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Preventive Action

Quarterly Risk Management Newsletter for Policyholders of FPIC

Second Quarter 2010
Vol. 23, No. 2

Can Your Practice Survive a Disaster?

By the Risk Management Experts at First Professionals Insurance Company

With the recent increase in the number of natural disasters, the approach of the anticipated active hurricane season, and potential threat of man-made disasters, physicians should review policies and procedures related to their individual disaster and recovery plans.

Just as you train to handle emergency medical situations that might arise, anticipating and preparing contingency plans for coping with natural and man-made disasters can make a significant difference in how well your practice survives the impact of such an event. Without a predefined plan to protect and recover operations, the odds are that most private practices will be unable to survive an extended business interruption. Recovery planning is essential. Even a minor business interruption can destroy a small business or private practice.

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To place a potential interruption of your practice into better focus, consider what occurred, or rather failed to occur following Hurricane Katrina in 2005. At three months post-Katrina, 75 percent of New Orleans remained uninhabitable.[1] Three out of four private-practice doctors had failed to return to their practices[2] and only two of nine pre-Katrina hospitals were open.[1] At five months post-Katrina, seven of those nine hospitals remained closed.[3] Two years after Katrina occurred, the private medical practices in the New Orleans area had not fully recovered. While having your office burn down or blow away would present a financial hardship to be sure, surviving without a revenue stream for an extended period of time is the more serious threat and challenge to financial recovery.

In developing a preparedness plan, consider your patients, your employees and staff members, the physical assets, and the supporting business associates of the practice. Effective loss prevention measures should be addressed as part of preparedness and recovery procedures.

Disaster and recovery planning is an integral component of risk management entailing:

- Self-assessment
- Business impact analysis
- Asset protection; and
- Recovery measures

Self-Assessment

Begin your D&R plan by conducting a self-assessment. Ask yourself if the practice can withstand a disruption. Is the practice likely to survive following the disruption? If so, for how long can it survive financially and to what extent? A few questions to address in a self-assessment include:

- What aspects of the practice need to be operational as soon as possible?
- Do you currently have a disaster response plan in place?
- Are vital records protected?
- Can the practice remain open, even if you cannot use or reach the office?

Business Impact Analysis

Conducting a business impact analysis (BIA) is a fundamental component of managing risk of any kind. All levels of staff should be asked to participate in the BIA. Analyze each of the critical processes that must be recovered following an unplanned disruption. Realistically consider the recovery time objectives associated with each of those processes. Estimate the economic impact that a disruption in each critical process will have to the practice cumulatively.

Do not assume that the same labs will be operable or that the same level of diagnostic services will remain available. A BIA should consider both diminished market share as well as increased market share. Indeed, your practice might very well be the only one in town that is up and running.

Normally, your practice relies on services provided by other business and professional entities. The availability

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For comments, questions or to obtain additional copies contact the First Professionals Insurance Company Risk Management department at 800-741-3742, ext. 3016.

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of these ancillary and derivative services that could possibly impact your practice operations following a disaster include:

- Pharmacies
- Diagnostic centers
- Hospitals
- Labs
- Imaging centers
- Medical & pharmaceutical supplies
- Ambulatory care facilities
- Billing and collections

Asset Protection

In terms of asset protection, consider the fact that your practice has both tangible and intangible assets – they may be the obvious and the not so obvious: the building, property and equipment, accounts receivable, ancillary investment and revenue streams and even the equity in the practice itself. When identifying your assets, include your employees, your "customer base" (patients), the tremendous amount of time that you have invested in the practice, and the future earnings potential of the practice. One of the major mistakes made in managing the risk of business interruption is limiting asset protection to that of tangible property.

A fundamental component of disaster planning is risk transfer – namely insurance. However, remember that not all losses can or will be covered by insurance. There will almost certainly be non-covered situations and unforeseen expenses due to policy deductibles, exclusions, depreciation factors, policy limits and damage caps. An important type of insurance to consider is business interruption coverage. This type of coverage helps to protect against economic loss due to lost revenue attributed to forced closure of the practice.

It is always a good idea to take photos or video of the practice to complement your inventory list. Secure insurance policies and other important documents at a location other than your practice. Maintain a current list of insurance agents and company contact information, as well as a listing of the other vendors your practice relies upon.

Recovery Measures

As part of a comprehensive recovery strategy, a business recovery plan should serve as a repository of critical recovery information to minimize both upstream and downstream losses. An important factor in successful business recovery is the availability of a temporary recovery location. This could include an agreement to work out of the office of another practitioner in the event a peril is confined solely to your office or location. Temporary space will likely be at premium, if available at all, following a hurricane or major storm.

Several assumptions should be considered when developing your business recovery plan:

- Practices and partnerships can and do dissolve
- Practice acquisitions and mergers often occur
- Downsizing can occur and greater outsourcing may be necessary
- Most practices will undergo a change of dependency in their distribution network to accommodate new market conditions
- Federal and state regulations may be implemented
- Local zoning and building codes can and do impact business recovery

Implementing a Plan

Now is the time to evaluate preparedness procedures, meet with office staff and address these issues. The use of a D&R Plan is an efficient loss prevention measure. Seek

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guidance from your insurance agent, accountant or personal attorney. An hour or two spent discussing preparedness can help avoid chaos and confusion, reduce exposure to loss and maintain patient safety if and when your practice is faced with a disaster.

While there is no one way to predict how well a medical practice will survive the next disaster, one thing is for certain: some things will be temporary, some things will be permanent, some things will be worse, and some things will be better, but nothing will ever be the same.

References
[1] USA Today, December 19, 2005
[2] Parish County Medical Society
[3] Louisiana Hospital Association

First Professionals Insurance Company has developed an easy-to-use guide, ***Disaster and Recovery Plan: Physician Office Practice***, to help identify key areas of a medical practice that could be impacted by a natural or man-made disaster. To obtain a complimentary copy, contact the Risk Management Department at (800) 741-3742, extension 3016 or send an e-mail to rm@fpic.com.

Reporting Impaired Drivers

Occasionally, a physician will encounter a patient whose ability to operate a vehicle has become compromised due to physical or mental illness. Impairment is most commonly attributed to advanced age, diminished vision, poor reflexes and failing mental capacity. Such chronic conditions often create a dilemma for the practitioner who is placed in the uncomfortable position of having to advise the patient to cease operating a motor vehicle. However, driving is a difficult privilege to relinquish and may very well represent a patient's last vestige of independence and dignity. This begs the question: Does a physician have a duty to report an impaired driver?

Reporting requirements and reporting thresholds vary by state. Florida does not have a mandatory "Duty to Report" impaired driver statute or administrative rule (for physicians). Consequently, a physician cannot be sanctioned from a disciplinary standpoint for failing to report.

However, in Florida a physician may report a patient impairment if, in the physician's judgment, the patient is at risk of harming himself or others.

Section 322.126 (2), (3), Florida Statutes, provides that "Any physician, person, or agency having knowledge of any licensed driver's or applicant's mental or physical disability to drive... is authorized to report such knowledge to the Department of Highway Safety and Motor Vehicles... The reports authorized by this section shall be confidential... No civil or criminal action may be brought against any physician, person, or agency who provides the information required herein."

It is important to determine if the impairment – i.e. a seizure disorder – is an "uncontrolled" disorder. If medication or therapy renders the medical condition a "controlled" disorder, then reporting is generally unnecessary.

News Alerts

Doctors and Risk Managers Take Different Approach to Disclosing Adverse Events

Hospital risk managers are more likely to favor telling patients about mistakes, but physicians are more likely to offer full apologies. When adverse events occur and patients incur harm, doctors and risk managers have reasons to fear telling patients what happened and offering an apology. For a physician, the result could be a years-long MPL lawsuit. For a risk manager, the hospital's bottom line could be hurt. So it might be expected that there may be differences in how these two groups approach the issue of disclosure. A new study has found that physicians are more hesitant than risk managers to tell patients when an error occurs. But doctors are likelier than risk managers to use the word "error" in describing the mistakes and are quicker to say, "I'm sorry." The study was published in the March Joint Commission Journal on Quality and Patient Safety. Nearly 3,000 risk managers at healthcare facilities nationwide were surveyed in 2004 and 2005 for the study. More than 1,300 doctors in Washington state and Missouri were surveyed in 2003 and 2004. Each group was faced with the same scenarios in which patients were seriously injured by errors—a sloppily written prescription order, a missed lab test—and asked what would be told to the patients. Three-quarters of risk managers said they favored disclosure in the error scenarios, compared with half of physicians. But 56% of physicians said they would use the word "error" to describe the mistakes, compared with

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42% of risk managers. Four in 10 doctors would offer a “full apology,” compared with 21% of risk managers. (***American Medical News***, 3/8/10)

Hospital Infections Resulted in 48,000 Deaths in 2006, Report Shows

Pneumonia and blood-borne infections caught in U.S. hospitals cost $8.1 billion and resulted in 48,000 patient deaths in 2006, according to a new report. The study is one of the first to put a price tag on hospital infections, which some experts say is worsening and adding to the growing cost of healthcare in the United States. “In many cases, these conditions could have been avoided with better infection control in hospitals,” said Ramanan Laxminarayan of Resources for the Future, a think tank that sponsored the study. Sepsis—a blood infection—killed 20 percent of patients who developed it after surgery, the study reported in the Archives of Internal Medicine. Laxminarayan and colleagues studied hospital discharge records from 69 million patients at hospitals in 40 U.S. states between 1998 and 2006, looking for two diagnoses—hospital-acquired pneumonia and sepsis. Patients who developed sepsis after surgery had to stay in the hospital on average nearly 11 days extra, at a cost of $32,900 per patient, they found. And just under 20 percent of them died. Pneumonia patients stayed an extra 14 days after surgery, at a cost of $46,400 and more than 11 percent of them died, the researchers found. “That’s the tragedy of such cases,” said Anup Malani of the University of Chicago, who worked on the study. “In some cases, relatively healthy people check into the hospital for routine surgery. They develop sepsis because of a lapse in infection control and they can die.” (***MSNBC***, 2/22/10)

National Practitioner Data Bank Expanded

Now, the National Practitioner Data Bank (NPDB) will include disciplinary information on all of the licensed healthcare professionals, not just on physicians, in accordance with a new federal rule. The new rule— which is a result of the implementation of Section 1921 of the Social Security Act—expands the data bank to include chiropractors, nurses, podiatrists, and physician assistants. A final rule published on January 28 by the Department of Health and Human Services broadened the scope of data reported to the Health Resources and Services Administration, in the interest of patient safety. The regulation, set to take effect March 1, also requires that new kinds of organizations, such as peer review and private accreditation organizations, report adverse actions against health professionals. The NPDB already had similar reporting requirements regarding doctors. The recent changes were mandated to incorporate statutory requirements in the Medicare and Medicaid Patient and Program Protection Act of 1987 and the Omnibus Budget Reconciliation Act of 1990. (***American Medical News***, 3/8/10)

HIPAA Risk Management Product

Reducing Liability:
HIPAA Compliance Guide

First Professionals is pleased to announce the development and release of our most recent risk management product: ***Reducing Liability – HIPAA Compliance Guide***. This guide was developed as a comprehensive risk management reference tool that utilizes a highly-focused approach to HIPAA issues.

This reference guide contains information regarding many of the HIPAA liability challenges commonly confronted by practitioners, including:

- Privacy Rule Requirements
- Security Rule Requirements
- Risk Management Guidelines
- Office Forms for Physician Practices
- Brochures for Distribution to Patients

Reducing Liability – HIPAA Compliance Guide evidences First Professionals’ commitment to effective risk management products and services for our policyholders. This publication is available in hard copy and, for your convenience, USB flash drives.

To request your copy of this new risk management product, please call our Risk Management Department at (800) 741-3742, ext. 3016 or send an e-mail to rm@fpic.com.

Case Study: Failure to Diagnose Inadequate Surgical Margins

Editor's Note: This case analysis reflects an actual First Professionals' case.

Case Analysis

A 56-year-old male was seen in consultation by a dermatologist for a lesion on the left thumb in January. It was diagnosed and treated uneventfully as a wart. Six months later the lesion recurred. Biopsy, desiccation and cautery were performed. Pathology revealed squamous cell carcinoma. However, the patient was not advised of the pathology nor was there any evidence that the physician reviewed the pathology report. In November of the following year, the lesion again recurred and was treated in a similar fashion - pathology again indicated squamous cell carcinoma. The wound subsequently healed poorly and care was transferred to another dermatologist. Due to metastasis, the patient ultimately underwent amputation of the thumb. Suit was filed against the dermatologist alleging delay in diagnosis and improper treatment resulting in disfigurement and decreased prognosis. Experts were unable to support a defense in light of the initial biopsy report that revealed inadequate surgical margins, necessitating follow-up for a wider excision.

Risk Management Discussion

Documentation is a key tool for defending medical malpractice cases. The lack of supporting documentation may actually contribute to a finding of negligence. Consider the following recommendations:

- Review and initial diagnostic studies/reports and document patient discussions as well as treatment rationale
- Confirm that the results of diagnostic studies does not warrant further follow-up
- Utilize informed consent, outlining potential risks and benefits as well as alternative treatments:
    - ✓ Do not delegate Informed Consent discussions
    - ✓ Disclose those increased risks and complications unique to the patient
    - ✓ Document your discussion
    - ✓ Obtain formal consent – copy the patient
    - ✓ Use and catalogue educational material
    - ✓ Obtain informed refusal
    - ✓ The more elective the procedure, the more discussion
- Provide patients with educational materials regarding their medical conditions
- Document patient compliance and non-compliance
- Send written confirmation of the need for follow-up care and treatment

This information does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. First Professionals recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

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Legal FAQs

For information specific to your state of practice, contact First Professionals' Risk Management department

What procedures should be followed when actual or suspected biological/chemical exposure is encountered?

Physicians should follow current guidelines issued by the Department of Health, Centers for Disease Control, and County Medical Societies. Carefully document in the patient's chart the severity of symptoms and your clinical examination and findings.

Are there restrictions on physician advertisements?

According to the AMA guideline E-5.02 Advertising and Publicity, "there are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices." Pursuant to the AMA, "objective claims regarding experience, competence, and the quality of the physicians and services they provide may be made only if they are factually supportable."

If the patient is present and has the capacity to make healthcare decisions, when does HIPAA allow a healthcare provider to discuss the patient's health information with the patient's family, friends, or others involved in the patient's care or payment for care?

If the patient is present and has the capacity to make healthcare decisions, a healthcare provider may discuss the patient's health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object. A healthcare provider also may share information with these persons if, using professional judgment, he or she decides that the patient does not object. In either case, the healthcare provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care.

What is the purpose of a "Business Associate agreement"?

HIPAA privacy rules require that healthcare providers enter into a Business Associate Agreement in order to obtain assurance that business associates will safeguard the personal health information received or exchanged in connection with a healthcare provider.

Must a physician sign all progress notes made?

Although state law does not specifically require a signature, Medicare, Medicaid and most HMO's require such documentation.

Is a waiver by the patient an exception to the obligation of obtaining informed consent?

Yes. If an adult patient insists upon not being informed of the nature of the procedure or risks attendant to it, then the patient relieves the physician of the obligation to obtain an informed consent.