Vital Sounds
A Newsletter for Health Care Professionals and Facilities
KaMMCO
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Save the Date—September 12, KaMMCO Announces Fall Loss Prevention Event

Mark your calendar now for the KaMMCO Fall 2017 Loss Prevention Event! Physicians and healthcare professionals across the state are invited to "Finding Joy in Medicine Again," presented by Starla Fitch, MD, wellness expert, life coach, and inspirational speaker. It's a *one-of-a-kind* event on Tuesday, September 12.

Starla Fitch, MD
Physician, Professional Speaker, Physician Wellness Consultant, Certified Life Coach

"Dr. Fitch is a dynamic and energetic speaker who seeks ways to help physicians remember the joy and satisfaction of practicing medicine," said Shannon Haire, KaMMCO Vice President of Member Services. Dr. Fitch will make her presentation at the KaMMCO Conference Center, Topeka. The event will be live-webcast to four additional Kansas locations:

- Hays – Ft. Hays State University Memorial Union
- Overland Park – Overland Park Marriott
- Salina – The Tony's Pizza Event Center (formerly the Bicentennial Center)
- Wichita – DoubleTree by Hilton Wichita Airport

Just as in past years, members are encouraged to attend one of the in-person locations to share the experience with their peers. Individuals may also choose to view the event on their personal computer from their office or home. More details on the viewing options will be released at a later date. In addition, the event will be recorded, so those who cannot attend on September 12, will have the opportunity to view the recording on KaMMCO's website. All viewing options will offer the 5 percent policy premium credit for attendance for a specified period of time following the event.

There will be more details coming soon regarding Fall 2017 Loss Prevention! In the meantime, if you have questions, contact Janie Rutherford, KaMMCO Education Coordinator, jrutherford@kammco.com.

Have you heard? CMS Emergency Preparedness Rule Effective November 2017

By Connie Dyke Christian, MBA, CPHRM
Facility Risk Management & Patient Safety Advisor

The Centers for Medicare and Medicaid (CMS) Emergency Preparedness Rule was effective November 16, 2016, with an implementation date of November 16, 2017. The rule requires emergency preparedness planning as a Condition of Participation for those providers receiving Medicare and Medicaid funds. The goal of the rule is to establish consistent emergency preparedness requirements, improve patient safety during emergencies and establish a coordinated response to both natural and man-made disasters such as severe weather, earthquakes, wildfires, infectious epidemics and homeland security threats.

CMS has identified three key essentials for maintaining continued access to healthcare during an emergency: safeguarding human resources, maintaining business continuity, and protecting physical resources.

The four core elements of the rule include:

1. Address your facility's risk assessment (different from the HIPAA/HITECH risk assessment) and emergency planning by using an "all-hazards" approach to mitigate risk.

2. Develop and implement policies and procedures that support the execution of the emergency plan.
3. Establish a communication plan.
4. Provide a well-organized training program, including annual refresher programs.

Those entities required to comply with the Emergency Preparedness rule include:

- Religious Nonmedical Health Care Institutions (RNHCI)
- Ambulatory Surgical Centers (ASC)
- Hospices
- Inpatient Psychiatric Services for individuals under age 21 in Psychiatric Residential Treatment Facilities (PRTF)
- Programs of All-Inclusive Care for the Elderly (PACE)
- Hospitals
- Transplant Centers
- Long Term Care (LTC) Facilities
- Nursing Facilities (NF)
- Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID)
- Home Health Agencies (HHA)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Critical Access Hospitals (CAH)
- Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
- Community Mental Health Centers (CMHC)
- Organ Procurement Organizations (OPO)
- Rural Health Clinics (RHC)
- Federally Qualified Health Centers (FQHC)
- End Stage Renal Disease (ESRD) Facilities

With implementation on the horizon in November, 2017, there are only six months to finalize Emergency Operations plans, determine communication methods, acquire additional equipment and train staff. KaMMCO encourages insureds to review the resources available for a successful implementation.

Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers final rule: www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid

Downloadable plans and procedures - US Department of Health and Human Services (HHS) Health Care Emergency Preparedness Information Gateway: https://asprtracie.hhs.gov/

Downloadable Quick Reference Table - CMS Emergency Preparedness Requirements by Provider Type: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/EP-Rule-Table-Provider-Type.pdf

Kansas Department of Health and Environment Emergency Preparedness Grant Program for Hospitals and Health Agencies: http://www.kdheks.gov/cphp/index.htm

KaMMCO Emergency/Disaster Preparedness Checklist for Physician Practices. www.KaMMCO.com Member Services, Resources and Tools, Sample Policies and Forms.

Low Health Literacy: Serious Barrier to Quality Healthcare

Three facts on low health literacy:

- More than 90 million Americans are affected by low health literacy;
- Low health literacy costs the US healthcare system an estimated $73 billion annually in unnecessary doctor visits, hospitalizations and longer hospital stays; and
- All segments of the US population are affected, particularly older patients and those with chronic illnesses.

So what can your practice do to combat low health literacy?

Have your staff register to attend **Health Literacy: What's at Stake for Physicians and Patients**, a one-hour webinar on Wednesday, May 24, presented by Yolanda Sims, JD, MHA, KaMMCO Loss Prevention & Risk Management Advisor. Beginning at 12 p.m., this educational event will help KaMMCO members improve communications with patients.

At the conclusion of this program, attendees will be able to:

- Identify the warning signs of patients who may have low literacy;
- Remove elements of confusion when communicating with low literacy patients; and
- Understand how to better communicate basic health information and services.

To register for this webinar, visit www.KaMMCO.com/Events.

Tips from the Trenches: Claims Update

By: Cristy Anderson, JD
KaMMCO Vice President Claims

Specialty: Surgery - Urological

Procedure: On 7/23/11, this 57 year-old male with a history of hypertension, diabetes, previous angioplasty with cardiac stenting, recurrent hematuria and history of smoking was admitted to the hospital with complaints of shortness of breath and fever. A CT angiogram revealed a pulmonary embolism and lab work indicated a possible UTI. A kidney ultrasound revealed a normal right kidney and a simple renal cyst on the left kidney. The patient's condition did not improve and he was transferred to a larger facility. A CT scan was performed which revealed a 4.5 cm cyst on the left kidney and a "5.4 x 4.3 cm mass on the right kidney, renal cell carcinoma should be a consideration, carbuncles would also have to be entertained in the setting of sepsis." The KaMMCO insured was consulted and saw the patient. After consultation with the patient, the insured performed a laparoscopic nephrectomy and pathology revealed acute and chronic pyelonephritis with a large infarct and abscess formation. The patient was discharged from the hospital.

Allegations: The Claimant alleged the KaMMCO insured misdiagnosed the right renal abscess, did not offer percutaneous aspiration of the renal abscess, and lacked informed consent for a radical nephrectomy. The Claimant further alleged that as a result of negligence, he underwent an unnecessary radical nephrectomy and suffered a decline in renal function and associated permanent damages and delay in cardiac stenting as a decision was made not to place a coronary stent prior to the nephrectomy because this would require anticoagulation therapy that would have precluded surgery.

Resolution: This case was tried to a jury, twice. The first trial resulted in a mistrial because of a "hung jury." In other words, the jury deliberated for 9.5 hours but could not reach a decision as to whether the physician deviated from the standard of care. It was discovered after interviewing the

jury that eight jurors were in favor of the physician and four were in favor of the patient. In order for a jury to reach a decision on the verdict, they must reach a 10 to 2 consensus. The attorney, the insured and KaMMCO felt strongly about continuing to defend the care provided by the insured, even if that meant another trial. Therefore, the case went to trial again with a new jury eight months after the first trial. The second time the jury found in favor of the insured physician after 4.25 hours of deliberation.

Cost of Defense: $242,903

Risk Management Tips:

1. Have a complete "informed consent" discussion with the patient prior to surgery.
2. When possible, informed consent should include alternative, less invasive options along with the risks and benefits of electing those options.
3. Informed consent should also include the fact that unexpected results are possible.
4. Always document informed consent discussions and allow time for questions and answers.

Loss Prevention Tips:

If you feel the care you provided met the standard of care and your defense team feels your care is defensible, you may have to withstand quite an endurance test before reaching closure. Continue to trust in yourself and your team throughout this process for the best results.

Recent OCR Settlements Serve as a Cautionary Reminder to be HIPAA Compliant

By: Yolanda Sims, JD, MHA
KaMMCO Loss Prevention & Risk Management Advisor

The Office of Civil Rights (OCR), the enforcement arm of the Department of Health and Human Services, has agreed to its first settlement involving the wireless service provider, CardioNet, a Pennsylvania-based company. CardioNet manufactures wireless remote devices that produce real-time results and analysis for patients at risk for cardiac arrhythmias. The company reported a breach to OCR in January, 2012, indicating a workforce member's laptop was stolen from a car outside of the employee's home. The laptop contained unsecured electronic protected health information (ePHI) for more than 1300 individuals.

OCR's investigation revealed CardioNet had insufficient risk analysis and risk management processes in place at the time of theft. Additional findings include: the HIPAA Security Rule had not been implemented and their policies and procedures for the Rule were still in draft form. Further, the organization was unable to produce any final policies and procedures regarding the implementation of safeguards for ePHI. On April 24, 2017, five years after the breach, OCR announced CardioNet agreed to implement a corrective action plan and pay $2.5 million.

Also in April, OCR announced two additional healthcare entities agreed to pay settlements for HIPAA violations and noncompliance under the HIPAA Privacy and Security Rules. Metro Community Provider Network (MCPN), a federally qualified health clinic in Denver, Colo., agreed to pay $400,000 for failing to conduct an appropriate risk analysis to identify vulnerabilities, as required by the Security Rule. MCPN provides primary medical care, dental care, pharmacy, social work and behavioral health care services to patients throughout the Denver metropolitan area, the majority of whom fall at or below the poverty level. A breach report was submitted to OCR on January 27, 2012 indicating that a hacker accessed employees' email accounts and obtained 3,200 individuals ePHI through a phishing scam. OCR investigated and found MCPN took necessary corrective measures to respond to the breach, but it failed to conduct a risk analysis until mid-February.

The other organization is The Center for Children's Digestive Health, a small healthcare provider with a pediatric sub-specialty practice with seven locations in Illinois. The center agreed to pay $31,000 for failing to establish a business associate agreement (BAA) with Filefax, a records storage company. OCR began a compliance review of the practice's business associates in August 2015, which revealed no BAA was on file. Filefax began storing records for the center in 2003, but upon request, neither party could produce a signed BAA prior to October 12, 2015.

Generally, organizations settle with the OCR over complaints or potential violations before civil monetary penalties are levied. Penalties are assessed on a per violation basis and can add up quickly, well in excess of $1.2 million.

To date, OCR settlements have highlighted deficiencies in several of the following areas:

- Security Risk Analysis/Management
- HIPAA Workforce Training
- Breach Notification Content and Timeliness
- Portable Device Security
- Encryption/Transmission Security
- BAAs: missing, non-existent or unsigned

OCR advisers have hinted that more onsite HIPAA audits will continue in 2017. To avoid a potentially costly mistake, dedicate time to understanding how the HIPAA Security Rules apply to your organization, develop and implement meaningful policies and procedures, and conduct periodic audits to ensure compliance. Visit http://www.hhs.gov/ocr/hipaa for the latest guidance, tools, resources, FAQs and other information on the HIPAA Security Rule.

Keep in mind KaMMCO members have additional resources available through KaMMCO cyber security insurance. For more information, visit, http://www.kammco.com/Insurance/Cyber-Security-Insurance.aspx.

Key pieces of advice as physicians begin participating in the Quality Payment Program

By: James Walton, DO, MBA, FACP
President, CEO Genesis Physicians Group

Editor's note: KaMMCO has committed to providing multiple opportunities for physicians to learn more about MACRA and the steps necessary to be compliant in this first year of the Quality Payment Program.

On April 24, Jim Walton, DO, President and CEO of Genesis Physicians Group, presented a webinar on "Using Data to Improve Care Delivery." During the question and answer portion of the event, he offered the following "advice" for doctors and practice managers. We wanted to share his insightful comments with those who could not be on the call. We also would like to remind members that there are MACRA educational opportunities upcoming in June, July and August. For more information, visit www.KAMMCO.com/events.

What are the key pieces of advice for doctors and practice managers, and the things they need to be thinking about in the next year with regards to MACRA?

Number 1, they need to get ready to use data and move into this data-driven atmosphere. Generally, the provider community is starting to mobilize and respond to what they understand about the MACRA/MIPS (i.e. QPP) regulations.

But there's still a lot of confusion about how a practice will successfully respond, because it seems daunting to our practices. Clearly, this change is not isolated to Medicare, and all providers should expect this trend around data collection and utilization to increase,

whether or not the current administration in Washington delays the rollout of QPP. It reminds me of the ICD 10 rollout; it got delayed, but ultimately it has become part of the practice landscape. Similarly, along with MACRA and MIPS, the commercial payer community also has joined the bandwagon and is looking for data information.

And Number 2, we all know that ACOs (Affordable Care Organizations) got tainted a little because of its connection to the timing of the ACA (Affordable Care Act) and Obamacare rollout. The whole idea of ACOs became a negative in some quarters because of its proximity to the ACA. The ACO language was imbedded in the ACA legislation, but the truth is, our healthcare costs are so poorly controlled that the rate of cost increase is driving the innovation and change around how doctors and providers get paid. I don't see that changing.

The pressure on healthcare cost is going to continue to go up--patients demand more services, patients are more ill, have more chronic conditions, surviving longer with more complexity, while our treatment choices continue to expand exponentially. As such, the high quality care doctors provide day-in and day-out becomes much more difficult. The new ideas of how to pay doctors differently for producing results are here to stay, and will only accelerate in the near future as the total costs of care continue to grow.

Finally, it's important for practices to develop a plan and say "let's start planning on how we use data more effectively to manage the care we deliver." There are organizations like KHS (KaMMCO Health Solutions), KHIN (Kansas Health Information Network) and PTN (Kansas' Practice Transformation Network), that are available to facilitate planning discussions so physicians and practices can move forward. I'm working with about 350 specialists in our community (North Texas) doing just that. Approximately nine different independent specialty physician groups are now collaborating, to share the costs of collecting, analyzing and reporting data for care delivery improvement. Together, they will develop one IT solution that they will share to help them remain independent while succeeding in the new healthcare market.

New MACRA resources available

CMS has published new resources on the Merit-based Incentive Payment System (MIPS), one of two new payment pathways for clinicians under the Medicare Access and CHIP Reauthorization Act of 2015. You will find helpful links on KaMMCO's Quality Payment Program (QPP) Resources page. www.kammco.com/Member-Services/Member-Services-Education.aspx

- Explore QPP Measures: https://qpp.cms.gov/measures/quality
- MIPS participation factsheet: https://qpp.cms.gov/docs/QPP_MIPS_Participation_Fact_Sheet.pdf
- MIPS improvement factsheet: https://qpp.cms.gov/docs/QPP_2017_Improvement_Activities_Fact_Sheet.pdf
- MIPS list of registries: https://qpp.cms.gov/docs/QPP_MIPS_2017_Qualified_Registries.pdf

PDSA tool results in positive changes

Amber Dawson had been at her new job as Administrator of Sumner County Family Care Center only a few days when she opened an email from Jill Daughtee, Kanas Practice Transformation Network (PTN) Quality Improvement Advisor (QIA).

With 11 providers and 30 employees, the Sumner County Family Care Center, Wellington is celebrating 40 years of service, however, a string of administrative turnovers had left the lines of communication down and employee moral down, too. Amber wanted to change that and PTN offered the tools.

Sumner County Family Care Center physicians include (l-r): Lacie Gregory, M.D., Stephen Hawks, D.O., Joel Weigand, M.D., Steven Scheufler, M.D., and Shana Jarmer, M.D. Not Pictured: Larry Anderson, M.D.

One of the tools PTN offers participants is a PDSA worksheet. “It stands for Plan/Do/Study/Act,” Jill explained. It’s an organized approach to quality improvement that asks the questions: What do we want to improve? Where are we now? Where do we want to be? When do we want to be there? What are the steps we need to do to meet this goal? Who will do the work and when will they do the work? How will we know our change had a positive impact? The worksheet is simple.

At their first meeting, Amber recognized the potential of the PDSA. “Amber embraced use of the PDSA,” Jill said, “and that quickly resulted in improvement in five of the Transforming Clinical Practice Initiative (TCPI) change concepts which all PTN practices recognize from the assessments we perform every six months.”

“I was thinking on a very broad scale,” Amber said. “Communication had broken down and things were deteriorating. I wanted to bring everybody back together. We’re all here for one goal and that’s the patient. I wanted to find a way to keep staff motivated and excited to come to work.”

She started with lots of meetings–meetings with the doctors, meetings with the supervisors, meetings with front end staff, and quarterly meetings that brought everyone together. She incorporated the PDSA tool into the meetings, using it to identify areas that needed improvement, and making the meetings worthwhile and productive. “I told them, ‘Bring your PDSA and we’ll talk about where you are.’”

Since starting her position in February, Amber is encouraging staff to use the PDSAs for their annual evaluations as well. She sees its influence as staff start to initiate new projects. “They’re getting innovative and every day they are thinking about new ways to move the clinic forward.” They “feel like they have a voice again, that their opinion matters.”

“The PDSA will help me, too,” Amber said, as she has plans to increase community involvement, design a new website and more. Measurable improvement will be helpful when she wants to talk to management about expansion. “I’ll have the numbers to back-up my case.” Morale is improving, too. The staff is finding opportunities to get together outside of the office.

Amber is quick to appreciate the PTN and Jill’s assistance. “There’s never a time when she’s not been available to help me, even if it was a quick phone call or email. She’s really been my life support. Additionally, Jill was helpful in connecting me with others who have similar situations.”

“Amber is a great example of a leader who embraces quality improvement and empowers staff to innovate and improve,” Jill said. “She was already wanting to map their progress and she recognized right away that she could use the PDSA in a number of ways to help the practice. When a practice begins to incorporate the change methodology throughout, we start to really have fun making impactful improvements.”