MIEC

The Exchange

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INSIDE

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From Underwriting: Liability Risks of Indemnification Clauses

By: Susan F. Halman, Esq. from Selvin, Wraith, Halman LLP, Oakland, CA

An indemnification clause in a professional service agreement ("PSA") can create onerous and uninsured financial exposures when it requires the physician to assume liability for risks outside of their control. Before signing a PSA that contains an indemnification clause, it is important to understand the breadth of the parties' respective indemnity obligations, and the extent to which you will be assuming a duty to defend and indemnify third parties for liability exposures that are not insured by your MIEC policy.

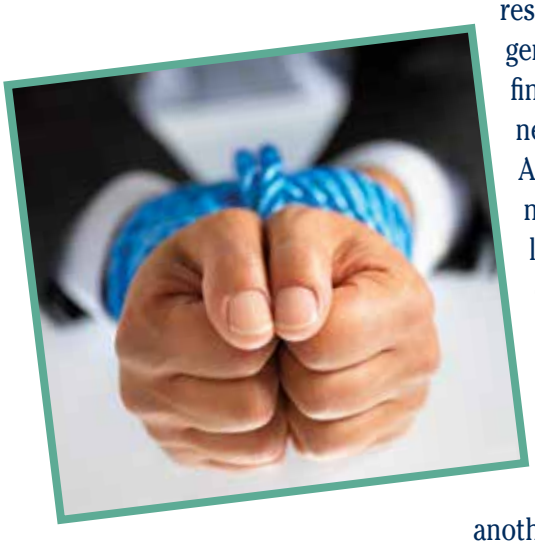
An indemnification clause operates to allocate legal risks between the parties to the PSA. For example, a risk-transferring indemnification clause in a PSA may state:

> " Physician shall defend, indemnify and hold harmless the Medical Center from any and all liability claims, losses, damages, expenses, costs, and attorney's fees which Medical Center may incur, suffer, or sustain or be threatened with arising in whole or in part from or related to Physician's professional services, medical conduct, medical acts or omissions, including specific directions given by Physician to non-physician personnel, or performance or failure to perform any service set out in this Agreement, or in any manner related to Physician's performance at the Medical Center."

Under this type of indemnification clause, the physician may be held liable to defend and indemnify the Medical Center for all of the Medical Center's liability exposure for a claimant's damages – even that portion of the damages that are not arising directly from the physician's own professional services. This contractual obligation can place a tremendous financial burden upon the physician. In

addition, some states interpret an indemnification clause that contains a duty to defend as requiring the physician to begin defending immediately upon receiving the medical center's tender of a claim merely alleging the physician's liability for the claimant's injury, rather than to reimburse the medical center for its attorneys' fees and costs after the physician's liability for the claimant's injury is proven.

Recently, MIEC has seen an increase in cross-claims for contractual indemnity filed against its physician policyholders by co-defendants – e.g., a medical center or a medical equipment manufacturer – to enforce the co-defendant's indemnity rights under contractual indemnification clauses. In these cross-claims, the co-defendant seeks to hold the physician liable to pay the co-defendant's attorneys' fees and costs incurred in defending against the claim, as well as to indemnify the co-defendant for all sums it pays in settlement or in satisfaction of an adverse judgment.



MIEC believes physicians should be responsible for their own negligence, but should not assume financial responsibility for the negligence of third parties. Accordingly, the MIEC policy does not provide coverage for your liability for damages or for your defense fees or costs incurred in connection with a claim which seeks to hold you liable because of your written or oral agreement to hold harmless, indemnify, or otherwise assume another's obligation or liability, if liability or the amount of damage sought or imposed upon you is greater than that which would exist in the absence of such an agreement. **Policyholders who enter into a PSA containing an indemnification clause must understand that they may be assuming personal obligations beyond the scope of the MIEC policy's insurance coverage**.

MIEC also does not offer "additional insured" coverage to a third party on your MIEC policy. By executing a PSA that includes an indemnification clause in favor of a third party, you have accepted responsibility for a liability exposure that is not insured by the MIEC policy.

Whenever an indemnification clause is included in a contract, MIEC recommends that physicians attempt to have it removed entirely. If this is not possible, it may be replaced by a simple clause which requires each party to maintain liability insurance for its own negligent acts and to provide evidence of insurance on request.

We recommend that you review your PSAs to determine whether they contain an indemnification clause and, if so, the scope of liability you have assumed under the agreements. If you have questions about whether the indemnification clause in your PSA may present an uninsured exposure to you, please contact your MIEC Underwriter or Claims Representative.

Our thanks to Susan F. Halman, Esq. from Selvin, Wraith, Halman LLP in Oakland, CA, a law firm specializing in all aspects of insurance coverage law and related fields of practice, for this informative article.

CRICO Corner

Pilot Project: Orthopedics and Neurosurgery

The MIEC/CRICO Strategies partnership began with a pilot project in which MIEC submitted claims data for orthopedic surgeons and neurosurgeons, report dates from 2006 to 2011, to CRICO Strategies for coding and analysis. One hundred sixteen (116) orthopedic and 42 neurosurgical medical incidents were deep coded and benchmarked against 152 orthopedic and 38 neurosurgical comparable CRICO peer group cases.

Orthopedic claims review

CRICO Strategies' analysts found that MIEC's rate of orthopedic claims has remained steady and comparable to peers since 2006. MIEC faces a higher percentage of surgical treatment allegations versus peers (78% vs. 61% respectively). Significantly more of MIEC's cases (frequency) originate in the outpatient setting; however, inpatient OR claims result in greater indemnity dollars paid to patients. When compared to the peer group, fewer of MIEC's orthopedic cases result in indemnity payments and the average indemnity payment is lower. Thirteen percent (13%) resulted in indemnity payments which averaged $171,566 per claim as compared to the peer claims, of which 35% resulted in payments averaging $273,955 per case.

CRICO Strategies' analysis found that communication and patient behavior-related contributing factors significantly impacted the patients' experiences. Communication problems between the providers and patients and their families, miscommunication of follow-up instructions, and issues with communication between co-treaters affected the outcome of these claims. Patient dissatisfaction with procedure outcomes, mismanaged expectations, and financial complaints proved to be prevalent factors in these cases as well.

Devices used intra-operatively or post-operatively were involved in 11% of the cases such as pedicle screws, polar ice packs, interspinous process decompression implants, allograft plugs,

Orthopedic Claims: Post-operative medical issues

Type of medical issue	Number of cases	Percent
Pain (continuous or new)	33	28%
Infection (wound, skin necrosis, bone, prosthesis, pin site)	15	13%
Non-union or mal-union	15	13%
Hardware issue (removal, loosening, infection, or revision)	14	12%
Foot drop	12	10%
Reported nerve damage	10	8%
Embolism (pulmonary, fossa, saddle)	7	6%
Hematoma/hemorrhage	5	4%
Retained foreign body	4	3%
Necrosis	4	3%

ceramic femoral heads, prosthetic discs, interlocking screws and suture anchors. Five percent of the cases included a post-operative fall in the hospital or the patients' homes; 16% percent of the cases experienced record-keeping issues; 3% of the claims were impacted by nursing miscommunication; and 3% involved pain medication mismanagement.

CRICO Strategies' recommendations included:

1. Educate insured providers on key surgical risk areas;

2. Enhance physician-patient communication;

3. Explore options for team training curriculum; and,

4. Investigate intra-operative technical challenges.

For additional reading about malpractice in orthopedics, review the study published by Frederick A. Matsen III, MD, Linda Stephens, PhD, et al., in the *Journal of Bone and Joint Surgery* titled, "The Orthopaedic Forum – Lessons Regarding the Safety of Orthopaedic Patient Care: An Analysis of Four Hundred and Sixty-Four Closed Malpractice Claims" [J Bone Joint Surg Am. 2013:95:320(1-8)].

Neurosurgical claims review

Neurosurgery Claims: Post-operative medical issues

Type of medical issue	Number of cases	Percent
Pain (continuous or new)	15	36%
Hematoma/hemorrhage	11	26%
Infection (wound, skin necrosis, bone, prosthesis, pin site)	11	26%
Hardware issue (removal, loosening, infection, or revision)	7	17%
Leg weakness/diminished function	6	14%

CRICO Strategies' analysts found that MIEC's rate of neurosurgical cases have remained consistently above comparable peers since 2006. As with orthopedic cases, MIEC's neurosurgery cases experience a higher percentage of surgical treatment allegations versus peers (79% vs. 65% respectively). MIEC's distribution of inpatient versus outpatient neurosurgical claims are on par with peers.

Fewer of MIEC's neurosurgical cases result in indemnity payments than the peer group; however, MIEC's average indemnity payment was much higher. Twenty-five percent (25%) of MIEC's neurosurgery cases resulted in indemnity payments averaging $545,682 per claim as compared to the CRICO peer claims, of which 37% resulted in payments averaging $286,823 per case.

By comparison to peers, technical skill factors were more prevalent for MIEC neurosurgeons (76% of MIEC cases vs. 50% for peers). Clinical judgment issues affected 62% of the cases vs. 50% for peers while documentation issues affected 17% of the MIEC neurosurgical cases vs. 26% in peer cases.

CRICO Strategies' findings and/or recommendations after analyzing the 42 neurosurgical medical events:

1. When compared with peers, MIEC faces a higher frequency of neurosurgical claims, but claims are driven by a similar distribution of clinical factors.

2. MIEC neurosurgeons experience was dominated by *unrecognized intra-operative*

technical errors, manifesting as post-operative complications.

3. Providers' "disconnectedness" from the inpatient care team is a notable root cause of many surgical misadventures.

4. There appears to be a connection between Items 2 and 3. If providers wish to avoid malpractice claims while improving their relationships with patients, sharpening providers' ability to detect and respond to intra-operative complications is critical to improving post-op outcomes.

Overall, the top drivers of risk across both specialties upon which interventions should focus include technical skills, clinical judgment, communication, and behavior-related issues.

CRICO Strategies' helpful patient safety articles titled Strategies for Patient Safety are available on MIEC's website at www.miec.com in the Patent Safety Toolbox. We invite you to visit today!

From MIEC's Board of Governors:

Protecting patients and colleagues: When caring and your duty to report coincide

By: Gene Cleaver, MD, Chair, MIEC Loss Prevention Committee

The AMA Code of Medical Ethics, *Principles of Medical Ethics,* Principle II states:

> " A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."

In addition, the AMA *Council on Ethical and Judicial Affairs* (CEJA) Opinion No. 9.031 states:

> " Physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements in each state and assisted by the …[CEJA] guidelines [listed in the Opinion]. "

Although physicians have an ethical duty to report, some doctors say nothing to a colleague who may be incompetent, impaired, or who operates on the fringe of the acceptable, and we certainly are reluctant to report this behavior to the appropriate body. One third of physicians who don't make such a report blame their decision on the fear of retribution. Maybe it is easier to be silent, or we don't want to chance harming an old friendship or referral source. Maybe we are sympathetic, knowing that our colleague was just as bright, made the same sacrifices and is enduring the same stressors as ourselves. It may not occur to us that there are ways of approaching a doctor that will be less likely perceived as threatening or punitive.

We can sometimes do the most harm by being silent, by not taking the responsibility to speak up and take action. Whistleblowing is seen as accusatory and confrontational. Yet there are often

those who don't want to "blow a whistle" if reporting means to judge. These physicians are willing to do the hard work of helping a fellow physician see how his or her behavior endangers patient safety and threatens other healthcare providers. Not only can we prevent harm from being done by saying something, but by doing so, we do not abandon another doctor.

In this article I will outline for you: the process of reporting the incompetent, impaired, and unethical colleague; immunities accessible to you as the reporting party; and resources available to you should you be contemplating such action.

Step 1: Talk to your colleague

In the mid-1980's the California Medical Association and the Board of Medical Quality Assurance (now the Medical Board of California) released a joint statement on a physician's responsibility to report. Discussing the problem with the doctor was the first step advised by writers of the statement.[1] Studies show that physicians who are addicted to work or substances are reluctant to seek help and frequently believe they can manage the issue on their own. Based upon my 47 years of experience as a treating physician largely in Northern California, I offer this advice when contemplating whether or not to confront a "problem physician."

- ✓ Consider your relationship with the physician. Are you long-time colleagues?
- ✓ Consider how your friend might respond to this type of message, "I'm very concerned about you and the safety of your patients. It seems that you are experiencing some personal issues. How can I help? Assistance is available. You can talk to a member of the hospital's Well-being or Peer Review Committee. I'll accompany you if you like."
- ✓ As much as your intentions are good, limit what you discuss outside of a "protected communication" (e.g., Peer Review, Well-being and Medical Society Committee).
- ✓ When you first make contact with your colleague, consider taking someone with you, preferably a member of the Well-being, Peer Review or Ethics Committees. It is important to find a colleague to go with you who is kind and direct, without being angry, unless you know that you have the skill to do this alone.
- ✓ If your colleague appears to ignore your advice, go back a second time and advise him or her that you continue to be concerned. Put the physician on notice that you plan to report him or her to the Well-being Committee or Department Chair if you do not see evidence of change.

Understand to whom you should report physician behavior

Physicians should understand that they are not alone in this process of reporting an incompetent, unethical, or impaired colleague and that there is some flexibility on a case by case basis as to how to proceed. CMA Legal Counsel advises, "… problems should first be reported to the appropriate medical staff or medical society committee. Reporting to the Medical Board should be reserved for cases which are not resolved by those bodies or where an immediate risk to patient safety exists."[2]

The AMA CEJA Opinion No. 9.031 requires the following when reporting incompetent

1 CMA and BMQA. *Physician Responsibility…a joint statement.* January 1985. Page 2.

2 CMA. "Reporting Incompetent, Impaired, or Unethical Colleagues." On-Call Document #1435. January 2012. Page 4.

and unethical doctors. When reporting *incompetence:*

"
- Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action. [For example: in the hospital setting, the department head, and chief of staff; outside of a hospital, to the county medical society or specialty society.]
- The hospital peer review body should be notified where appropriate.
- Incompetence that *poses an immediate threat* to the health and safety of patients should be reported directly to the state licensing board.
- Incompetence by physicians without a hospital affiliation should be reported to the local or state medical society and/or the state licensing or disciplinary board. "

When reporting *unethical conduct,* CEJA Opinion 9.031 advises:

"
- Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service.
- Unethical behavior which violates state licensing provisions should be reported to the state licensing board.
- It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities.
- All other unethical conduct should be reported to the local or state medical organizations.
- When the inappropriate conduct of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior, including reports submitted anonymously, have an ethical duty to critically, objectively, and confidentially evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Information regarding reporting or investigations of impairment or of incompetent or unethical behavior should be held in confidence until the matter is resolved. "

If you are concerned about a colleague who you believe is psychologically impaired or has issues with substance abuse, CMA's Legal Counsel advises, "In the medical staff setting, physicians and other personnel should contact the chair of the Well-being Committee (or the appropriate physician health program). Alternatively, the reporting physician or other personnel may contact the chief of staff. To the extent that the matter may be handled safely through the Well-being Committee, however, that route is recommended."[3]

The AMA CEJA Opinion No. 9.031 requires the following when reporting *impaired physicians:*

3 Ibid, page 5.

Risk Scoring Criteria and patient education

Steven Una, MD,
specializing
in infectious disease
Loss Prevention Committee

"I have been talking with my colleagues concerning use of risk scoring criteria (for example the APACHE scores in intensive care patients) and the development of risk criteria for pre-op surgical patients. Risk adjusted criteria for patient selection as well as patient education prior to going through procedures are vital considerations for MIEC's surgical policyholders. We are going through an evaluation of infectious complications of joint replacements at my local medical center with a mix of various orthopedists in the community.

OF NOTE: There is significant variance in "quality of patient protoplasm" from doctor to doctor as well as variance in technique. As the infectious disease doctor that comes in to clean up after the fact, I commonly run into patients who had no understanding that they are "high risk." Only after describing the multiple comorbidities (e.g., morbid obesity, diabetes mellitus, venous and vascular disease) and their significant increased risk for infections do they better appreciate the potential risks. The process of defining risk for patients before or early in the process of care would certainly decrease physician risk."

> "• Physicians' responsibilities to colleagues who are impaired by a condition that interferes with their ability to engage safely in professional activities include timely intervention to ensure that these colleagues cease practicing and receive appropriate assistance from a physician health program.
>
> • Ethically and legally, it may be necessary to report an impaired physician who continues to practice despite reasonable offers of assistance and referral to a hospital or state physician health program.
>
> • The duty to report under such circumstances, which stems from physicians' obligations to protect patients against harm, may entail reporting to the licensing authority."

AMA CEJA Opinion E-9.035, "Physician Health and Wellness" also states, in part:

> "• The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by. . . reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority."

Be familiar with legal immunities

Phillip Goldberg, Esq., of Hassard Bonnington, et al., in San Francisco, CA, advises that Alaska, California, Hawaii, and Idaho all have state laws that afford individuals the opportunity to report misconduct or inappropriate care to a person or entity in a position to investigate and act on the information with some assurance that the disclosing individual will be protected against personal liability. California, Alaska and Idaho all have statutes that provide absolute or qualified protection for those reporting to the state agency licensing physicians. Hawaii has no such express protection to date. However, Hawaii (like the other states) does provide protection for those providing information to peer review bodies. Accordingly, in Hawaii individuals with information on physician misconduct or inappropriate care may enjoy greater protection by disclosing to a hospital medical staff when appropriate as opposed to the Board of Medical Examiners. Many - if not most - state law protections are only available if the disclosing party acts in good faith and without malice in making the disclosure, so those who disclose should ensure they have appropriate motives when making a report.

For state-specific laws, see ***Figure 1*** (page 21). When in doubt as to reporting misconduct or inappropriate care, contact MIEC's Claims Department at 800/227-4527 or contact your local medical society for assistance.

Resources

Alaska:

The Alaska State Medical Association (**ASMA**) has a Physician Health Committee that addresses substance abuse and other, more serious issues. ASMA also manages a grievance committee that investigates, adjudicates and mediates patient complaints regarding the practice of medicine by physicians. For more information, call 907/562-0304.

California:

The **CMA** operates a **Physician's Confidential Line**, which may be called by any physician, family member, or any other person who may have concerns about a doctor possibly impaired due to substance or alcohol abuse, or who displays psychological, behavioral or other problems.[4] Callers will be put in touch with various resources such as medical society physician Well-being Committees, rehabilitation centers, physicians who specialize in addiction medicine, psychiatrists, and more, depending upon the need expressed by the caller. Telephone discussions are confidential. In Northern California, call 650/756-7787 and in Southern California, call: 213/383-2691.[5]

The Alameda Contra Costa Medical Association (**ACCMA)** has a Physicians Advisory Committee dealing with physician impairment (drug and alcohol addiction, anger issues, etc.) and a Physicians Litigation Stress Committee. The organization's Ethics Committee addresses questions of ethical behavior and Mediation Committees handle payment disputes between physicians and patients. All are confidential peer review committees. Call the ACCMA at 510/654-5383 for more information.

Hawaii:

The Hawaii Medical Association (HMA) has a grievance committee in the form of an Investigation Committee (operated by Honolulu County Medical Society) and Peer Review Committee. Additionally, while independent of the HMA, the association works closely with Pu`ulu Lapa`au, a wellness program for healthcare providers. For more information, call 808/ 536-7702.

Idaho:

The Idaho Medical Association (**IMA**) administers the Physicians Recover Network (PRN) under contract with the Idaho Board of Medicine. PRN offers evaluation and treatment for drug and alcohol addiction, plus severe mental health issues. For more information, contact Southworth Associates at 800/386-1695 or Ron Hodge, JD, at the IMA at 208/344-7888.

A final thought

If we are to keep to the Hippocratic Oath to practice medicine ethically and honestly, we are compelled to learn ways of finding out the facts and making recommendations for doctor and patient safety without the heat of anger and judgment. If we insist within ourselves on unrelenting kindness and compassion for the people on both sides of an issue, we make it so much easier on ourselves. We are not the ones who are hurt if they blow up. The key is preparation, by understanding the facts of the case, and just as important, being keenly aware that an angry physician is a scared physician. We ourselves, through groundwork, have the option of kindness.

4 Ibid, page 6.

5 CMA. "Assisting Physicians with Substance Abuse or Mental Health Problems." On-Call Document #1403. January 2010. Page 5.

Article: HIPAA Update: Omnibus Rule Finalized

The federal government has published its final regulations implementing the "Health Information Technology for Economic and Clinical Health (HITECH) Act," which modified and expanded the existing HIPAA Privacy and Security Rules, and other statutes. An interim set of guidelines has been in place since 2010, and MIEC provided guidance at that time on complying with the interim rule; therefore, you may have already implemented many of the required changes (such as data-breach notification requirements) into your HIPAA policies and procedures. The following summarizes key points from the Interim and Final Rules, and includes action items for updating your HIPAA policies and procedures. Unless otherwise noted, Covered Entities (CE) must comply with the final rule by September 23, 2013.

Business Associates

The definition of Business Associates (BA) has been clarified to include Patient Safety Organizations, health information exchanges, records storage facilities, cloud-based back-up and commercial data centers. Business Associates have the same responsibilities as covered entities to protect PHI, including abiding by HIPAA Privacy and Security Rules, and are liable for the conduct of their subcontractors.

Action Items:

- Review the entities that use or maintain PHI on your behalf and determine if any should be added to your list of Business Associates.
- Ensure that BA agreements reflect the data breach notification requirements (these have been in place since 2010 and should already be included in your agreements). For more information go to: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html.
- If your current BA agreements don't comply with the HITECH interim rule requirements, or no BA agreement yet exists, you must execute compliant agreements by September 23, 2013. If existing contracts are compliant with pre-omnibus rule provisions, Covered Entities have until September 23, **2014** to bring BA agreements into conformance with the new rules.

Privacy changes

Patients have expanded rights with respect to how their protected health information (PHI) is used, accessed, and disclosed:

- Patients who pay in full, out of pocket, for treatment can request that information regarding the treatment not be disclosed to their health plan; providers must comply with these requests.
- Physicians may disclose immunizations to schools required to obtain proof of immunization prior to admitting the student so long as the physicians have and document the parent or guardian's "informal agreement" to the disclosure.
- Physicians may make disclosures to a decedent's family and friends under the same circumstances such disclosures were permitted when the patient was alive. In addition, HIPAA protections for PHI are eliminated 50 years after the patient's death.

- Physicians must produce copies of *e*PHI in the electronic form and format requested by the individual if the records are "readily reproducible" in that format. Physicians will now have 30 days to respond to a patient's written request for his or her PHI with one 30-day extension, regardless of where the records are kept (eliminating the longer 60-day timeframe for records maintained offsite).
- Physicians *may* send copies of medical records via unencrypted e-mails only if the requesting individual is advised of the risk and still requests that form of transmission. The covered entity will not be held responsible for unauthorized access of PHI while in transmission to the patient based on the patient's informed request. **NOTE:** This protection only applies to situations in which the patient requests copies of their medical records via e-mail; it does not apply to general e-mail exchanges in which PHI is involved.
- You may charge the patient to produce copies: cost is limited to a reasonable, cost-based fee including labor and supply costs including cost of any portable media (e.g., USB memory stick, CD).
- There are some changes regarding the sale of PHI, marketing to patients, and fundraising from patients. For more information, view the AMA's excellent summary at: http://www.ama-assn.org/resources/doc/washington/hipaa-omnibus-final-rule-summary.pdf.

Action Items:

- Implement a consent form for patients who request copies of medical records via e-mail, including the potential risks of communicating in this fashion.
- Update your Privacy Policy and Notice of Privacy Practices (NPP); sample language is available at MIEC's website (www.miec.com, HIPAA forms).
- Post updated NPP in the office and on your web site.
- Determine with input from all affected departments how you will comply with patient requests to not disclose information to a health plan (if the patient has paid in full, out of pocket).

Breach notification

For a full description of the "breach notification" requirements, which have been in effect since 2010, see MIEC's newsletter on the HITECH Act (*Special Report Claims Alert,* No. 43). In a nutshell, physicians and Business Associates are required to notify patients and the federal government of breaches of PHI, and conduct and document risk assessments. The obligation to notify patients (and the government) if there is a breach of their PHI is expanded and clarified under the new rules. Breaches are now presumed reportable unless, after completing a risk assessment applying four factors, it is determined that there is a "low probability of PHI compromise." This "low probability of compromise" language replaces the previous, more subjective "significant risk of financial, reputational or other harm" analysis for establishing a breach. Risk assessments are now required to be based on:

- The nature and extent of PHI involved, including the types of identifiers and the likelihood of re-identification, and the sensitivity of the information;
- The unauthorized person who used

Accounting of Disclosures

The HIPAA Privacy Rule requires that physicians, upon patient request, produce an accounting of "non-routine" disclosures of the patient's PHI that are unrelated to treatment, payment, or operations. The interim rule would require that covered entities who use electronic health records be required to produce an accounting of all disclosures upon patient request, including those made for purposes of treatment, payment, and operations. The final rule guidelines have not included an ultimate determination on whether this will be required of Covered Entities. MIEC will update policyholders as clarification on the Accounting of Disclosures becomes available.

the PHI or to whom the disclosure was made and whether that person has an independent obligation to protect the confidentiality of the information;

- Whether PHI was actually acquired or accessed (this may be determined forensically in some instances); and
- The extent to which the risk to PHI has been mitigated (e.g., assurances from trusted third-parties that the information was destroyed).

MIEC policyholders who have or believe they have experienced a potential data breach should contact MIEC's Claims Department for assistance.

Action Items:

- Update data breach risk assessment policies to reflect the replacement of the "harm threshold" with the "probability of compromise" assessment criteria.

Penalties and enforcement

The Interim Rule increased penalties and expanded enforcement authority to include Attorneys General. In addition, the Office for Civil Rights has begun auditing covered entities rather than solely relying on complaints or reported data breaches to trigger an investigation. The OCR continues to work with Covered Entities toward HIPAA compliance; the severity of fines is commensurate with the extent to which the CE has made a good faith effort to comply with the HIPAA and HITECH rules and regulations.

Action Items:

- Workforce training to update staff on the new requirements.

Using patient satisfaction data to improve performance

In Issue No. 3 of *The Exchange*, we published Part I of this two-part series on patient satisfaction and performance improvement. In Part I, we presented tools that are available for surveying patients' satisfaction with the care and treatment provided and offered compelling reasons for measuring the patient experience. This article describes a proven approach for employing performance improvement strategies to increase patient satisfaction based upon patient satisfaction survey results. Specifically, the Model for Improvement,[6] a method that has been widely used by the Institute for Healthcare Improvement (IHI) for rapid cycle improvement will be discussed. We believe that, if thoughtfully employed, this method can effectively enhance the quality of healthcare and services you provide, as well as help decrease your liability risk.

The necessity for both measuring patient satisfaction and enacting evidence-based quality improvement initiatives permeates healthcare today. There are numerous factors that contribute to and affect patients' satisfaction. These factors may include:

- Patients' perceptions around long wait times;
- Problems with patient-physician communication; and
- Patients' inability to access care.

These factors and more are critical

6 Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

aspects of care and are worthy topics for performance improvement studies. The Model for Improvement, (aka the Plan-Do-Study-Act [PDSA] cycle) is an excellent way to use the data collected from patient satisfaction surveys to improve both processes and outcomes.

What is it and how can it help me?

You can use PDSA cycles to try out an idea by temporarily testing a change and measuring its impact. This approach is critical because new ideas are frequently introduced without adequate testing. There are four stages of the PDSA cycle:

- **P**lan - the change to be tested or implemented;
- **D**o - carry out the test or change;
- **S**tudy - the data before and after the change to determine if the change is an improvement; and,
- **A**ct - plan the next change cycle or implement the improvement.

For more information about the model for improvement, and how to use it, you can access the IHI's website at http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx.

When does it work best?

It is always a good idea to make small tests of change before implementing anything full-scale. Using PDSA cycles enables you to do just that and it gives staff members the opportunity to see if the proposed modification will work.

Examples of using the PDSA cycle to test new change ideas:

- Try out a new way to schedule appointments (test open scheduling one day of the week).
- Test a patient call-back program for the patients of one physician for one week.
- Provide a sample (10 patients) "welcome" communication for new patients, including important practice processes, office hours, emergency contact numbers, etc., and solicit feedback from those patients.
- Test e-mail communications for existing patients (practice news, wellness information and care reminders).

Who should be involved?

As with any change, ownership is critical to success. If you involve key staff, you will reduce the barriers to change. A meaningful quality improvement initiative always includes key stakeholders and ultimately benefits patients, physicians and staff.

Why does it matter?

Employing quality improvement strategies to enhance patient satisfaction matters to your patients. If a patient or family member has taken the time to fill out a satisfaction survey and provide you with valuable feedback, they care. An effective patient experience program: measures patient satisfaction; uses data to improve services and outcomes; establishes and maintains practice norms (e.g., policies and procedures); encourages physicians and staff to strive for constant quality development by identifying areas that need improvement; engages physicians and staff in the process; and is a team effort that will be well worth the time invested – not only for your patients, but for you and your practice as well.

Loss Prevention FAQ: Medispas

MIEC's Underwriting and Loss Prevention Departments frequently receive questions from policyholders about cosmetic procedures, participation in Medispas, what procedures can be performed by staff, and more. The following are answers to FAQs that we hope will provide physicians with some useful information.

Do I escape responsibility for patients if I, as a physician, simply sign up with a Medispa and lend my name on paper to the facility while receiving a monthly payment to do so?

(California) No! According to the Medical Board of California (MBC), this type of arrangement is a violation of current laws governing the business of medical practices. Violations include, "…violations of the corporate practice prohibitions, as well as fee-splitting and payment for referrals. The illegal business models give rise to the use of unlicensed or inappropriately licensed personnel, paper-only supervision ("rent-a-license") of allied health professionals, consumer confusion over the medical nature of the procedures, and confusion over who is responsible for the patients. Patients are not fully informed of risks and often do not know the medical nature of the treatments or who is responsible for their care." (from MBC's publication *The Bottom Line: The Business of Medicine – Medical Spas*)

(Idaho) Idaho Code §54-1814(8) states, "Division of fees or gifts or agreement to split or divide fees or gifts received for professional services with any person, institution or corporation in exchange for referral" violates the Medical Practices Act. Further, under Idaho case law, a physician or other person who acts in such a way as to lead a reasonable patient to believe that the he or she is the employer of or responsible for the medical spa personnel may be held vicariously accountable under the theory of ostensible agency.

Alaska and **Hawaii** laws are silent on the topic.

It's my understanding that some states prohibit the corporate practice of medicine. What does that mean?

(California) According to California's Business & Professions Code §2400, laypersons or lay entities may not own any part of a medical practice. Physicians must either own the practice, or must be employed or contracted by a physician-owned medical corporation or practice. California licensed physicians must own the majority of the stock in a medical corporation, with no more than 49% owned by other licensed health care professionals including nurse practitioners, nurses, physician assistants, etc. No stock in a medical corporation may be owned by a lay-person. [Corporation Code §13401.5(a)].

(Idaho) Idaho's common law prohibits the corporate practice of medicine. However, according to Steven J. Hippler, Esq., from Givens Pursley LLP in Boise, ID, licensed hospitals, hospital districts, health maintenance organizations and captive professional corporations are exempt from the corporate practice of medicine prohibition. The Idaho Supreme Court stated in Worlton v. Davis, 73 Idaho 217 (1952), "It is well established that no unlicensed person or entity may engage in the practice of medical profession through licensed employees; nor may a licensed physician practice as an employee of an unlicensed person or entity. Such practices are contrary to public policy." [73 Idaho at 221]

It is the position of the Idaho State Board of Medicine that. "… non-physician businesses and individuals may not hire physicians as employees to operate clinics for those entities or individuals. Physicians who accept employment from unlicensed businesses and individuals risk disciplinary action by the Board. Similarly, physicians who allow unlicensed businesses or individuals to bill for services provided by unlicensed, lay people also risk disciplinary action…" (Steven J. Hippler, Esq., *Summary of Fraud and Abuse Statutes & Regulations Idaho*, October 27, 2008)

(Hawaii) According to Kevin H. Kaneshiro, Esq. from the law firm of O'Connor Playdon & Guben LLP in Honolulu, HI, "Although Hawaii does not have a statute that specifically applies to the corporate practice of medicine, Hawaii Revised

Statutes ("HRS") Chapter 415A, Hawaii's Professional Corporation Act, applies to any professional corporation which would include a corporation that practices medicine or provides medical services…a professional corporation can only provide professional services that it is authorized to provide under its articles of incorporation through an individual who is licensed to provide the professional services of the corporation. In other words, a medical corporation can only provide medical services through individuals who are licensed to practice medicine in Hawaii."

"Moreover, regarding the ownership of a professional corporation, HRS Chapter 415A provides...all shareholders of a professional corporation must be authorized by law, i.e., licensed, to render the professional services of the corporation. Furthermore, at least a half of the directors of the corporation and all officers other than the secretary and treasurer, i.e., the president and vice-presidents, must be 'qualified persons' who are defined as individuals who are 'eligible under this chapter to own shares issued by a professional corporation,' (HRS §415A-2); in other words, individuals who are licensed to render the professional services. Consequently, non-licensed individuals cannot own any shares in a medical professional corporation nor can they comprise a majority of the directors or serve as officers other than as secretary or treasurer."

"On a somewhat related note, HRS §453-8(a) provides that '[i]n addition to any other actions authorized by law, any license to practice medicine and surgery may be revoked, limited, or suspended by the Board at any time in a proceeding before the board, and may be denied, for any cause authorized by law, including but not limited to the following: …(9) Conduct or practice contrary to recognized standards of ethics of the medical profession as adopted by the Hawaii Medical Association, the American Medical Association[.]' Opinion 3.05 of the AMA Code of Ethics provides, in part, as follows:

'…When nonphysicians employ physicians to supervise the employer's clinical practice, conditions are created that can lead to ethical dilemmas for the physician. If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, a physician's personal and financial interests can be put at odds with patient care interests. Similarly, the administrative and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of his or her employer.

Physicians in such arrangements must give precedence to their ethical obligation to act in the patient's best interest by always exercising independent professional judgment, even if that puts the physician at odds with the employer/supervisee.'"

"Although Opinion 3.05 does not specifically prohibit the employment of a physician by a nonphysician, it does caution a physician in such circumstances about the conflict between the interests of the nonphysician employer and the patient. Thus, even if a physician is permitted to be employed by a nonphysician to provide medical services to patients, the physician cannot be controlled by the nonphysician employer in the physician's exercise of independent professional judgment. To do so may be contrary to an AMA Standard of Ethics which in turn would be a violation of HRS §485-8(a)(9)."

Alaska state laws do not speak to the corporate practice of medicine.

Laser treatments, Botox, and cosmetic filler injections are only cosmetic treatments, right?

(California) Wrong! According to the MBC, they are medical treatments. "The use of prescriptive drugs and devices…is the practice of medicine, and the same laws and regulations apply to these types of treatments as those driven by medical necessity. There are no separate laws governing these procedures, and physicians will be held to the same standard as they are for their routine medical practices. This means that the standards for informed consent, delegation to allied health professionals, physician-patient confidentiality and boundaries, maintaining medical records, as well as responsibility and liability apply to physicians, even those denominated "medical directors."

(Alaska) In 2004 and 2007 respectively, the Alaska State Medical Board adopted the American Medical Association's policies on laser surgery and the American College of Surgeons statement on surgery using lasers, pulsed light, radiofrequency

Loss Prevention FAQ: Medispas cont.

devices or other techniques. Techniques are defined as *ablative* (i.e., expected to excise, burn or vaporize the skin below the dermo-epidermal junction) or *non-ablative* (i.e., not expected or intended to excise, burn or vaporize the epidermal surface of the skin). The American College of Surgeons believes "…that surgery using lasers, pulsed light, radio frequency devices or other means is the practice of medicine and constitutes standard forms of surgical intervention."

According to Keith E. Brown, Esq., of Brown, Waller & Gibbs in Anchorage, Alaska, "Although not directly addressed by statute or regulation in the context of Medispas, it can be assumed that given the broad definition of the practice of medicine in Alaska, physicians will be held to the same standards regarding informed consent, maintaining medical records, and patient confidentiality (HIPAA compliance must be assured), as well as the usual requirements relating to delegation to other health care professionals. For example, Alaska has addressed delegation as authorized by AS 08.68.805 of routine nursing duties, specialized nursing duties, the administration of medication (12 AAC 44.965), the administration of injectable medication (12 AAC 44.966) (which can only be delegated by an ANP to a certified medical assistant in limited circumstances). Whistleblower protection is afforded nurses who report improper delegation of nursing functions (AS 08.16.279). The physician operating, supervising or staffing a Medispa will likely have the same vicarious responsibility that a physician would have in the operation of any clinic."

I'm accustomed to delegating responsibilities to my allied health professionals. To whom may I delegate the utilization of lasers and other prescriptive devices and drugs?

(California) Be careful! A physician can delegate laser treatments, Botox and cosmetic fillers to licensed registered nurses, nurse practitioners or physician assistants who the physician knows to be capable of performing the task. The physician should also be proficient in performing the treatment. Supervisory requirements vary by the licensure of the allied health professional.

Registered nurses: Standardized procedure guidelines allow nurses to perform the laser treatments and injections while the physician is not physically present; however, the guidelines do not take the place of the physician's supervisory responsibilities, which include: ensuring and documenting the nurse's experience, training and education requirements, as well as initially and continually evaluating the nurse's competence.

Please note: It is the responsibility of the physician to conduct a patient examination **before** delegating the task to a registered nurse. Also, according to the MBC, supervising physicians must be within "a geographical distance that enables them to effectively provide supervision and support when needed or upon request."

According the MBC, licensed vocational nurses, cosmetologists, electrologists, or estheticians may not legally perform treatments using lasers or intense pulse light devices. Electrologists remove or destroy hair using an electronic needle only (Business & Professions Code §7316); therefore, it is outside the scope of their practice to use a laser. Likewise, cosmetologists or estheticians, while licensed professionals and highly qualified in superficial treatments such as facials and microdermabrasion, may never inject the skin, use lasers, or perform medical-level (i.e., deeper levels of epidermis) dermabrasion or skin peels. Unlicensed personnel, including medical assistants, are not allowed to perform any type of microdermabrasion or laser treatments.

For more information in California, go to: http://www.mbc.ca.gov/allied/medical_assistants_lasers.html

(Alaska) Alaska physicians may delegate the use of ablative lasers to nurse practitioners and physician assistants who are trained and licensed to practice medicine in the state of Alaska; the treatments should fall within the statutory and/or regulatory scope of the practitioner's specialty. Delegation of the ablative treatments must be through the use of written protocols. Physicians should provide direct supervision when he/she has delegated the procedure to a midlevel. Physicians are responsible for performing initial reviews of the patients and authorizing treatment plans, and documenting examinations in the patients' charts prior to the first treatment.

According to the American College of Surgeons' guidelines, in those cases where a surgeon may utilize the services of a "non-physician advanced health practitioner or non-physician health practitioner" as an assistant during the performance of an ablative or non-ablative laser surgery, the assistant must be properly licensed, certified and/or credentialed to practice his/her profession; must have appropriate education and training for assisting the surgeon in the laser surgery; and complete assigned duties under the direct supervision of the surgeon performing the procedure.

Physicians may delegate non-ablative procedures to registered nurses, cosmetologists, estheticians and medical assistants or other qualified personnel. Procedures must be performed under the direct supervision by the physician. Non-physician practitioners must be appropriately trained, licensed within the state, practicing within the scope of their practice and be provided with written protocols. As with ablative procedures, a physician must conduct the initial evaluation, determine the non-ablative treatment plan and document the encounter.

Please note: According to the Alaska Licensing Examiner's office, aestheticians cannot go below the dermal layer, cannot use hot lasers and may not provide injections. According to Alaska Statute 08.13.220 (5) and (8), esthetics is defined and limited to, "…the use of the hands, appliances, cosmetic preparations, antiseptics, or lotions in massaging, cleansing, stimulating, or similar work on the scalp, face or neck, including skin care, make-up, and temporary removal of superfluous hair, for cosmetic purposes for a fee…"

PLEASE NOTE: According to Keith E. Brown, Esq., he does not believe that the American College of Surgeon's guidelines can be construed as limiting the role of nurse practitioners in the Medispa setting. The collaboration requirement set for in 12 AAC 44.410 was repealed in 1984. Nurse practitioners practice independently within the practice areas set forth in 12 AAC 44.380 which include acute care/emergency medicine; adult care; family, geriatric, neonatal, and pediatric care; women's health; and, family and adult psychiatric mental health.

What are the Idaho rules governing physicians and staff who provide cosmetic treatments?

To best answer this question, we will outline Idaho's administrative rules that went into effect in March 2007. Policyholders can find the rules in the Idaho Administrative Code **IDAPA 22.01.04** – *Rules of the Board of Medicine for Registration of Supervising and Directing Physicians*.

The scope of the rules governs the activities of, "physicians and osteopathic physicians licensed in Idaho… who supervise the provision of cosmetic treatments using prescriptive medical/cosmetic devices and products by medical personnel" [Subsection 001.02.].

By definition, "medical personnel" are individuals who exclusively provide *non-incisive* and *non-ablative* cosmetic treatments using prescriptive medical/cosmetic devices and products under the direction and supervision of a supervising physician registered with the Medical Board. The supervising physician cannot supervise more than a total of three (3) such medical personnel at once; however, the Board may authorize the supervising physician to supervise a total of six (6) medical personnel contemporaneously "if necessary to provide adequate cosmetic treatments and upon prior petition documenting adequate safeguards to protect the public health and safety" [Subsection 010.11 and 17].

OF NOTE: According the Idaho Board of Medicine, the chapter does not authorize the practice of medicine by a person not licensed by the Board. However, medical personnel referenced in this administrative rule include nurses, medical assistants, or any non-licensed personnel that a supervising physician has trained to perform non-incisive and non-ablative cosmetic treatments.

Prescriptive medical/cosmetic *devices* are federal FDA-approved prescriptive devices that use waveform energy including, but not limited to, intense pulsed light (IPL) or lasers, to cosmetically alter human tissue. A prescriptive medical/cosmetic *product* is an FDA-approved prescriptive product whose primary intended use is achieved through chemical action and which

Loss Prevention FAQ: Medispas cont.

cosmetically alters human tissue with filler substances such as collagen or fat, lipo transfer, muscle immobilizers or sclerosing agents [Subsection.023.01, paragraphs d. and e.].

According to Idaho rules, a supervising physician's duties and responsibilities for medical personnel who perform cosmetic treatments include:

1. Accept full responsibility for the cosmetic treatments provided by medical personnel using prescription medical/cosmetic devices and products.
2. Be trained in the safety and use of the cosmetic devices and products.
3. Document his/her evaluation and assessment of the patient prior to commencement of a cosmetic treatment. An adequate record must contain, at a minimum, subjective information, an evaluation and report of objective findings, assessment or diagnosis, and the plan of care including, but not limited to, a prescription of the cosmetic devices and products.
4. Be available on-site or immediately while medical personnel perform cosmetic treatments in order to promptly respond to any questions or problems that may occur. Supervision includes: periodic review of the medical records to evaluate the cosmetic treatments including any adverse outcomes or changes in treatment protocols and regularly scheduled conferences between the supervising physician and medical personnel.
5. Ensure that cosmetic treatments using prescription medical/cosmetic devices and products are limited to and consistent with the supervising physician's scope of practice.
6. Ensure that the medical personnel are not independently providing cosmetic treatments using cosmetic devices and products.
7. Ensure that the medical personnel possess the proper training in cutaneous medicine, indications for the prescribed treatment, and the pre- and post-treatment care for *each* procedure performed. The supervising physician must certify training on each device or product the medical personnel will use include:
    a. Physics and safety of the prescriptive medical/cosmetic devices and products;
    b. Basic principle of the planned procedure and treatment;
    c. Clinical application of the cosmetic devices and products including, but not limited to, wavelengths to be used with intense pulse light/lasers;
    d. Indications and contraindications for the use of the devices and products;
    e. Pre-and post-procedure care;
    f. Recognition and acute management of complications that may result from a treatment or procedure; and,
    g. Infectious disease control procedures required for each treatment.
8. Assure compliance with the medical personnel training and reporting requirements outlined by the rule.
9. Submit a "Certification of Training" form provided by the Idaho Board of Medicine to the Board for approval before medical personnel may perform cosmetic treatments using prescriptive medical/cosmetic devices and products. The Board may require the supervising physician to provide additional information (e.g., physician's affidavit attesting to the medical personnel's qualifications and clinical abilities to perform the cosmetic treatments). The Certification of Training must be sent to the Board and a copy must be on file at each practice location and at the address of record of the supervising physician.
10. Prepare a written protocol for medical personnel to follow when using the cosmetic devices and products. The supervising physician must ensure that the medical personnel use prescriptive medical/cosmetic devices and products in accordance with the written protocols and do not exercise independent judgment when using the devices and products.

11. Disclose to patients receiving cosmetic treatments that medical personnel are not licensed physicians. Disclosure requirement can be fulfilled using name tags, correspondence, oral statements, office signs, or other procedures that "under the involved circumstances adequately advise the patient of the education and training of the medical personnel rendering such cosmetic treatments."
12. Report to the Board of Medicine all patient complaints received against medical personnel related to the quality and nature of cosmetic treatments rendered [Subsections 023.02, paragraphs a. through h.].

According to the Idaho State Board of Medicine's *Guidelines for Hair Removal using Intense Pulsed Light and/or Laser Devices by Supervised Medical Personnel*, a licensed Idaho physician must prescribe the use of an IPL and/or laser prescriptive device to cosmetically alter human tissue. Properly trained medical personnel may perform the actual hair removal treatment using IPL and/or laser.

Q **What are the Hawaii laws or rules governing physicians and staff providing cosmetic treatments?**

A According to the Hawaii Board of Medical Examiners, both physicians and physician assistants can perform laser hair removal, intense pulse light treatments, Botox injections, chemical peels, and filler injections. They are governed by Hawaii Revised Statutes Chapter 453 and Hawaii Administrative Rules, Title 16, Chapter 85.

According to the Executive Officer of Hawaii's Board of Barbering and Cosmetology, cosmetologists and estheticians may not perform hair removal using lasers or intense pulse devices. They cannot inject collagen, Botox or cosmetic fillers and they can only apply chemical peels if the procedure does not extend below the surface of the skin.

Cosmetologists are defined as hairdressers, estheticians, or nail technicians who are compensated for their services. HRS 439-1 defines an esthetician as a person who, "with hands or nonmedically prescribed mechanical or electrical apparatus or devices or by use of cosmetic preparations, antiseptics, tonics, lotions, or creams, engages for compensation..." in: massaging, cleansing, stimulating, manipulating, exercising, beautifying the scalp, face, neck, hands, arms, bust, upper part of the body, legs, or feet; cleansing, exfoliating, wrapping, or doing similar work upon the entire body without direct contact by the hands and utilizing gloves, loofah mitts, or brushes; or removing superfluous hair about the body of any person by means other than electrolysis.

Finally, according to Hawaii's Board of Nursing, "The Board of Nursing ("Board") previously determined that performing laser treatments was not a nursing task, whether supervised by a physician or not."

Value Added Benefits:

New CME provider – ELM Exchange!

MIEC has partnered with ELM Exchange, Inc., the leading provider of online healthcare risk management and patient safety education programs and resources, to offer its healthcare providers access to the highest quality risk management continuing education courses. This no-cost, convenient curriculum is proven to help physicians create a culture of enhanced patient safety and increased quality of care.

About ELM: For more than 25 years, ELM Exchange has advanced healthcare quality and patient safety by proactively enabling healthcare professionals to better identify and mitigate risk in their clinical practice. ELM's best-in-class, comprehensive suite of online healthcare risk management and patient safety education programs and resources serve as an invaluable loss prevention initiative for professional liability insurers. Strategically developed by a core team of physician attorneys and medical-legal experts, ELM's curriculum of more than 150 different courses including offerings for 26 different medical specialties, provides a risk management solution unmatched in its ability to decrease the errors that lead to litigation - increasing quality of care and reducing costs.

CME in pain medication management: From June 2013 to June 2014, the coursework offered to MIEC policy-holders will focus on pain medication management. A classroom containing six courses covering pain management, difficult patients and terminating the patient-physician relationship will be available free of charge to all primary care providers. **If you specialize in a non-primary care field of medicine and are interested in the course work, please contact Kathy Kenady or Claudia Dobbs at 510/428-9411** or toll free at 800/227-4527 for access to ELM Exchange.

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- User-friendly system allows you to stop and start at your convenience and print CE certificates right from your account; and,
- Case study-based education is engaging and represents actual medical malpractice claims.

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2. As a service, you have already been registered. Simply enter your Username [i.e., email address or, if you did not provide MIEC with an email address, enter your first name and the first letter of your last name (e.g., Ronald Smith = ronalds)]. Enter the Password elm123. You will be prompted to personalize your password.
3. Once login has been completed, you will be greeted by a Welcome page and guided to your courses.

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Call: (888) 315-4ELM (4356) or (646) 536-7544
Email: elmsupport@elmexchange.com
Visit: www.elmexchange.com

Disclosure Protections: STATE OF ALASKA

PURPOSE OF DISCLOSURE	BY WHOM	TO WHOM	PRIVILEGE / IMMUNITY	QUALIFICATION
Misconduct AS Annotated *§08.64.362*	Any person	■ Report to a public agency ■ Participating in an investigation by a public agency or an administrative or judicial proceeding ■ "Public agency" defined in case law to include nature of organization's funding sources ■ "Administrative proceeding" also defined in case law	Qualified	Made in good faith
Medical review organizations AS Annotated *§18.23.010*	Any person	Medical review organizations: ■ State Medical Board ■ Committees established by the board to review public health issues regarding morbidity and mortality ■ The Joint Commission ■ A hospital's governing body or committee that reviews information to improve quality of health care, reviews the quality of health care services provided, acts as a professional standards review organization, and reviews disputes between the following: ■ A health insurance carrier or HMO and an insured or enrollee ■ A professional licensing board and a health care provider ■ A health care provider and patients relating to care, treatment, or fees ■ A health care provider and a health insurance carrier or HMO or ■ A health care provider or patients and the federal, state, or local government		
Communication with the Alaska State Medical Association or to MIEC				Nothing in Alaska law provides ex-press protection for communication with ASMA or MIEC.

Figure 1

Disclosure Protections: STATE OF CALIFORNIA

PURPOSE OF DISCLOSURE	BY WHOM	TO WHOM	PRIVILEGE / IMMUNITY	QUALIFICATION
Reporting ■ Unprofessional conduct ■ Impairment due to drug or alcohol abuse or mental illness *B&P Code §2318*	Any person, including: ■ Physician ■ Peer review body ■ Medical society ■ Professional association	■ Medical Board ■ Board of Podiatric Medicine ■ Department of Justice	Absolute	■ N/A
Official proceedings, including (but not limited to) those intended to prompt action by a state healthcare agency *Civil Code §47(b)*		■ Proceedings by internal hospital committees ■ Judicial proceedings ■ State healthcare agencies	Absolute	N/A
Very broad: Disclosures between "interested parties," including (but not limited to): ■ Prospective employment, specifically including job performance ■ Would apply to disclosures a physician makes to medical association about another member ■ Would apply to disclosures to MIEC about another policyholder ■ Might apply to disclosures to the DMHC regarding insurance fraud *Civil Code §47(c)*	Very broad: By one who stands in such a relation to the person interested as to afford a reasonable ground for supposing the motive for the communication to be innocent, or who is requested by the person interested to give the information.	Very broad: "Interested parties"	Qualified	■ The communication must be without malice. ■ Does not apply to a communication concerning the speech or activities of an applicant for employment if the speech or activities are constitutionally protected (e.g., leaving work to vote, etc.).
Communications meant to assist in the evaluation of the qualifications, fitness, character, or insurability of a physician. Clearly relevant to credentialing and peer review activities, but has application in other contexts as well. *Civil Code §43.8*	Any person	■ Hospital ■ Medical staff ■ Professional society ■ Medical school ■ Professional licensing board ■ Senior Assistant AG of the Health Quality Enforcement Section ■ Peer review committee ■ Quality assurance committees ■ Underwriting committee	Qualified	

Figure 1 cont.

PURPOSE OF DISCLOSURE	BY WHOM	TO WHOM	PRIVILEGE / IMMUNITY	QUALIFICATION
Acts or proceedings undertaken or performed in evaluating physicians and surgeons for the writing of professional liability insurance *Civil Code §43.7*	Any physician who is a member of an underwriting committee		Qualified	■ Without malice ■ Makes a reasonable effort to obtain the facts of the matter ■ Acts in reasonable belief that the action taken by him or her is warranted by the facts known
Disclosures of medical information to a licensing body (potentially absent a patient authorization) *Civil Code §§56.10, 56.14, 56.23*	The disclosing physician and his or her medical group employer	A licensing body	Qualified	Statutes protect the physician and employer from disclosure of medical information to a licensing entity as long as the physician states any limitations relating to the authorization regarding the use of the medical information. These limitations may include those specifically provided for within a patient's signed authorization. If a disclosure is made without a patient's authorization, the physician should state that the disclosure is being made pursuant to one or more provisions of *Civil Code §56.10(b) or (c).*
Reporting insurance fraud violations: Medicare and Medi-Cal only *Insurance Code §1879.5*	Any person who believes a violation is being made	Department of Insurance	Qualified	In good faith and without malice
Suspected unsafe patient care and conditions: ■ Presenting a grievance, complaint, or report ■ Initiating, participating, or cooperating in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility *H&S Code §1278.5*	■ Patient ■ Employee of health facility ■ Member of medical staff ■ Healthcare worker	■ Healthcare facility ■ An entity or agency responsible for accrediting or evaluating the facility ■ The medical staff of the facility ■ To any other governmental entity		**NOTE:** An individual would be protected under this statute from retaliation by a hospital for disclosing inappropriate care by a big admitter to the hospital, but it does not protect the disclosing individual from retaliation from the big admitter. However, *Civil Code §47(c)* should protect against an action by the offender.

Figure 1 cont.

Disclosure Protections: STATE OF HAWAII

PURPOSE OF DISCLOSURE	BY WHOM	TO WHOM	PRIVILEGE / IMMUNITY	QUALIFICATION
Misconduct *HRS Annotated §663-1.7*	■ Any member of a peer review committee, ethics committee, or quality assurance committee ■ Any person who files a complaint with or appears as a witness before those committees ■ Any person who participates with or assists a peer review or QA committee ■ Any person providing information to a peer review or QA committee	■ Ethics committee ■ Peer review committee ■ Quality assurance committee	Qualified	No civil liability for any acts done in the furtherance of the purpose for which the committee was established, provided that: ■ The member, witness, or complainant acted without malice; and ■ The member was authorized to perform in the manner in which the member did. ■ And unless: ■ The information provided is false and ■ The person providing it knew such information was false.
Misconduct or other wrongdoing by a physician to the Hawaii Board of Medical Examiners.				There is no general immunity for persons who report misconduct or other wrongdoing by a physician to the Hawaii Board of Medical Examiners.
Peer review: providing information to a professional review body, as a witness or otherwise, regarding the competence or professional conduct of a physician. *HRS Annotated §671D-10*	Any person who participates with or assists a professional peer review body	A "professional peer review body." This includes the Hawaii Medical Association, but not MIEC.	Qualified	If a professional review action of a professional review body meets all the standards specified in section 671D-11(a): The action is taken: (1) In the reasonable belief that the action was in the furtherance of quality health care; (2) After a reasonable effort to obtain the facts of the matter; (3) After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.

Figure 1 cont.

Disclosure Protections: STATE OF IDAHO

PURPOSE OF DISCLOSURE	BY WHOM	TO WHOM	PRIVILEGE / IMMUNITY	QUALIFICATION
Violations: ■ The provision of healthcare which fails to meet the standard of healthcare provided by other qualified physicians in the same community or similar communities, taking into account his training, experience and the degree of expertise to which he holds himself out to the public. ■ Giving or receiving or aiding or abetting the giving or receiving of rebates, either directly or indirectly. ■ Engaging in any conduct which constitutes an abuse or exploitation of a patient arising out of the trust and confidence placed in the physician by the patient. *Idaho Code Annotated §54-1818*	A licensed physician and surgeon possessing knowledge of a violation. **Physicians have an affirmative duty to report these violations,** with reasonable promptness, unless the information is known, learned or discovered as a result of peer review. Failure to report shall subject physicians to disciplinary action by the board of medicine.	The Idaho Board of Medicine	Absolute	N/A
Peer review: The furnishing of information or provision of opinions to any health care organization or the receiving and use of such information and opinions. "Peer review" is the collection, interpretation, and analysis of data by a health care organization to better the system of delivering health care, improve the provision of health care, or reduce patient morbidity and mortality and improve the quality of patient care. Includes credentialing, privileging, and affiliating health care providers with a health care organization; quality assurance and improvement; and professional review action based on the competence or conduct of a physician or EMS personnel where such conduct could adversely affect a patient or the physician's privileges or employment. *Idaho Code Annotated §39-1392c*	Health care organization or person	A health care organization. Any health care organization may receive such disclosures, subject to an obligation to preserve the confidential privileged character thereof. Must be for purpose of peer review. ■ Hospital ■ In-hospital medical staff committee ■ Medical Society ■ Managed care organization ■ Licensed emergency medical service ■ Group medical practice ■ Skilled nursing facility	Absolute	N/A

Figure 1 cont.

Disclosure Protections: STATE OF IDAHO cont.

PURPOSE OF DISCLOSURE	BY WHOM	TO WHOM	PRIVILEGE / IMMUNITY	QUALIFICATION
Disabled Physician Act A physician's unfitness to practice medicine due to mental or physical disability, or due to drug or alcohol abuse. *Idaho Code Annotated §§ 54-1832, 54-1833, 54-1840*	The Idaho Board of Medicine is required to examine a physician if there is reasonable cause to believe the physician is unable to practice medicine. A qualified immunity attaches to members of the examining committee and to any person who provides information to the examining committee.	The Board of Medicine	Qualified	■ Any member of the examining committee or the board for any action undertaken or performed within the scope of the functions of the committee when acting without malice and in the reasonable belief that the action taken is warranted. ■ Any person providing information to the committee or to the board without malice and in reasonable belief that such information is accurate.

Figure 1 cont.

How to reach MIEC

PHONE:

Oakland Office: 510/428-9411

Honolulu Office: 808/545-7231

Boise Office: 208/344-6378

Outside: 800/227-4527

FAX:

Main Oakland Fax: 510/654-4634

Honolulu Fax: 808/531-5224

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