. Might the respiratory physician also face investigation and possible charges?
While there isn’t a man with a gun involved in this instance, the singing of songs and the carrying of signs over U.S. healthcare are clear indicators that it is undergoing truly tumultuous change. In addition to the consolidation of medical practices, greater provider-system alignment, interest in value-based payment reform, and increasing government involvement, the physicians that the PIAA companies insure are also changing: now, there are greater numbers of employed and part-time physicians.

What’s more, those physician populations are becoming more diverse, with ever greater numbers of non-white and non-male physicians.

My unscientific review of many of the major PIAA member companies’ websites indicates that their boards and senior management teams similarly reflect our insureds’ diversity. The members of PIAA have witnessed change before and have a long history of adapting. Whether they explicitly realize it or not, they are adapting by making their work force, as well as their boards, as diverse as the providers they serve.

After all, it comes down to a competitive advantage. Women, and myriad ethnic and cultural groups, bring a host of viewpoints and values that influence their purchasing decisions and ongoing loyalty. It is critical that company management and boards be aware of them in the many small and large decisions that go into gaining, securing, and serving their customer base.

Diversity, and the broad range of opinion that it engenders, can only help MPL companies face challenges, since it is precisely the out-of-the-box thinking and skills from culturally disparate points of view that can hold the key to the success of a new product or initiative. That’s doubly true in changing or highly competitive markets, where innovation can make the difference between growing and shrinking.

Regulators, policymakers, and politicians also support companies’ commitments to diversity, seeing it as a public good that serves larger societal interests. For example, while its actions may not specifically apply to many PIAA members, the Securities and Exchange Commission has identified diversity as an important factor in assessing the performance of a company’s board.

Best practices for diversity
This is not to say that diversity is the function of some sort of formulaic approach. The value of any employee or board member should ultimately
mately be skills-based. The point, however, is that individual skills are often enhanced, not diminished, by our backgrounds. Those varied skills can, in the right company ecosystem, add up to far more than just the sum of their parts.

Other than doing an intuitive comparison of the backgrounds of the individuals in their meeting rooms with their physician population, what other best practices can PIAA companies use to capitalize on this pace of change?

■ Company leadership needs to ask if the company’s workforce and board talent “pipeline” reflect its insured provider population. If not, it may be time to reexamine the assumptions that go into the building of a company’s stock of human capital.

■ Assess each individual’s commitment to diversity in board and senior management evaluations. While these assessments could simply examine if there is sufficient awareness of the issue, explicitly linking how well the person works to promote diversity with board performance evaluations and management-compensation arrangements is an important option.

■ Diversity (arguably) warrants inclusion as a regular agenda item or topic of discussion in C suites and board rooms.

Regulators, policy-makers, and politicians also support companies’ commitments to diversity, seeing it as a public good that serves larger societal interests.

■ The “tone at the top” needs to meaningfully convey a commitment to diversity, in action as well as in spoken word. Promoting persons who have achieved greater diversity, embracing it as a performance metric, and including it on the agenda will be for naught if senior leaders “talk the talk” without “walking the walk” every day, in actions both large and small.

The PIAA member companies remain at the center of healthcare reform. For what it’s worth, diversity has become a critically important success factor for the years ahead. Mr. Stills couldn’t have said it better: hooray for our side.

Learn more about diversity
3. Broysberg B, Bell D. Dysfunction in the Boardroom. Understanding the persistent gender gap at the highest levels. TPIAA
In light of the growing shortage of primary care physicians, this trend will likely continue, especially in rural areas where physician shortages are particularly acute. As more and more nurse practitioners expand their roster of responsibilities beyond their traditional role, they will experience risk exposures and medical professional liability (MPL) claims similar to those of primary care physicians, particularly those that result from an incorrect or delayed diagnosis.

As one of the largest providers of MPL insurance solutions for nurse practitioners, we at CNA are witness to this trend and its associated exposures. Every four years, we conduct a closed-claim study with the Nurses Services Organization (NSO) to provide nurse practitioners with a comprehensive overview of emerging risks. The most recent study, “Nurse Practitioner 2012 Liability Update: A Three-part Approach” (“CNA/NSO study”), revealed that nurse practitioners who worked in adult medical/primary care and family practice specialties were most likely to experience a claim (Table 1). The most frequent allegations made against nurse practitioners involved (Table 2):

- Failure to and/or delay in making a correct diagnosis
- Failure to provide proper treatment and care
- Medication prescription errors.

Please note the following definitions in regard to these figures:

- **Closed Claims:** Claims that closed between January 1, 2007 and December 31, 2011 and resulted in an indemnity payment of $10,000 or greater. The final CNA database for the “Nurse Practitioner 2012 Liability Update: A Three-part Approach” claim study comprised 200 nurse practitioner closed claims.

- **Paid indemnity:** Monies paid on behalf of a CNA-insured nurse practitioner in the settlement or judgment of a claim.

Diagnosis-related allegations accounted for 43% of all nurse practitioner closed claims between 2007 and 2011. Two allegations, failure to diagnose infection/abscess/sepsis and failure to diagnose cancer

---

**Nurse Practitioners: New Roles and Responsibilities Bring New Liability Exposures**

**BY LYNN PIERCE**

*One of the major shifts among medical service providers over the past few years is the increased scope of practice, and patient care responsibilities, assumed by nurse practitioners. They are no longer tertiary care providers; in many instances, they are now primary care providers.*

---

**Lynn Pierce, BSN, RN, CPHRM, is Risk Control Consultant, Healthcare, CNA.**
and benign tumors, accounted for more than half of these claims.

For example, in one claim scenario, a nurse practitioner performed two cryosurgical removal procedures of a lesion without considering the patient’s family history of melanoma, obtaining a biopsy, or consulting with the collaborating physician, dermatologist, or surgeon. The lesion was subsequently diagnosed as malignant melanoma, which metastasized to the patient’s brain and caused her death.

Overall, between 2009 and 2012, there was an increase in average paid indemnity for nurse practitioner claims: from $186,282 (2009) to $221,852 (2012).

An ounce of prevention

Becoming familiar with the most frequent allegations can help nurse practitioners identify strategies to help prevent errors and reduce exposure in various types of practice settings. Some of the strategies from the CNA/NSO study include:

- Practice within one’s clinical specialty and area of expertise.
- Comply with state regulations regarding physician involvement, including collaborative or supervisory agreements.
- Request and review the facility’s policies, procedures, and clinical protocols; obtain clarification and assistance or training, as needed.
- Obtain, review, and consider pertinent patient and family medical history, and document all findings.
- Perform patient clinical assessment and physical examination to evaluate and address the specific clinical issues under consideration.
- Engage in an informed consent discussion with the patient or responsible party, including, at a minimum, an explanation of the patient’s condition, the risks and benefits of the proposed procedure, the risks and benefits of alternative procedures or treatments, the right to decline treatment, and the risks of no treatment.
- Respond to patient questions or concerns prior to obtaining a witnessed, signed consent for the procedure.
- Establish the patient’s diagnosis by obtaining and documenting the results of biopsies and other appropriate diagnostics tests, as well as by initiating consultations and referrals, as indicated.
- Notify the practice as well as the MPL insurance carrier immediately after the unexpected death of a patient or whenever one’s actions may be under scrutiny.

### Table 1: Severity by Allegation Category
(Closed claims with indemnity payment of $10,000)

<table>
<thead>
<tr>
<th>Nurse practitioner specialty</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>1.0%</td>
<td>$1,050,000</td>
<td>$525,000</td>
</tr>
<tr>
<td>Women’s health (obstetrics)</td>
<td>2.5%</td>
<td>$2,185,000</td>
<td>$437,000</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>3.5%</td>
<td>$1,915,292</td>
<td>$273,613</td>
</tr>
<tr>
<td>Adult medical/primary care</td>
<td>52.0%</td>
<td>$26,349,319</td>
<td>$253,359</td>
</tr>
<tr>
<td>Women’s health (gynecology)</td>
<td>5.0%</td>
<td>$2,357,833</td>
<td>$235,783</td>
</tr>
<tr>
<td>Occupational health</td>
<td>0.5%</td>
<td>$225,000</td>
<td>$225,000</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>6.5%</td>
<td>$2,643,750</td>
<td>$203,365</td>
</tr>
<tr>
<td>Family practice</td>
<td>23.5%</td>
<td>$6,904,296</td>
<td>$146,890</td>
</tr>
<tr>
<td>Gerontology</td>
<td>1.0%</td>
<td>$272,500</td>
<td>$136,250</td>
</tr>
<tr>
<td>Aesthetics/cosmetics</td>
<td>4.5%</td>
<td>$467,500</td>
<td>$51,944</td>
</tr>
<tr>
<td>Overall</td>
<td>100.0%</td>
<td>$44,370,490</td>
<td>$221,852</td>
</tr>
</tbody>
</table>

### Table 2: Severity by Nurse Practitioner Specialty
(Closed claims with indemnity payment of $10,000)

<table>
<thead>
<tr>
<th>Allegations related to</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>1.5%</td>
<td>$965,000</td>
<td>$321,667</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>43.0%</td>
<td>$21,573,135</td>
<td>$250,850</td>
</tr>
<tr>
<td>Medication prescribing</td>
<td>16.5%</td>
<td>$7,640,197</td>
<td>$232,127</td>
</tr>
<tr>
<td>Treatment and care management</td>
<td>29.5%</td>
<td>$13,005,408</td>
<td>$220,431</td>
</tr>
<tr>
<td>Equipment</td>
<td>3.5%</td>
<td>$640,000</td>
<td>$91,429</td>
</tr>
<tr>
<td>Assessment</td>
<td>1.5%</td>
<td>$271,250</td>
<td>$90,417</td>
</tr>
<tr>
<td>Abuse/patient’s rights/professional conduct</td>
<td>3.5%</td>
<td>$216,000</td>
<td>$30,857</td>
</tr>
<tr>
<td>Communication</td>
<td>0.5%</td>
<td>$27,500</td>
<td>$27,500</td>
</tr>
<tr>
<td>Scope of practice</td>
<td>0.5%</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Overall</td>
<td>100.0%</td>
<td>$44,370,490</td>
<td>$221,852</td>
</tr>
</tbody>
</table>
In addition to these strategies, a self-assessment checklist may help nurse practitioners evaluate their diagnosis-related risk exposures. An extensive self-assessment checklist, which covers this topic, was included in the CNA/NSO claim study. Figure 1 shows one section of this assessment, on diagnosis. For each item in the list, the nurse practitioner checks off “Yes,” “No,” and if yes, notes the “Actions needed to reduce risks.”

Figure 1  CNA and NSO Risk Control Self-assessment Checklist for Nurse Practitioners

**Self-assessment topic: Diagnosis**
- I utilize an objective, evidence-based approach, applying organization-approved clinical guidelines and standards of care to timely and accurately determine the patient’s differential diagnosis.
- I consider the findings of the patient’s assessment, history and physical examination, as well as the patient’s expressed concerns, in establishing the diagnosis, and document my findings.
- I order and timely obtain results of appropriate diagnostic testing—including laboratory analysis, radiography, EKG, etc.—before determining the diagnosis, and document ordered tests and results.
- I consult with my collaborating/supervising physician, as required, to establish the diagnosis and treatment plan, and document all such encounters.
- I request, facilitate and obtain other appropriate consultations, as necessary, to achieve a timely and correct diagnosis.
- When establishing the diagnosis, I comply with the standard of care, as well as my facility’s policies, procedures, and clinical and documentation protocols. If a patient is unstable, acutely ill, and in need of immediate diagnostic testing and/or consultation, I refer him or her to hospital emergency care and facilitate this process, if necessary.
- If a diagnostic test or procedure involves risk, I conduct and document an informed consent discussion with the patient and obtain the patient’s witnessed consent.
- I order and timely obtain results of appropriate diagnostic testing—including laboratory analysis, radiography, EKG, etc.—before determining the diagnosis, and document ordered tests and results.
- I consult with my collaborating/supervising physician, as required, to establish the diagnosis and treatment plan, and document all such encounters.
- I request, facilitate and obtain other appropriate consultations, as necessary, to achieve a timely and correct diagnosis.
- When establishing the diagnosis, I comply with the standard of care, as well as my facility’s policies, procedures, and clinical and documentation protocols. If a patient is unstable, acutely ill, and in need of immediate diagnostic testing and/or consultation, I refer him or her to hospital emergency care and facilitate this process, if necessary.
- If a diagnostic test or procedure involves risk, I conduct and document an informed consent discussion with the patient and obtain the patient’s witnessed consent.
- I discuss clinical findings, diagnostic test/procedure results, consultant findings, diagnosis, the proposed treatment plan and reasonable expectations for a desired outcome with patients, in order to ensure their understanding of their care or treatment responsibilities. I document this process, noting the patient’s response.
- If the patient is uninsured or unable to afford necessary diagnostic and consultative procedures, I refer him or her for financial assistance, payment counseling, and/or free or low-cost alternatives, and document these actions.
- If I work in a state with autonomous nurse practitioner authority, I regularly seek peer review to assess my diagnostic skills and expertise and to identify opportunities for improvement.

**Conclusion**
Nurse practitioners must educate themselves to find out if their current services and practices may be leaving them vulnerable to patient complaints and potential litigation. By evaluating their practices in relation to the types of claims and losses experienced by their peers, nurse practitioners can potentially modify their clinical practice so as to enhance safety, while minimizing their exposure to liability.

**Disclaimer**
As the inclusion criteria in the "Nurse Practitioner 2012 Liability Update: A Three-part Approach" differ from those of prior CNA/NSO claims analysis and claim studies from other organizations, readers should exercise caution about comparing these finding with other reviews.
Simplify the Complexities of Your MPL Business

OneShield provides a proven, easy-to-use online and real-time rating and issuance system for complete lifecycle and customer management across all your products.

- Work in real-time with producers, practitioners and third-parties
- Customize rates and manage your own underwriting rules and STP
- Leverage integrated document management
- Rate and invoice down to the most discrete level
- Automatically upload large volumes of data

For more information visit www.oneshield.com/mpl or email info@oneshield.com

OneShield.com
First, what do you think will happen with ACOs if there’s a Republican takeover of the Senate this November, and maybe the White House as well in 2016? Will that be the end of new ACOs?

Muhlestein: We don’t expect a Republican takeover to end ACOs. One reason is that it’s generally a program that people are in favor of, because it’s designed to improve the quality of outcomes while lowering the cost of care. But what is probably the more important reason is that it’s not being driven by Medicare alone. State Medicaid plans are actually pursuing this, in both Republican and Democrat states. And there’s a lot of commercial activity around ACOs.

So even if Medicare didn’t expand ACO enrollment, ACOs would still continue to develop and expand.

IML: What should we be looking for—early indicators—to find out if ACOs are linked with greater numbers, or higher awards, of MPL suits?

Muhlestein: This one is tricky. We have seen only limited information on how ACOs respond to liability. There have been only a handful of reports on it. What we have seen is more people voicing their concerns about it, versus actually reporting data on it.

The only tangible evidence of reporting happens when the named provider in a claim is part of a Medicare program, and the ensuing settlement involves the ACO. Then, the settlement has to mention the ACO in some way. But this is really just a legal formality, and it hasn’t changed anything, as far as I’m aware.

So I would say there have been no early indicators, in terms of what companies should be looking for—they should just continue to watch the situation closely. There are exactly zero early indicators that I’m aware of regarding frequency or severity increases.

IML: All we have now are hypotheses as to what might happen, then?

Muhlestein: Correct.

IML: Are there any steps that MPL companies can take now to minimize the likelihood that providing coverage for ACOs will lead to more claims against providers?

Muhlestein: The concern that people have with ACOs is that—because providers get bonuses for a lower volume of service—they will be incentivized to not provide care that they should have provided.

The concern that people have with ACOs is that—because providers get bonuses for a lower volume of service—they will be incentivized to not provide care that they should have provided.
capitated payments to providers. So if you are a physician group, and you are taking fully capitated payments, you have an incentive to provide less care. In terms of liability, the ACO is basically the same model that we’ve seen in the past. There is precedent for it. MPL companies and providers can learn from their past experience.

So consider: if you’re going to insure a physician group that takes capitated payments, how are you going to do that? How are you going to manage the potential risk that they have? You’d be looking closely at the organization, identifying what your concerns are in advance, and so what you do is really based on that prior experience.

**IML:** Is there information about the response of health system risk managers to the challenges of ACOs? Will they need to play new roles?

**Muhlestein:** There is a wide variety of approaches. I’ll highlight just a few of them.

First of all, it starts with who is really making decisions about the ACO. In some cases, the ACO is being run by a health system CEO. So the same person has to make decisions about everything else. He is also responsible for the ACO.

In most cases, there is somebody else that is responsible. Sometimes, it’s coming from the chief medical officer, or it’s coming from the chief operating officer—there is a variety of people who are heading up the ACO. Who’s in charge, to a great extent, determines how he or she is going to look at the risk of the ACO.

When you’re focusing more from a chief medical officer standpoint, the focus is really on how to evolve the clinical care. They’re not necessarily seeing it as a new form of risk, just something that is going to continue to evolve.

If it’s the chief operating officer, they might be concerned about how running an ACO affects overall risk. They’ll be looking at the risks they’re taking on. And there is a long list of risks to consider. Of these, I would say that the liability risk is further down the list of their priorities, compared with financial risk.

That is where we are seeing a lot of activity in these ACOs—assessing what their financial risk could be and how they can manage it. Many of the organizations that are becoming ACOs don’t have any meaningful past experience with this sort of financial risk.

They are thinking about (for example) whether they need stop loss insurance. The liability side of it definitely comes into the picture, but it’s not nearly as important. Because if you can’t even figure out your healthcare claims risk, the liability issue is so far down the road that they’re not really thinking about it—at least not with the same degree of interest.

**IML:** Is there a wide variety of contracts used to establish an ACO—or are they all pretty much the same?

**Muhlestein:** Yes, there are many different types. They range from, at the simple side, what we would call an “upside only.” The way that the shared savings concept works here is that you project how much the population you are insuring is likely to cost this year.

Let’s say you expect that each patient will cost Medicare $10,000. Then you get to the end of the year and find out how much each patient actually cost. If it was $9,000, then there was a $1,000 per patient in savings. That savings is then split between Medicare and the ACO. There would be a $500-per-patient payment to the ACO.

In contrast, in a “two-sided-risk” arrangement, if, at the end of the year the cost per patient is $11,000, then the ACO would be responsible to send back a $500-per-patient check back to Medicare.

The high-ninety-percentage of all ACOs chose one-sided risk. So a lot of them—with Medicare at least—only have that upside risk. They do have to invest in the entire infrastructure needed to become an ACO. But basically there is only an opportunity for improved savings.

On the commercial side, there are also many models for ACOs. Some of them are upside-only shared savings arrangements. Some are two-sided shared savings. Some are fully capitated, with a per-member, per-month payment in advance, and the ACO is fully responsible for the population.

Then, there are variations within these basic models. Some are built around bundled payments. Some are built around partial capitation. And some are shared savings plans with P4P bonuses.

**IML:** Are these all in a sense experiments? Will we know ten years from now which of these is the best model?

**Muhlestein:** No. Every case is different. But they all share the same challenge with shared savings, since it’s based on the premise that there is an opportunity to lower future costs from what they would otherwise be.

This concept assumes that there is something like slack—room in the system to really pull out savings—because you are spending more than you reasonably should.

If you continue to get shared savings year over year, eventually your projected amount is going to be the same as what you can realistically save. So there is a finite life cycle to how long you can share in these savings year over year, until you’ve really shifted the cost curve down to what it should have been.

We project a three- to five-year period where shared savings is actually viable. What will happen after that point is the focus of a lot of discussion and uncertainty in the industry.
one switch to capitation, or set up their own insurance plans? Just how it’s going to work out isn’t known.

**IML:** Is this similar to what happened back in the 90s, with managed care? They had patients switch to generic drugs and eliminated unnecessary procedures—and then there was little more to squeeze out of the costs.

**Muhlestein:** No, this is different, because with ACOs much of the savings will derive from more closely coordinated and/or higher-quality care. This is something that will take longer, simply because it takes a lot of time and effort to implement all of these changes in how you’re actually delivering care.

In the course of a year, you can kind of stiff-arm people into using generics. But changing the process of care takes longer. That’s why it’s going to take time, but there will always be a finite limit just from the shared savings approach.

**IML:** Can you suggest some strategies for limiting exposure to MPL claims in the ACO environment?

**Muhlestein:** The first one is that ACOs need to get insurance—managed care insurance or some other cover. Some companies are starting to offer ACO-specific type products. That is very important. Until you fully understand what your risk is, you need to be protected.

Think of the worst-case scenario, at least initially, and protect yourself from that. Then, as the years go on, as ACOs have some familiarity with the operation and some data to compare against, they will have a better perspective on what their actual risk is.

But at least in the short term, I think it makes sense to have some amount of insurance. It doesn’t have to be full coverage insurance. It can be stop loss insurance, for instance.

Secondly, how should you work best with an incentive-based program? What you want to do is incent providers to not provide unnecessary care, but provide all of the necessary care that they should—and do it in an effective and efficient manner.

With any model—capitation, fee for service, ACO—there should be a look back a year later

---

**MPL Expert Witness Database**

*The MPL Industry’s First Choice for Sharing and Retrieving Expert Witness Information!*

**Features include:**
- Open to all MPL insurance entities
- Collects and stores documents in “real time”
- Archive includes video depositions
- Accessible 24/7
- Economical cost structure
- Houses a vast array of information on expert witnesses, in every sort of medical specialty
- Powered by Second Chair, the leader in witness-deposition management services

Give your defense team the same tools that personal injury lawyers have been using for years.

Join the list of companies using the MPL Expert Witness Database today!

Go to www.secondchair.com for more information or call Dennis Costello at 239.410.5797 or via e-mail at dcostello@secondchair.com
to see if there were any unintended consequences with this model. Consider whether this is something you should reevaluate going forward. Taking the time to do this is essential.

IML: Would adhering to evidence-based medicine as a safe harbor be an effective strategy?

Muhlestein: If there is a specialty society that has released a set of best practices for the management of some disease, then as long as you are following these practices— theoretically, you shouldn’t be able to be sued for it.

That’s the general concept, and it makes a lot of sense. But when it comes down to it, how can you tell if someone is really following the best practices, particularly when there may be competing recommendations from specialty societies, from the ACO itself (from physicians within the organization)? Everybody seems to have their own opinion about what the best practices are.

The second challenge, which a lot of people fear, is that if you practice in this one way, which was set out as the best practice, then you stop acting as a physician. You become more like a person just carrying out the orders.

There are probably a few conditions and situations where detailed guidance might work. But I think it’s going to be really hard to spell those out in legislation—and figure out what a “safe harbor” actually is.

IML: Do you have any general advice for the PIAA members—MPL entities?

Muhlestein: For the companies, I would say that you do already have experience with ACO-like entities. Just look at your past experience with managed care, and with capitated provider groups. In a lot of cases, it’s very similar. That’s what they can base their new ACO business on.

This is really not a big change in the liability side of healthcare. The change with ACOs is on the clinical side of healthcare.

The assumption with ACOs is that if you can provide better care, you will have better outcomes. So in that sense, it may lead to lower total volumes of liability claims. In that case, it could alter the MPL business over time—over the longer term.

So consider: if you’re going to insure a physician group that takes capitated payments, how are you going to do that?
After the quarterly review of your company’s investment portfolio and strategies, there is a good chance that you, as a board member, committee member, or part of the management team, have asked yourself, “How can I get access to these strategies?” or “Why does my personal portfolio look so different?” This article is the first in a series that will help you distinguish corporate from personal portfolio strategies. The articles will, eventually, provide some investment ideas that could be of personal benefit to you.

Table 1 outlines some basic differences in the profiles of the company’s portfolio vs. your personal portfolio.

- **Responsibility.** The key term here is “fiduciary,” which means someone who stands in a special relation of trust, confidence, and/or legal responsibility. As a member of your investment committee, you are in a position of trust and have a legal responsibility to review and approve investment decisions on behalf of the company. In your personal portfolio, which is based on your time horizon, your appetite for risk, and your expectations on investment returns, you cannot be held legally responsible for poor or imprudent investment decisions.

- **Time horizon.** Insurance company portfolios are typically split between two components—a general account and a surplus, or capital, portfolio. The general account usually comprises 100% investment-grade fixed-income securities (i.e., NAIC 1 and 2), with an asset duration that matches, or slightly exceeds, the company’s duration for its liabilities. Depending on your company’s metrics for its investments, BCAR, for example, the surplus portfolio can be invested across a broader spectrum of investments (i.e., in stocks) and the time horizon will be dictated by the investment objectives for the surplus (for example, to maintain or increase it) and risk tolerance. In your personal portfolio, your time horizon is not usually dictated by the timing of a liability stream. You can view your assets in total, as opposed to dividing them into general and surplus assets. Thus, the time horizon of your personal investments could vary significantly from that of the company’s time horizon.

- **Risk tolerance.** Insurance investment portfolios are invested conservatively; the company strives to maintain an optimal combination of investment return and underwriting income or loss. The general account, which constitutes a majority of the company’s total assets, seeks to generate current income to provide sufficient funds for the payment of claims, cover administrative expenses, and provide policyholder dividends. With any excess capital (surplus), the company can take on as much risk as the board feels is prudent for meeting the company’s overall business needs. In your personal portfolio, your risk tolerance is dependent on multiple factors, including time horizon, your age, income needs, spending requirements, etc. For this reason, you may want to assume a more aggressive posture on risk, something that most insurance companies cannot accommodate.

_T.C. Wilson_ is Managing Director-Investments and Institutional Consulting Director, The Optimal Service Group of Wells Fargo Advisors.
Revenue source. Premiums are the primary source of revenue for insurance companies, and they are collected to fund the overall operations of the company. If it is unable to write an adequate volume of premium, the company may fail to function and could eventually become insolvent. Hence, the retention of premium and the prudent investing of the cash flow from it are critical decisions that fall on the company. In your personal portfolio, the revenue source is primarily your personal income; you have control over how the money is allocated for your various personal expenditures. The decisions you make with your personal revenue affect only you.

Regulatory. The insurance industry is highly-regulated by A.M. Best, the NAIC, and the state of domicile of the company (or, where you write business). With increased oversight come certain investment restrictions and expectations that the company is encouraged, if not compelled, to comply with. A.M. Best looks at investment metrics such as extent of investment leverage (assets at risk as a percent of surplus) and the credit quality of the bond portfolio when determining your company’s rating. The NAIC expects securities to be rated by the Securities Valuation Office, and some states set limits on the types of investments that insurance companies are permitted to use. In your personal portfolio, you do not have to deal with regulations, so you do not have to dedicate an exuberant amount of resources to ensure compliance. This is a critical difference, given that the company’s investments are always under a microscope; and keeping tabs on this aspect of the portfolio entails a significant undertaking for the management team and staff.

Accounting. This can be a complex task for insurers, especially those that prudently take advantage of a wider range of investment opportunities like high-yield bonds, alternatives, foreign debt, and equity in ordinary shares. The details of ensuring proper registration of individual securities, monitoring other-than-temporary impairment situations, and documenting securities on the appropriate financial statement schedule can be both cumbersome and excruciating. One of the accounting “benefits,” though, is that the company can carry bonds at amortized cost if they are of investment grade quality (i.e., no lower than BBB-). This eliminates the interest rate risk if the bonds are held to maturity. With your personal portfolio, accounting is much simpler. Most of the challenges pertain to any alternative investments that you might hold or the taxes you can expect to pay. Also, your bonds are recorded as marked-to-market prices (current rather than historical values), and these values are therefore exposed to interest rate risk.

Asset class exposure. The number and types of asset classes that insurers have been able to invest in has evolved significantly over time. Regulators are becoming better educated about the risks and opportunities that proper diversification offers. Investment committees are more familiar with various types of investments that had previously been forbidden or misunderstood. In your personal portfolio, there is no limit to the number of asset classes in which you can invest. It used to be that minimum-dollar requirements limited your options, but now, with lower minimums and the increase in the availability of pooled vehicles (i.e., mutual funds and exchange-traded funds), you can, more or less, invest in the same types of asset classes.

While this article touched on the basic differences between your company’s portfolio and your personal portfolio, it does close on a significant similarity: asset class exposure. The next article in the series will delve into some of the investment opportunities that are appropriate for individual investors, not just institutions.

So, the next time you are in the board room reviewing investments, please keep some of these concepts in mind, and remember the importance of your fiduciary role with the company and how that affects the decisions you are considering.

Table 1 Corporate vs. Personal Portfolio

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Corporate Portfolio</th>
<th>Personal Portfolio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility</td>
<td>Corporate Portfolio</td>
<td>Personal Portfolio</td>
</tr>
<tr>
<td>Fiduciary</td>
<td>Based on liability duration and capital objectives</td>
<td>Usually not liability dependent and maximizes capital</td>
</tr>
<tr>
<td>Time horizon</td>
<td>Conservative</td>
<td>Conservative to aggressive</td>
</tr>
<tr>
<td>Risk tolerance</td>
<td>Risk tolerant</td>
<td>Risk tolerant</td>
</tr>
<tr>
<td>Revenue source</td>
<td>Premium</td>
<td>Personal income</td>
</tr>
<tr>
<td>Regulatory</td>
<td>State, NAIC, A.M. Best</td>
<td>None</td>
</tr>
<tr>
<td>Accounting</td>
<td>Complex</td>
<td>Modest</td>
</tr>
<tr>
<td>Asset class exposure</td>
<td>Limited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Footnote
1. Note that all investment and insurance products are not FDIC-insured; also, there is no bank guarantee, and they may lose value.
DEALING WITH THE RISKS OF TOMORROW

BY ERIC R. ANDERSON

There has been a good deal of talk recently about the proliferation of new risks for healthcare professionals in the wake of developments in the medical delivery system. Whether it is new models of care, increased patient loads and greater burdens in the management of care, or the focus on quality standards, the medical professional liability (MPL) community has done an admirable job of identifying, and then assessing, increased exposures caused by systemic upheaval.

But those are the risks we’ve had some sense of for a good while. Now, quite suddenly, we have had to confront the risks that emanate from the early attempts at care of patients with the unfamiliar Ebola virus.

The Ebola outbreak has taught us a lot, very quickly, about the critical elements needed for the robust containment of disease. But what have we learned of the repercussions of this outbreak for potential liability?

Since the passing of Thomas Eric Duncan, a Liberian national, in Dallas, questions have been raised about whether the doctors and nurses, and the hospital where he was treated, followed adequate protocols.

As those of us who work in MPL know only too well, hospitals and healthcare professionals who fail to diagnose a patient or lack proper protocols in the face of a disease like Ebola could face litigation—despite heroic efforts on the patient’s behalf. However, in light of Texas’s MPL standards for emergency department care, stemming from tort reform passed in 2003, a doctor has to have evidenced “willful and wanton negligence,” meaning that he knowingly put a patient at risk, to be held culpable. So, in this state, the plaintiff’s bar may need considerable creativity to file a successful claim.

But of course, healthcare professionals in states that don’t have MPL reforms like those in Texas or California may be considerably more vulnerable.

It is interesting to note that companies in industries other than healthcare may actually be at greater risk of legal action. In time, the threat of lawsuits could extend to include airlines and other businesses whose employees or customers might be exposed to the virus.

A passenger who contracted Ebola might have a case against an airline that allowed another passenger exhibiting symptoms of the disease to board a plane. It would seem that the airline could be accused of having been negligent in allowing the passenger to get on the plane in close quarters and infect other people, particularly if the plane was coming from a country with a known history of Ebola.

We don’t have to deal with the risks of events like those in airline travel in the MPL business. But we do have to remain vigilant in identifying and assessing the full spectrum of risks for healthcare providers who treat patients with highly communicable diseases.

We can also work to help organized medicine educate healthcare professionals and the public about the disease. PIAA companies have always made patient safety a top priority. I’m certain that, as in the past, we will use our deep knowledge of risk and its abatement to find ways to reduce the potential harm of superbugs like Ebola.

Eric R. Anderson is Director of Public Relations and Marketing at PIAA; eanderson@piaa.us.
Changes in the insurance industry making your job feel like the wild, wild West?

You can’t get the job done without the right tools. Delphi Technology is the only solution provider that gives you all the tools you need... an innovative technology solution, a seamlessly integrated suite of business solutions, AND more than 20 years of industry knowledge and business expertise.

* Thin-Client Browser-Based Web Application
* Extensible SOA Web Services
* Highly Scalable Architecture well adapted for Virtualization
* Efficient Modular Design
* Flexible Product Definition Workbench
* Highly Configurable Interface, Business Rules and Workflow
* Highly Configurable Dynamic Intelligent Web Portal Services Platform
* Industry-Leading Data Warehouse, Data Cubes and OLAP / Predictive Analytics

Let Delphi Technology help you transform your critical business challenges into measurable business results.

470 Atlantic Avenue, Suite 702
Boston, MA 02210

617-259-1200
www.Delphi-Tech.com
PIAA Medical Liability Conference
Las Vegas, Nevada


Visit www.piaa.us for More Information