2017 Family Medicine Resident
Professional Development Seminar and Career Fair
October 20 – 21, 2017
Valley Medical Center Conference Center

Hosted by the King County Academy of Family Physicians

Faculty Bios

CONFERENCE CHAIRS:

Jeanne Cawse-Lucas, MD
Acting Assistant Professor of Family Medicine
University of Washington
Contact Info: cawse@uw.edu, 206-543-9425
Jeanne Cawse-Lucas graduated from the University of Massachusetts Medical School and did her family medicine residency at Swedish Cherry Hill. She practiced at a hospital-owned community clinic for two years and then joined the faculty at the UWSOM. At the UW, she maintains a clinical practice at the UWPN Northgate Clinic and works in medical student education as the co-director of the family medicine clerkship, FMIG advisor, and director of the Primary Care Practicums.

Tony Pedroza, MD
Clinical Professor of Family Medicine
Residency Program Director
Valley Family Medicine Residency Program
UW Medicine/Valley Medical Center
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Dr. Tony Pedroza is the Program Director of the Valley Family Medicine Residency located at UW Medicine/Valley Medical Center. He also serves as the Director of Graduate Medical Education at Valley Medical Center. He has been involved in family medicine residency education since 1989, and is a clinical professor of family medicine in the UW Department of Family Medicine. He is a current member of the executive committee of the UW WWAMI Family Medicine Residency Network. He has served as the co-course director of the KCAFP Professional Development Seminar and Career Fair for the last 4 years, and oversees the professional development curriculum at the Valley Family Medicine Residency Program.

CONFERENCE PRESENTERS:

Renee Fullerton, MPH
Rural Health Workforce Programs Manager
Washington State Department of Health
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Renee is the lead contact at the Department for the National Health Service Corps programs and advises the Washington State Health Professional Loan Repayment Program. She provides workforce assistance to rural and urban underserved healthcare facilities throughout Washington.

David Kinard, M.Ed.
Vice President Business Development
Physicians Insurance A Mutual Company
Contact Info: david@phyins.com 206-343-6618
David leads teams involved in providing medical professional liability coverage and related services to physicians, clinics, and hospitals throughout the Pacific Northwest. He regularly meets with physicians and physician leaders to develop solutions that address the challenges facing today's clinical and business sides of medicine.

Tamara L. Roe, JD
Attorney
Montgomery Purdue Blankinship & Austin PLLC
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Tamara Roe's practice focuses on representing health care practices and providers in employment issues and regulatory compliance matters. She represents both employers and employees in negotiating, drafting, and enforcing employment agreements and non-competes on a regular basis. Tammy also advises medical practices and individual physicians regarding medical staff membership and hospital privileges issues, partnership disputes, patient complaints, and charges before the United States Equal Employment Opportunity Commission, Washington State Human Rights Commission, and Washington State Department of Health. Tammy also represents employers and employees in connection with civil lawsuits involving employment contracts, discrimination, harassment, non-competes and other claims related to employment laws and health care regulations.

Carlton Wilson; MBA, MHA
Financial Manager
Swedish & Providence Health System
Contact Info: carlton.wilson@gmail.com
From 2010 – 2013 Carlton worked as a licensed Financial Advisor for middle-income families. As his wife went through residency and fellowship, he gained first-hand knowledge of the financial journey young physicians face. Though no longer a practicing advisor, Carlton continues share the fundamentals of financial planning with local residency programs.

CONFERENCE PHYSICIAN PANEL:

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Mary Swanson, MD
Family Care Network
Bellingham, Washington
Family Physician
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I have been in private group practice for the last 9 years. I practice full spectrum family medicine with obstetrics.

Lissa Lubinski, MD
Physician Owner of a Community-Inspired Family Medicine Clinic
Contact Info: connect@lissalubinskimd.com or my cell (360) 670-5131
I am a family physician and mother of two little boys and am honored to have trained at Swedish Cherry Hill with Sea Mar as my continuity clinic site. I am proficient in Spanish and originally trained for full-spectrum family medicine in an urban underserved, Spanish-speaking community. My path unfolded differently than expected when I moved to a tiny town in North Central Washington after residency, which led me to explore a variety of outpatient settings, start a hybrid hospitalist program, and ultimately open the first community-inspired family medicine clinic on the North Olympic Peninsula. My practice has low overhead and low volume, which allows me more time doing what I love best: caring for and cultivating relationships with my patients.

Dinelle Pineda MD
Medical Provider
Healthpoint Renton
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After finishing residency I spent a few months doing locums at Seamar before settling at Healthpoint in Renton where I have been for the past nine years.

James Wallace, MD MPH
Medical Director
Family Physician with OB/CS
Family Health Centers, Okanogan, WA
Contact Info: jwallace@myfamilyhealth.org
I completed FM residency at the University of North Carolina in Chapel Hill, completed the Swedish OB Fellowship and began practice in Okanogan County in 2012. Since then I've worked on hospital and clinic practice transformation, coordinated public and community health interventions, and helped build practices and organizations to meet the needs of rural underserved populations, while keeping grounded in practice as a family physician. I maintain a faculty position with the University of Washington to support their rural programs and host student/resident rotations. Since becoming Medical Director, I've developed a better understanding of how organizations work and how to advocate for physicians (and their patients) with administrators.

Kristin Parker, DO
Employer Valley Medical Center
Cascade Primary Care
Family Medicine Physician
Contact Info: Kristin_parker@valleymed.org
I can speak to my experience as both an employed physician by hospital system (currently employed by Valley Medical Center) and also from private practice since my first job out of residency was at a private clinic in Edmonds, WA. I also did obstetrics for the first 2 years of my career and do not anymore so can speak some on both of these perspectives

EVALUATING A PHYSICIAN CONTRACT

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INTRODUCTION: I am an employment and health law attorney at the law firm of Montgomery Purdue in downtown Seattle. My firm is a full-service firm and my practice consists of representing health care groups and practitioners, particularly in the areas of employment, health law, and business. I draft and review employment agreements and also handle lawsuits and disputes such as discrimination and harassment charges with the Equal Employment Opportunity Commission and unprofessional conduct complaints with the Department of Health's Medical Quality Assurance Commission.

First, I will address some of the legal issues that arise in connection with negotiating an employment contract. And then the second major topic I will address is your legal obligations as a practicing physician under Washington law.

OUTLINE

A. YOUR EMPLOYMENT CONTRACT
1. At-Will Employment
2. Terms of Employment
3. Work Load
4. Compensation
5. Benefits
6. Practice Support
7. Termination
8. Professional Liability Insurance
9. Competition Restrictions
10. Mandatory Arbitration
11. Opportunity for Partnership

B. YOUR STATUTORY OBLIGATIONS
1. Unprofessional Conduct
2. Sexual Misconduct Rules
3. Reports to Medical Quality Assurance Commission
4. Washington Health Professional Services Program

A. YOUR EMPLOYMENT CONTRACT

1. At-Will Employment

Washington is At-Will State
Exceptions to At-Will Doctrine
- Contractual provision requiring cause or advance notice
- Discrimination Statutes: protected characteristics

2. Term of Employment

Duration
Renewal: usually automatic: referred to as an "evergreen contract"

3. Work Load

Schedule
Site of Services: can you be transferred at their discretion?
Production Requirements
Call: equal rotating basis?
Outside Employment Restrictions: are you prevented from moonlighting?

4. Compensation

Salary: change after first year?
Annual Bonus: based on productivity?
Signing Bonus
Moving Expenses

5. Benefits

Health Insurance
Disability and Life Insurance
Sick and Vacation Leave
CME: standard is five (5) days and $3,000 to $5,000
Business Expenses

6. Practice Support

Equipment
Support Staff

7. Termination

Termination with Advance Notice: standard is 90 to 180 days
Termination for Cause: ***consider narrowing the definition of cause***
Notice and Opportunity to Cure
Automatic Termination:
- Death or disability
- Practice sold or bankrupt
- Loss of license, privileges or malpractice insurance
- Felony conviction

8. Professional Liability Insurance

Occurrence Coverage:

Covers any act of malpractice that occurs during the coverage period

Claims-Made Coverage:

Most common type of policy
Covers acts of malpractice reported to insurance carrier during coverage period
Premiums low during first few years – usually increases in years 5, 6 or 7

Who is the insurance carrier?

Physicians Insurance is rated Excellent and is recommended by the WSMA
Check the rating of your carrier: should be Excellent or Superior

What are the limits? Standard is $1M per claim and $3M per year to $3M/$6M

Tail and Nose Coverage

Necessary when terminating claims-made coverage
Tail = extended reporting endorsement from old insurance carrier
Nose = prior acts coverage from new insurance carrier
Many contracts are silent as to who is responsible for tail/nose premium
Consider negotiating payment by employer, at least if they let you go

9. Competition Restrictions

Non-Disclosure of Confidential Information

Usually mirrors obligation under Washington Trade Secrets Act
Common definition is all information not generally made available to the public

Non-Compete

Washington law: reasonable restrictions enforceable
Reasonable if protects legitimate business interests – must look at various factors
Consider negotiating the scope of the non-compete
- Duration: 1 to 3 years following termination of employment
- Geographic scope: 3 to 15 miles from any practice location
  - *From where does the practice draw patients?*
- Definition of competition:
  - practice of medicine or limited to specialty?
  - Exception for working at hospital or taking academic position?

Non-Solicitation

- Patients
- Employees

Remedies for Breach of Competition Restrictions

Injunctive Relief
Liquidated Damages: specific monetary penalty for breach
Attorneys' Fees

10. Mandatory Arbitration

Washington law: mandatory arbitration now enforceable if properly drafted
Exceptions: charges to EEOC or other governmental agencies
Is it one-sided?
Who is paying for arbitrator fees and costs?
Lose Constitutional Right to Trial by Judge or Jury
Favors Employers
Advantages: Less expensive
Takes less time to resolve (court cases take two years)
More predictable outcome

11. Opportunity for Partnership

When Eligible
Basis for Decision
Buy-In Amount
Consider asking for financial statements and consulting a CPA

Do you need legal counsel to review your contract? Yes

Keep in mind that contracts, including non-competes, are legally enforceable!

B. YOUR STATUTORY OBLIGATIONS

Now I will discuss some of your legal obligations under Washington law.

B.1. UNPROFESSIONAL CONDUCT

All of you are likely already familiar with the Uniform Disciplinary Act, which is the set of Washington statutes governing physician conduct.

Your packet includes as **ATTACHMENT ONE** a copy of **RCW 18.130.180**. This statute defines what is unprofessional conduct for a physician. This definition is important because any physician who engages in unprofessional conduct can be disciplined or have their license suspended or revoked and any physician who knows that another physician has committed unprofessional conduct is required to report that physician to the Medical Quality Assurance Commission which is a branch of the Washington State Department of Health.

All types of discipline are becoming increasingly important these days because of the wide knowledge and quick and easy accessibility of the **National Practitioner Data Bank**. The Data Bank is where hospitals and other health care organization are required to report certain events such as:

1. Malpractice payments, including settlements;
2. Adverse action against your license or clinical privileges;
3. Unprofessional conduct in violation of the UDA.

ATTACHMENT TWO is a **Fact Sheet on the National Practitioner Data Bank**.

Washington law actually defines 25 separate categories of unprofessional conduct. I will highlight the major categories here:

Unprofessional Conduct Relating to Medical License:
Misrepresenting or Concealing a Material Fact to Obtain a Medical License
Practicing Without License or Beyond Scope of Licensure

Unprofessional Conduct Relating to Medical Practice:
Malpractice or Incompetence
Violation of Law Regulating Profession
Commission of Crime or Act Involving Moral Turpitude Relating to Practice
Illegally Prescribing Controlled Substances or Legend Drugs
Promotion of Unnecessary or Inefficacious Drug or Treatment for Personal Gain

Unprofessional Conduct Relating to Business:
Misrepresentation or Fraud in Conducting Business
False or Misleading Advertising
Failure to Adequate Supervise Staff If Poses Public Safety Risk

Unprofessional Conduct Relating to Behavior:
Current Misuse of Alcohol, Controlled Substances or Legend Drugs
Prescribing Controlled Substances for Oneself
Sexual Misconduct

B.2. SEXUAL MISCONDUCT RULES

The Medical Quality Assurance Commission prohibits practitioners from engaging in sexual misconduct with patients or former patients.

The rules are included with your packet of materials as **ATTACHMENT THREE**:
Washington Administrative Code 246-16-100

What behaviors constitute sexual misconduct?

Obvious:

(1) Any type of sexual contact including kissing or touching that is not medically required

(2) Asking for dates or sexual favors or offering services or medications in exchange for dates or sexual favors

Not So Obvious:

(1) Not allowing the patient privacy to dress and undress

(2) Discussing sexual history or preferences unless medically necessary

(3) Accepting a date at the initiation of a patient

With whom are physicians prevented from engaging in these behaviors?

Patients, former patients, and key third parties

When is a patient no longer a patient?

The fact that a patient is not actively receiving treatment or has not received treatment recently is not determinative

In order for the physician-patient relationship to be effectively terminated, you are required to terminate the patient relationship in writing and ensure referral to another health care practice

The regulations specify that you cannot engage in any of the listed behaviors within **two years** after the physician-patient relationship ends

And then the regulations go even further – they specify that you cannot engage in any of the listed behaviors even if more than two years has passed since the patient-physician relationship was terminated if:

There is a significant likelihood that the patient will require additional treatment from you; or

There is an imbalance of power, influence, opportunity, and/or special knowledge

Who is a key third party?

Immediate family members and others who could reasonably be expected to play a significant role in the patient's health care decisions, such as a spouse, domestic partner, sibling, parent, guardian, or child

So you are prohibited under the regulations from asking out or dating or engaging in the other listed behaviors not only with your patients, but also your patients' family **members**

It is not a defense if the patient initiates or consents to the conduct.

B.3. MANDATORY REPORTS TO MEDICAL QUALITY ASSURANCE COMMISSION:

Under the Uniform Disciplinary Act, you must report to MQAC:

1. Any finding that a practitioner committed Unprofessional Conduct or

2. Any information that a practitioner is Unable to Practice with Reasonable Skill and Safety

Exceptions to Reporting Obligation:

1. A report is NOT required by a licensed hospital or appropriately designated professional review committee during the **Investigative Phase** in connection with possible Unprofessional Conduct or Impairment IF the investigation is completed in a timely manner.

2. Another exception to the Washington reporting obligation applies to health care providers providing **Treatment** to impaired or potentially impaired physicians.
A report is NOT required by a physician giving treatment to another physician currently involved in a treatment program IF:

The Physician Actively Participates in the treatment program, AND
The Physician Does Not Present a Clear and Present Danger to the Public.

3. The Requirement of a Mandatory Report to the Washington Medical Quality Assurance Commission may be satisfied by reporting to the Washington Physicians Health Program.

B.4. WASHINGTON PHYSICIANS HEALTH PROGRAM

Washington Physicians Health Program:
Charles Meredith, MD, Medical Director
Scott Alberti, Clinic Director
720 Olive Way, Suite 1010
Seattle, WA 98101
206.583.0127
http://www.wphp.org

A report to the Program allows the physician to be evaluated by professionals and receive help if necessary and also allows the reporting professional or organization to avoid the decision of whether to report the physician to the Medical Quality Assurance Commission.

Once referred to the Program, the physician is evaluated and the Program makes the decision of whether treatment is necessary, whether the physician may continue to work while receiving treatment, and whether a report to the Commission is required.

In most cases, a report to the Commission will not be required.

The Washington Physicians Health Program is required to report to the Commission ONLY IF:

(1) Physician Presents Imminent Danger to the Public
(2) Physician Fails to Comply with Treatment Program
    Fails to Submit to Evaluation
    Fails to Sign Contract with Program
    Fails to Comply with Contract
(3) Physician Fails to Respond to Treatment

Immunity for Reporting:
Under Washington Law, anyone who makes a **Good Faith Report** to the Washington Quality Assurance Commission or Washington Physicians Health Program is immune from civil liability.

A **Good Faith Report** means providing information that is true to the best of your knowledge and making the report with good faith intent in light of all of the circumstances, as opposed to providing information that you know is false for malicious purposes.

CONCLUSION

I will leave you with parting comment from the book Blink by Malcolm Gladwell. His book is about the concept of thin-slicing and interestingly, he applies the concept to medical malpractice.

He poses a fascinating question and I will do the same here. Suppose you wanted to figure out which physician in this room was most likely to be sued for medical malpractice. You have two choices, you can examine the physicians' training and credentials and analyze their records to see how many errors they have made. The other option is to listen to very brief snippets of conversation between each physician and his or her patients. Which method would you think would be most likely to tell you who will be sued? The latter method because the risk of being sued for malpractice has very little to do with how many mistakes you make. Believe it or not, analysis of malpractice suits show that there are highly skilled doctors that get sued a lot and doctors who make lots of mistakes but never get sued.

Also, the overwhelming numbers of people who suffer an injury due to malpractice never sue at all. Patients don't file lawsuits because they've been harmed. Patients file suits because they've been harmed and they don't like the way they were treated by their doctor on a personal level. In other words, patients sue the doctors they don't like.

A medical researcher recorded hundreds of conversations between a group of physicians and their patients. Roughly half had never been sued and the other half has been sued at least twice. She easily found clear differences in the way the two groups of physicians communicated with their patients. But it wasn't how much details they provided. There was a slight difference in how much time they spend, with the doctors who had never been sued spending a few extra minutes with their patients, but the real difference was found to be in the way they communicated.

The physicians who had never been sued used "orienting statements" indicating what they will be doing and why, and engaged in "active listening" and responded to their patients' questions. Also, the doctors who had never been sued were much more likely to laugh and be funny. There was no difference in the amount or quality of information they gave their patients: the difference was entirely in how they communicated with their patients.

Tone of voice was found to be important. Whereas physicians with dominant tones were in the group that had been sued, physicians with a concerned, caring tone of voice were found to be in the group that had never been sued.

The key to avoiding lawsuits then is to use a tone of voice that conveys respect and compassion for your patients.

RCW 18.130.180
Unprofessional conduct.

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by RCW 18.130.345, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented,

as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

[2010 c 9 § 5; 2008 c 134 § 25; 1995 c 336 § 9; 1993 c 367 § 22. Prior: 1991 c 332 § 34; 1991 c 215 § 3; 1989 c 270 § 33; 1986 c 259 § 10; 1984 c 279 § 18.]

Notes:

Intent -- 2010 c 9: See note following RCW 69.50.315.

Finding -- Intent -- Severability -- 2008 c 134: See notes following RCW 18.130.020.

Application to scope of practice -- Captions not law -- 1991 c 332: See notes following RCW 18.130.010.

Severability -- 1986 c 259: See note following RCW 18.130.010.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

FACT SHEET ON THE NATIONAL PRACTITIONER DATA BANK

Background of the National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established through Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986* (the Act), as amended. Final regulations governing the NPDB are codified at 45 CFR Part 60. Responsibility for NPDB implementation resides in the Bureau of Health Professions, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS).

The intent of Title IV of P.L. 99-660 is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid.

Interpretation of NPDB Information

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. Eligible entities should use the information contained in the NPDB in conjunction with information from other sources when granting clinical privileges or in employment, affiliation, or licensure decisions.

The information contained in the NPDB is intended to direct discrete inquiry into and scrutiny of specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. NPDB information is an important supplement to a comprehensive and careful review of a practitioner's professional credentials. The NPDB is intended to augment, not replace, traditional forms of credentials review. As a nationwide flagging system, it provides another resource to assist State licensing boards, hospitals, and other health care entities in conducting extensive, independent investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant clinical privileges.

Settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician, dentist, or other health care practitioner. Thus, a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred.

The information in the NPDB should serve only to alert State licensing authorities and health care entities that there **may** be a problem with a particular practitioner's professional competence or conduct. NPDB information should be considered together with other relevant data in evaluating a practitioner's credentials (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, health status, verification of training and experience, and relationships with patients and colleagues).

Confidentiality of NPDB Information

Information reported to the NPDB is considered confidential and shall not be disclosed except as specified in the NPDB regulations at 45 CFR Part 60. The Office of Inspector General (OIG), HHS, has been delegated the authority to impose civil money penalties on those who violate the confidentiality provisions of Title IV. Persons or entities who receive information from the NPDB either directly or indirectly are subject to the confidentiality provisions and the imposition of a civil money penalty if they violate those provisions. When an authorized agent is designated to handle NPDB queries or reports, both the entity and the agent are required to maintain confidentiality in accordance with Title IV requirements.

For each violation of confidentiality, a civil money penalty of up to $11,000 can be levied. In any case in which it is determined that more than one party was responsible for improperly disclosing confidential information, a penalty of up to the maximum $11,000 limit can be imposed against each responsible individual, entity, or organization.

Eligible Entities

Entities entitled to participate in the NPDB are defined in the provisions of P.L. 99-660 and the NPDB regulations. Eligible entities are responsible for meeting Title IV reporting and querying requirements, as appropriate. Each eligible entity must certify its eligibility to the NPDB in order to report to or query the NPDB. Refer to the *Fact Sheet on Entity Eligibility*, available at *www.npdb-hipdb.hrsa.gov*.

The NPDB is available to State licensing boards; hospitals and other health care entities, including professional societies; Federal agencies; and others as specified in the law to provide information on the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners. The NPDB collects information on medical

malpractice payments and adverse licensure, clinical privilege, professional society membership actions. The NPDB also contains information regarding practitioners who have been declared ineligible to participate in Medicare or Medicaid under the *Social Security Act*.

Querying

The NPDB is a resource to assist State licensing boards, hospitals, and other health care entities in conducting investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant membership or clinical privileges.

Eligible entities may query as follows:

- **Mandatory Querying:** Hospitals **must** query when a practitioner applies for privileges and every 2 years on practitioners on the medical staff or holding privileges. Hospitals are also required to query the NPDB when a practitioner wishes to add to or expand existing privileges and when a practitioner submits an application for temporary privileges.

- **Voluntary Querying:** Hospitals **may** query at other times as necessary for professional review activity.

  Other health care entities that provide health care services and have a formal peer review process, including professional societies, **may** query when entering an employment or affiliation relationship with a physician, dentist, or other health care practitioner, or in conjunction with professional review activities.

  State licensing boards **may** query at any time on physicians, dentists, and other health care practitioners.

  Health care practitioners **may** self-query at any time.

  Plaintiff's attorneys or a plaintiff representing himself or herself (pro se) **may** query under certain circumstances.

The NPDB is prohibited by law from disclosing information on a specific practitioner to a medical malpractice insurer, defense attorney, or member of the general public.

Sanctions for Failing to Query the NPDB

Any hospital that does not query on a practitioner (1) at the time the practitioner applies for a position on its medical staff or for clinical privileges at the hospital, and (2) every 2 years concerning any practitioner who is on its medical staff or has clinical privileges at the hospital, is presumed to have knowledge of any information reported to the NPDB concerning the practitioner. A hospital's failure to query on a practitioner may give a plaintiff's attorney or a plaintiff representing himself or herself access to NPDB information on that practitioner, for use in litigation against the hospital.

Fees for Requesting Information

Fees are charged for all queries to the NPDB and are announced in the *Federal Register*. Query fees are based on the cost of processing requests and providing information to eligible entities. The NPDB only accepts payments for query fees by pre-authorized Electronic Funds Transfer (EFT) or credit card (VISA, MasterCard, Discover, or American Express). To establish an EFT account, complete an on-line *Electronic Funds Transfer Authorization* form. You may obtain the form from the NPDB-HIPDB Web site. For information on Data Bank querying fees and acceptable payment methods, see the *Fact Sheet on Query Fees*.

Practitioner Self-Queries

A practitioner may self-query the Data Banks at any time by visiting the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. All self-query fees must be paid by credit card. For detailed instructions about self-querying, see the *Fact Sheet on Self-Querying*.

Reporting

The information required to be reported to the NPDB is applicable to physicians and dentists and, in some cases, other health care practitioners who are licensed or otherwise authorized by a State to provide health care services.

The NPDB is committed to maintaining accurate information and ensuring that health care practitioners are informed when medical malpractice payments or adverse actions are reported concerning them. The NPDB cannot edit any information contained in a report. Reporting entities are responsible for the accuracy of the information they report to the NPDB.

When the NPDB processes a Medical Malpractice Payment Report or an Adverse Action Report, notice is sent to the reporting entity and to the subject. Both parties should review the report for accuracy. Subjects may not submit changes to reports. If any information in a report is inaccurate, the subject must contact the reporting entity to request that it correct the information.

The subject of a Medical Malpractice Payment Report or an Adverse Action Report may add a Statement to the report, dispute either the factual accuracy of the information in the report or whether the report was submitted in accordance with NPDB reporting requirements, or both.

If the subject and the reporting entity cannot resolve the issues in dispute, the subject may request that the Secretary of HHS review the disputed report.

Medical Malpractice Payments

Each entity that makes a medical malpractice payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or a judgment against that practitioner, must

report certain payment information to the NPDB. A payment made as result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable.

Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services. A written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any State or Federal court or other adjudicative body, such as a claims arbitration board.

Medical malpractice payers must report medical malpractice payments within 30 days of the date a payment is made. The report must be submitted to the NPDB. Once processed, a copy of the report must immediately be sent to the appropriate State licensing board in the State in which the malpractice claim occurred. Reports must be submitted regardless of how, or if, the matter was settled (for instance, court judgment, out-of-court settlement, or arbitration).

Adverse Licensure Actions

State medical and dental boards must report certain disciplinary actions related to professional competence or conduct taken against the licenses of physicians or dentists. Such licensure actions include revocation, suspension, censure, reprimand, probation, and surrender. State medical and dental boards must also report revisions to adverse licensure actions. Adverse licensure actions must be reported to the NPDB within 30 days from the date of the action.

Adverse Clinical Privileges Actions

- **Mandatory Reporting**: Hospitals and other eligible health care entities **must** report professional review actions that adversely affect a physician's or dentist's clinical privileges for a period of more than 30 days. They must also report the acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting an investigation or professional review action. Revisions to such actions must also be reported.

- **Voluntary Reporting:** Hospitals and other health care entities **may** report adverse actions taken against the clinical privileges of licensed health care practitioners other than physicians and dentists. Revisions to such actions must also be reported.

Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. The health care entity must print a copy of each report submitted to the NPDB and mail it to the appropriate State licensing board for its use. The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB must be used for submission to the appropriate State licensing board.

Adverse Professional Membership Actions

- **Mandatory Reporting**: Professional societies must report specific information when any professional review action, based on reasons related to professional competence or conduct, adversely affects the membership of a physician or dentist. Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Revisions to such actions must also be reported.

- **Voluntary Reporting:** A professional society of health disciplines other than medicine and dentistry may similarly report adverse actions taken against the membership of their health care practitioners. Revisions to such actions must also be reported.

Medicare/Medicaid Exclusion Reports

The NPDB currently includes information regarding practitioners who have been declared ineligible from participating in, or have been reinstated to participate in, Medicare or Medicaid. Hospitals, managed care organizations, and other providers are prohibited from billing Medicare and Medicaid for any services that might be rendered by these practitioners.

Medicare/Medicaid Exclusion Reports were added to the NPDB through a collective effort and Memorandum of Understanding among the HRSA, OIG, and the Centers for Medicare & Medicaid Services (CMS). This information is released in accordance with the *Social Security Act* and the *Privacy Act*. CMS retains full responsibility for the content and accuracy of Medicare/Medicaid Exclusion Reports; the NPDB acts only as a disclosure service. Notification of exclusion from Medicare and Medicaid programs is made by CMS.

Sanctions for Failing to Report to the NPDB

Medical Malpractice Payers

The HHS OIG has the authority to impose civil money penalties in accordance with Sections 421(c) and 427(b) of Title IV of P.L. 99-660, the *Health Care Quality Improvement Act of 1986*, as amended. Under the statute, any medical malpractice payer that fails to report medical malpractice payments in accordance with Section 421(c) is subject to a civil money penalty of up to $11,000 for each such payment involved.

Hospitals and Other Health Care Entities

If HHS determines that a hospital or other health care entity, including a professional society, has substantially failed to report information in accordance with Title IV requirements, the name of the entity will be published in the *Federal Register*, and the entity will lose the immunity provisions of Title IV with respect to professional review activities for a period of 3 years, commencing 30 days from the date of publication in the *Federal Register*.

State Boards

State medical and dental boards that fail to comply with NPDB reporting requirements can have the responsibility to report removed from them by the Secretary of HHS. In such instances, the Secretary will designate another qualified entity to report NPDB information.

Attorney Access

A plaintiff's attorney or a plaintiff representing himself or herself (pro se) is permitted to obtain information from the NPDB under limited conditions:

- A medical malpractice action or claim must have been filed by the plaintiff against a hospital in a State or Federal court or other adjudicative body.
- The practitioner on whom the information is requested must be named in the action or claim.

Obtaining NPDB information on the specified practitioner is permitted only after evidence is submitted to HHS demonstrating that the hospital failed to submit a mandatory query to the NPDB regarding the practitioner named by the plaintiff in the action. This evidence is not available to the plaintiff through the NPDB. Evidence that the hospital failed to request information from the NPDB must be obtained by the plaintiff from the hospital through discovery in the litigation process. Defense attorneys are not permitted to query because the defendant can self-query.

Coordination with the HIPDB

The Healthcare Integrity and Protection Data Bank (HIPDB) was established through the *Health Insurance Portability and Accountability Act of 1996*, Section 221(a), Public Law 104-191. The HIPDB is a national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, criminal convictions, and civil judgments related to health care, and other adjudicated actions or decisions.

To alleviate the burden on those entities that must report to both the HIPDB and the NPDB, a system has been created to allow an entity that must report to both Data Banks to submit the report only once. This Integrated Querying and Reporting Service (IQRS) is able to sort the appropriate actions into the NPDB, the HIPDB, or both. Similarly, entities authorized to query both Data Banks have the option of querying both the NPDB and the HIPDB with a single query submission.

All final adverse actions taken on or after August 21, 1996 (the date Section 1128E was passed), must be reported to the HIPDB. The HIPDB cannot accept any report with a date of action taken prior to August 21, 1996.

NPDB-HIPDB Assistance

For additional information, visit the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. If you need assistance, contact the NPDB-HIPDB Customer Service Center by e-mail at *help@npdb-hipdb.hrsa.gov* or by phone at 1-800-767-6732 (TDD 703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

Chapter 246-16 WAC
STANDARDS OF PROFESSIONAL CONDUCT

WAC

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WAC 246-16-010 Purpose of chapter. The rules in this chapter define certain acts of unprofessional conduct for health care providers under the jurisdiction of the secretary of the department of health as provided in RCW 18.130.040 (2)(a) including persons licensed or certified by the secretary under chapter 18.73 RCW or RCW 18.71.205. The rules also provide for sanctions. The secretary may adopt rules applicable to specific professions under RCW 18.130.040(2). These rules also serve as model rules for the disciplining authorities listed in RCW 18.130.040 (2)(b).

[Statutory Authority: RCW 18.130.050 (1), (12) and 18.130.180. 06-18-045, § 246-16-010, filed 8/30/06, effective 9/30/06.]

WAC 246-16-020 Definitions. (1) "Health care information" means any information, whether oral or recorded in any form or medium that identifies or can readily be associated with the identity of, and relates to the health care of, a patient or client.

(2) "Health care provider" means an individual applying for a credential or credentialed in a profession listed in RCW 18.130.040 (2)(a).

(3) "Key party" means immediate family members and others who would be reasonably expected to play a significant role in the health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client.

(4) "Legitimate health care purpose" means activities for examination, diagnosis, treatment, and personal care of patients or clients, including palliative care, as consistent with community standards of practice for the profession. The activity must be within the scope of practice of the health care provider.

(5) "Patient" or "client" means an individual who receives health care from a health care provider.

[Statutory Authority: RCW 18.130.050 (1), (12) and 18.130.180. 06-18-045, § 246-16-020, filed 8/30/06, effective 9/30/06.]

SEXUAL MISCONDUCT

WAC 246-16-100 Sexual misconduct. (1) A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes but is not limited to:

(a) Sexual intercourse;

(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis and treatment and within the health care practitioner's scope of practice;

(c) Rubbing against a patient or client or key party for sexual gratification;

(d) Kissing;

(e) Hugging, touching, fondling or caressing of a romantic or sexual nature;

(f) Examination of or touching genitals without using gloves;

(g) Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient or client a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient, client or key party;

(j) Removing patient or client's clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;

(k) Encouraging masturbation or other sex act in the presence of the health care provider;

(l) Masturbation or other sex act by the health care provider in the presence of the patient, client or key party;

(m) Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;

(n) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;

(o) Soliciting a date with a patient, client or key party;

(p) Discussing the sexual history, preferences or fantasies of the health care provider;

(q) Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;

(r) Making statements regarding the patient, client or key party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;

(s) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or key party;

(t) Photographing or filming the body or any body part or pose of a patient, client, or key party, other than for legitimate health care purposes; and

(u) Showing a patient, client or key party sexually explicit photographs, other than for legitimate health care purposes.

(2) A health care provider shall not:

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;

(c) Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.

(3) A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client or key party within two years after the provider-patient/client relationship ends.

(4) After the two-year period of time described in subsection (3) of this section, a health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section if:

(a) There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care provider; or

(b) There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

(5) When evaluating whether a health care provider is prohibited from engaging, or attempting to engage, in sexual misconduct, the secretary will consider factors, including but not limited to:

(a) Documentation of a formal termination and the circumstances of termination of the provider-patient relationship;

(b) Transfer of care to another health care provider;

(c) Duration of the provider-patient relationship;

(d) Amount of time that has passed since the last health care services to the patient or client;

(e) Communication between the health care provider and the patient or client between the last health care services rendered and commencement of the personal relationship;

(f) Extent to which the patient's or client's personal or private information was shared with the health care provider;

(g) Nature of the patient or client's health condition during and since the professional relationship;

(h) The patient or client's emotional dependence and vulnerability; and

(i) Normal revisit cycle for the profession and service.

(6) Patient, client or key party initiation or consent does not excuse or negate the health care provider's responsibility.

(7) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or

(c) Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client.

[Statutory Authority: RCW 18.130.050 (1), (12) and 18.130.180. 06-18-045, § 246-16-100, filed 8/30/06, effective 9/30/06.]

MANDATORY REPORTING

WAC 246-16-200 Mandatory reporting—Intent. These mandatory reporting rules require certain reports about license holders and are intended to address patient safety. These rules are not intended to limit reports from any person who has a concern about a license holder's conduct or ability to practice safely.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-200, filed 3/31/08, effective 5/1/08.]

WAC 246-16-210 Mandatory reporting—Definitions. (1) "Approved impaired practitioner or voluntary substance abuse program" means a program authorized by RCW 18.130.175 and approved by a disciplining authority listed in RCW 18.130.040.

(2) "Conviction" means a court has decided a person is guilty of any gross misdemeanor or felony. It includes any guilty or no contest plea and all decisions with a deferred or suspended sentence.

(3) "Determination or finding" means a final decision by an entity required or requested to report under this chapter. This applies even if no adverse action or sanction has been imposed or if the license holder is appealing the decision.

(4) "License holder" means a person holding a credential in a profession regulated by a disciplining authority listed in RCW 18.130.040(2).

(5) "Unable to practice with reasonable skill and safety due to a mental or physical condition" means a license holder who:

(a) A court has declared to be incompetent or mentally ill; or

(b) Is not successfully managing a mental or physical condition and as a result poses a risk to patient safety.

(6) "Unprofessional conduct" means the acts, conduct, or conditions described in RCW 18.130.180.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-210, filed 3/31/08, effective 5/1/08.]

WAC 246-16-220 Mandatory reporting—How and when to report. (1) Reports are submitted to the department

of health. The department will give the report to the appropriate disciplining authority for review, possible investigation, and further action.

(a) When a patient has been harmed, a report to the department is required. A report to one of the approved impaired practitioner or voluntary substance abuse programs is not a substitute for reporting to the department.

(b) When there is no patient harm, reports of inability to practice with reasonable skill and safety due to a mental or physical condition may be submitted to one of the approved impaired practitioner or voluntary substance abuse programs or to the department. Reports of unprofessional conduct are submitted to the department.

(c) Reports to a national practitioner data bank do not meet the requirement of this section.

(2) The report must include enough information to enable the disciplining authority to assess the report. If these details are known, the report should include:

(a) The name, address, and telephone number of the person making the report.

(b) The name, address, and telephone number(s) of the license holder being reported.

(c) Identification of any patient or client who was harmed or placed at risk.

(d) A brief description or summary of the facts that caused the report, including dates.

(e) If court action is involved, the name of the court, the date of filing, and the docket number.

(f) Any other information that helps explain the situation.

(3) Reports must be submitted no later than thirty calendar days after the reporting person has actual knowledge of the information that must be reported.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-220, filed 3/31/08, effective 5/1/08.]

WAC 246-16-230 Mandatory reporting—License holder self reports. Each license holder must self report:

(1) Any conviction, determination, or finding that he or she has committed unprofessional conduct; or

(2) Information that he or she is unable to practice with reasonable skill and safety due to a mental or physical condition; or

(3) Any disqualification from participation in the federal medicare or medicaid program.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-230, filed 3/31/08, effective 5/1/08.]

WAC 246-16-235 Mandatory reporting—License holder reporting other license holders. A license holder must report another license holder in some circumstances.

(1) The reporting license holder must submit a report when he or she has actual knowledge of:

(a) Any conviction, determination, or finding that another license holder has committed an act that constitutes unprofessional conduct; or

(b) That another license holder may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition.

(2) The license holder does not have to report when he or she is:

(a) A member of a professional review organization as provided in WAC 246-16-255;

(b) Providing health care to the other license holder and the other license holder does not pose a clear and present danger to patients or clients; or

(c) Part of a federally funded substance abuse program or approved impaired practitioner or voluntary substance abuse program and the other license holder is participating in treatment and does not pose a clear and present danger to patients or clients.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-235, filed 3/31/08, effective 5/1/08.]

WAC 246-16-240 Mandatory reporting—Reports by professional liability insurance carriers. Every institution, corporation or organization providing professional liability insurance to a license holder must report:

(1) Any malpractice settlement, award, or payment in excess of twenty thousand dollars that results from a claim or action for damages allegedly caused by a license holder's incompetence or negligence in the practice of the profession.

(2) Award, settlement, or payment of three or more claims during a twelve-month period that result from claims or actions for damages allegedly caused by the license holder's incompetence or negligence in the practice of the profession.

(3) Reports made according to RCW 18.57.245 or 18.71.350 meet the requirement.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-240, filed 3/31/08, effective 5/1/08.]

WAC 246-16-245 Mandatory reporting—Reports by health care institutions. (1) This section applies to:

(a) Hospitals and specialty hospital defined in chapter 70.41 RCW;

(b) Ambulatory surgery facilities defined in chapter 70.230 RCW;

(c) Childbirth centers defined in chapter 18.46 RCW;

(d) Nursing homes defined in chapter 18.51 RCW;

(e) Chemical dependency treatment programs defined in chapter 70.96A RCW;

(f) Drug treatment agencies defined in chapter 69.54 RCW; and

(g) Public and private mental health treatment agencies defined in RCW 71.05.020 and 71.24.025.

(2) The chief administrator or executive officer or designee of these institutions must report when:

(a) A license holder's services are terminated or restricted because a license holder has harmed or placed at unreasonable risk of harm a patient or client; or

(b) A license holder poses an unreasonable risk of harm to patients or clients due to a mental or physical condition.

(3) Reports made by a hospital according to RCW 70.41.210 meet the requirement.

(4) Commencing July 1, 2009, reports made by an ambulatory surgical center according to RCW 70.230.110 meet the requirement.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-245, filed 3/31/08, effective 5/1/08.]

WAC 246-16-250 Mandatory reporting—Reports by health service contractors and disability insurers. The executive officer of health care service contractors and disability insurers licensed under chapters 48.20, 48.21, 48.21A, and 48.44 RCW must report when the entity has made a determination or finding that a license holder has engaged in billing fraud.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-250, filed 3/31/08, effective 5/1/08.]

WAC 246-16-255 Mandatory reporting—Reports by professional review organizations. (1) This section applies to every peer review committee, quality improvement committee, or other similarly designated professional review organization operating in the state of Washington.

(2) Unless prohibited by state or federal law, the professional review organization must report:

(a) When it makes a determination or finding that a license holder has caused harm to a patient or placed a patient at unreasonable risk of harm; and

(b) When it has actual knowledge that the license holder poses an unreasonable risk of harm due to a mental or physical condition.

(3) Professional review organizations and individual license holders participating in a professional review organization do not need to report during the investigative phase of the professional review organization's operation if the organization completes the investigation in a timely manner.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-255, filed 3/31/08, effective 5/1/08.]

WAC 246-16-260 Mandatory reporting—Reports by courts. The department requests that the clerks of trial courts in Washington report professional malpractice judgments and all convictions against a license holder.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-260, filed 3/31/08, effective 5/1/08.]

WAC 246-16-265 Mandatory reporting—Reports by state and federal agencies. The department requests that any state or federal program employing a license holder in Washington reports:

(1) When it determines a license holder has harmed or placed at unreasonable risk of harm a patient or client; and

(2) When it has actual knowledge that the license holder poses an unreasonable risk of harm due to a mental or physical condition.

[Statutory Authority: RCW 18.130.070 and 18.130.060. 08-08-066, § 246-16-265, filed 3/31/08, effective 5/1/08.]

WAC 246-16-270 Mandatory reporting—Reports by employers of license holders. (1) Every license holder, corporation, organization, health care facility, and state and local governmental agency that employs a license holder shall report to the department of health when the employed license holder's services have been terminated or restricted based on a final determination or finding that the license holder:

(a) Has committed an act or acts that may constitute unprofessional conduct; or

(b) May not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition.

(2) Reports under this section must be submitted to the department of health as soon as possible but no later than twenty days after a final determination or finding is made. The report should contain the information described in WAC 246-16-220(2).

(3) Reports made by a hospital according to RCW 70.41.210 and reports by ambulatory surgical facilities according to RCW 70.230.120 meet the requirement of this section.

(4) If a license holder fails to submit a report required by this section, a civil penalty of up to five hundred dollars may be imposed and the disciplining authority may take action against the license holder for unprofessional conduct.

[Statutory Authority: RCW 18.130.080. 09-04-050, § 246-16-270, filed 1/30/09, effective 3/2/09.]

SANCTIONS

WAC 246-16-800 Sanctions—General provisions. (1) Applying these rules.

(a) The disciplining authorities listed in RCW 18.130.040(2) will apply these rules to determine sanctions imposed for unprofessional conduct by a license holder in any active, inactive, or expired status. The rules do not apply to applicants.

(b) The disciplining authorities will apply the rules in:

(i) Orders under RCW 18.130.110 or 18.130.160; and

(ii) Stipulations to informal disposition under RCW 18.130.172.

(c) Sanctions will begin on the effective date of the order.

(2) Selecting sanctions.

(a) The disciplining authority will select sanctions to protect the public and, if possible, rehabilitate the license holder.

(b) The disciplining authority may impose the full range of sanctions listed in RCW 18.130.160 for orders and RCW 18.130.172 for stipulations to informal dispositions.

(i) Suspension or revocation will be imposed when the license holder cannot practice with reasonable skill or safety.

(ii) Permanent revocation may be imposed when the disciplining authority finds the license holder can never be rehabilitated or can never regain the ability to practice safely.

(iii) Surrender of a credential may be imposed when the license holder is at the end of his or her effective practice and surrender alone is enough to protect the public. The license holder must agree to retire and not resume practice.

(iv) Indefinite suspension may be imposed in default and waiver of hearing orders. If indefinite suspension is not imposed in a default or waiver of hearing order, the disciplining authority shall impose sanctions determined according to these rules.

(v) "Oversight" means a period of time during which respondent must engage in on-going affirmative conduct intended to encourage rehabilitation and ensure public safety. It also includes active compliance monitoring by the disciplining authority. The passage of time without additional

complaints or violations, with or without payment of a fine or costs, is not, by itself, oversight.

(c) The disciplining authority may deviate from the sanction schedules in these rules if the schedule does not adequately address the facts in a case. The disciplining authority will acknowledge the deviation and state its reasons for deviating from the sanction schedules in the order or stipulation to informal disposition.

(d) If the unprofessional conduct is not described in a schedule, the disciplining authority will use its judgment to determine appropriate sanctions. The disciplining authority will state in the order or stipulation to informal disposition that no sanction schedule applies.

(3) Using sanction schedules.

(a) Step 1: The findings of fact in an order or the allegations in an informal disposition describe the unprofessional conduct. The disciplining authority uses the unprofessional conduct described to select the appropriate sanction schedule contained in WAC 246-16-810 through 246-16-860.

(i) If the act of unprofessional conduct falls in more than one sanction schedule, the greater sanction is imposed.

(ii) If different acts of unprofessional conduct fall in the same sanction schedule, the highest sanction is imposed and the other acts of unprofessional conduct are considered aggravating factors.

(b) Step 2: The disciplining authority identifies the severity of the unprofessional conduct and identifies a tier using the sanction schedule tier descriptions.

(c) Step 3: The disciplining authority identifies aggravating or mitigating factors using the list in WAC 246-16-890. The disciplining authority describes the factors in the order or stipulation to informal disposition.

(d) Step 4: The disciplining authority selects sanctions within the identified tier. The starting point for duration of the sanctions is the middle of the tier range.

(i) Aggravating factors move the appropriate sanctions towards the maximum end of the tier range.

(ii) Mitigating factors move the appropriate sanctions towards the minimum end of the tier range.

(iii) Mitigating or aggravating factors may result in determination of a sanction outside the range in the tier. The disciplining authority will state its reasons for deviating from the tier range in the sanction schedule in the order or stipulation to informal disposition. The disciplining authority has complied with these rules if it acknowledges the deviation and states its reasons for deviating from the sanction schedules in the order or stipulation to informal disposition.

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-800, filed 7/22/09, effective 8/22/09.]

WAC 246-16-810 Sanction schedule—Practice below standard of care.

PRACTICE BELOW STANDARD OF CARE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least  greatest	A – Caused no or minimal patient harm or a risk of minimal patient harm	Conditions that may include reprimand, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Caused moderate patient harm or risk of moderate to severe patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
	C – Caused severe harm or death to a human patient	Oversight for 3 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. In addition - demonstration of knowledge or competency.	Permanent conditions, restrictions or revocation.	3 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-810, filed 7/22/09, effective 8/22/09.]

WAC 246-16-820 Sanction schedule—Sexual misconduct or contact.

SEXUAL MISCONDUCT OR CONTACT (including convictions for sexual misconduct)				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** –Inappropriate conduct, contact, or statements of a sexual or romantic nature	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Sexual contact, romantic relationship, or sexual statements that risk or result in patient harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Sexual contact, including but not limited to contact involving force and/or intimidation, and convictions of sexual offenses in RCW 9.94A.030.	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-820, filed 7/22/09, effective 8/22/09.]

WAC 246-16-830 Sanction schedule—Abuse—Physical and emotional.

ABUSE -- Physical and/or Emotional				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	**A** – Verbal or nonverbal intimidation, forceful contact, or disruptive or demeaning behavior, including general behavior not necessarily directed at a specific patient or patients	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 3 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-3 years
	B – Abusive unnecessary or forceful contact or disruptive or demeaning behavior causing or risking moderate mental or physical harm, including general behavior not directed at a specific patient or patients.	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	**C** – Severe physical, verbal, or forceful contact, or emotional disruptive behavior, that results in or risks significant harm or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions, or revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-830, filed 7/22/09, effective 8/22/09.]

WAC 246-16-840 Sanction schedule—Diversion of controlled substances or legend drugs.

DIVERSION OF CONTROLLED SUBSTANCES OR LEGEND DRUGS				
Severity	Tier/Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least	A – Diversion with no or minimal patient harm or risk of harm	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, treatment, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, treatment etc.	0-5 years
	B – Diversion with moderate patient harm or risk of harm or for distribution	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc.	Oversight for 7 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc. OR revocation.	2 - 7 years unless revocation
greatest	C – Diversion with severe physical injury or death of a patient or a risk of severe physical injury or death or for substantial distribution to others	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions OR revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-840, filed 7/22/09, effective 8/22/09.]

WAC 246-16-850 Sanction schedule—Substance abuse.

SUBSTANCE ABUSE				
Severity	Tier / Conduct	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least ↓ greatest	**A** – Misuse of drugs or alcohol with no to minimal patient harm or risk of harm	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, treatment, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, treatment, etc.	0-5 years
	B –Misuse of drugs or alcohol with moderate patient harm or risk of harm	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc.	Oversight for 7 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, treatment, etc. OR revocation.	2 - 7 years unless revocation
	C –Misuse of drugs or alcohol with severe physical injury or death of a patient or a risk of significant physical injury or death	1 year suspension AND oversight for 5 additional years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. AND demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions OR revocation.	6 years - permanent

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-850, filed 7/22/09, effective 8/22/09.]

WAC 246-16-860 Sanction schedule—Criminal convictions.

CRIMINAL CONVICTIONS (excluding sexual misconduct)				
Severity	Tier / Conviction	Sanction Range In consideration of Aggravating & Mitigating Circumstances		Duration
		Minimum	Maximum	
least ↓	A – Conviction of a Gross Misdemeanor except sexual offenses in RCW 9.94A.030	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for 5 years which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	0-5 years
	B – Conviction of a Class B, C, OR Unclassified Felony, except sexual offenses in RCW 9.94A.030	Oversight for 2 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for 5 years which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc. OR revocation.	2 years - 5 years unless revocation
greatest	C – Conviction of a Class A Felony, except sexual offenses in RCW 9.94A.030	5 years suspension	Permanent revocation	5 years - permanent revocation

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-860, filed 7/22/09, effective 8/22/09.]

WAC 246-16-890 Sanctions—Aggravating and mitigating factors. The following nonexclusive list identifies factors that may mitigate or aggravate the sanctions that should be imposed in an order or stipulation to informal disposition.

(1) Factors related to the unprofessional conduct:

(a) Gravity of the unprofessional conduct;

(b) Age, capacity and/or vulnerability of the patient, client or victim;

(c) Number or frequency of the acts of unprofessional conduct;

(d) Injury caused by the unprofessional conduct;

(e) Potential for injury to be caused by the unprofessional conduct;

(f) Degree of responsibility for the outcome;

(g) Abuse of trust;

(h) Intentional or inadvertent act(s);

(i) Motivation is criminal, immoral, dishonest or for personal gain;

(j) Length of time since the unprofessional conduct occurred.

(2) Factors related to the license holder:

(a) Experience in practice;

(b) Past disciplinary record;

(c) Previous character;

(d) Mental and/or physical health;

(e) Personal circumstances;

(f) Personal problems having a nexus with the unprofessional conduct.

(3) Factors related to the disciplinary process:

(a) Admission of key facts;

(b) Full and free disclosure to the disciplining authority;

(c) Voluntary restitution or other remedial action;

(d) Bad faith obstruction of the investigation or discipline process or proceedings;

(e) False evidence, statements or deceptive practices during the investigation or discipline process or proceedings;

(f) Remorse or awareness that the conduct was wrong;

(g) Impact on the patient, client, or victim.

(4) General factors:

(a) License holder's knowledge, intent, and degree of responsibility;

(b) Presence or pattern of other violations;

(c) Present moral fitness of the license holder;

(d) Potential for successful rehabilitation;

(e) Present competence to practice;

(f) Dishonest or selfish motives;

(g) Illegal conduct;

(h) Heinousness of the unprofessional conduct;

(i) Ill repute upon the profession;

(j) Isolated incident unlikely to reoccur.

[Statutory Authority: RCW 18.130.390. 09-15-190, § 246-16-890, filed 7/22/09, effective 8/22/09.]

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Medical Professional Liability and Risk Management for Family Practice Physicians

Family Medicine Resident Professional Development Seminar and Career Fair | 2016

OUR VALUES: PROTECTION | TRUST | INTEGRITY | SERVICE

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Today's Agenda

1. A Wee Bit about Physicians Insurance
   - Mutual Carriers versus Stock Companies
2. Policies, and Coverage
   - Policy Types, "Nose", "Tail" and other Claims-Made Terms
3. Claims and Claims Activity
   - Family Practice claims and risk management
4. Documentation and Data
   - Informed consent and charting

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Fast Facts about Physicians Insurance

- Northwest based mutual company
  - Owned by our policyholders rather than stockholders
  - Run by a board of mostly physicians
  - No obligations to stockholders
- Cover and serve nearly 8,000 physicians, clinics, and hospitals
  - Write in Oregon, Washington, Wyoming, and Idaho
  - Largest insurer of private practice physicians in the Pacific Northwest
- A financially strong company with an AM Best A- Excellent rating*
  - Consistent and stable rates making it easy to budget.
- More than $87 million in dividends to our physician policyholders since 1982, with $45 million provided in the last 9 years.

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Policy Types

- Occurrence Policy
  - Covers an incident made during the policy period regardless when the claim is reported
  - Rarely offered in medical professional liability
- Claims-Made Policy
  - Covers only an incident reported while the policy is in-force
- Limits
  - Expressed as Per Claim and Aggregate
  - Most common in WA $1 million/$5 million

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Claims-Made Distinctions

- Retroactive Date
  - Earliest date for which claims-made coverage applies
- Step Rating
  - How premium matures over first five years
  - First year claims made only covers claims which both occur and are reported in the first year so premium is much less that year

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Claims-Made Distinctions

- Prior Acts
  - Also known as “Nose Coverage”
  - Matches retroactive date from previous policy
- Reporting Endorsement
  - Commonly called “Tail” or “Tail Coverage”
  - Converts Claims-made to Occurrence
  - Cost varies by company: 175% – 200% of annual premium
  - Waived for Death, Disability or Retirement

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Policy Rates for Family Practice Physicians

- Base Mature Rates for $1M/5M limits (no surgery)
  - WA: $11,268
  - OR: $8,289
  - ID: $6,145
  - Sticker price—discounts may apply
- Regional Differences
  - Different laws and risk exposures = premium differences
- Specialty Rates/Classifications
  - Rates determined by how invasive a procedure physician performs
  - Neurosurgeons pay roughly 7X higher premium than FP

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Applying for Coverage

- Coming or going – negotiate your tail
  - Who is paying for it
- Don’t omit information or lie on your application
  - Underwriters have seen it all – you can’t surprise them
  - This information is treated as confidential
  - Underwriters are not there to judge you, but to find a way to provide you insurance
  - They will likely find out anyway
  - You put your policy in jeopardy with misinformation

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Claims and Risk Reduction

- We use a data-driven approach to reducing risk and promoting physician resiliency.
  - According to a recent report from RAND Health and the RAND Institute for Civil Justice, most physicians (75-99%) can expect to face at least one malpractice claim in their career. Our own proprietary research suggests that 26% of all **General Practice** claims and 30% of all **Family Practice** claims turn into a lawsuit.
  - Based on data shared amongst all PIAA companies (of which Physicians Insurance is a leading member), the average indemnity paid for **General and Family Practitioners** was $287,844

- Anupam Jena, Seth Seabury, Darius Lakdawalla, and Amitabh Chandra, "Malpractice Risk, by Physician Specialty," *Research Brief*, RAND Institute for Civil Justice and RAND Health, 2011, accessed February 24, 2014, http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9610.pdf.
- Physician Insurers Association of America, *Risk Management Review: 2013 Edition, General and Family Practice, January 1, 2003–December 31, 2012* (Rockville, MD: Physician Insurers Association of America, 2013).

Major Causes of Claims

Three top causes of claims—medical misadventure, procedures performed, and patient conditions.

- **Medical Misadventure**
  - The most prevalent medical misadventure for **General and Family Practitioners** was diagnostic error—cited as the primary issue 27% of the time.

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Major Causes of Claims

Medical Misadventure (by frequency)	Average Indemnity Payment
Errors in diagnosis	$339,937
No medical misadventure	$287,491
Medication errors	$202,298
Improper performance	$239,057
Failure to supervise or monitor case	$245,987
Failure to recognize a complication of treatment	$313,544
Failure to instruct or communicate with patient	$313,936
Failure/delay in referral or consultation	$267,916
Delay in performance	$389,126
Not performed	$290,593

Major Causes of Claims

Three top causes of claims—medical misadventure, procedures performed, and patient conditions.

- **Procedures Performed**
  - Approximately 26% of claims involved prescription of medication. More than $116 million was paid on behalf of **General and Family Practitioners** involved in this procedure.

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Major Causes of Claims

Procedures Performed (by frequency)	Average Indemnity Payment
Prescription of medication	$250,861
Diagnostic interview, evaluation, or consultation	$280,979
General physical examination	$345,011
No care rendered	$176,938
Miscellaneous manual examinations and nonoperative procedures	$313,761
Operative procedures on the skin, excluding skin grafts	$164,389
Injections and vaccinations	$205,767
Operative procedures of gallbladder and biliary tract	$173,288
Ordering of tests only	$248,554
Diagnostic Testing	$449,262

Major Causes of Claims

Three top causes of claims—medical misadventure, procedures performed, and patient conditions.

- **Patient Conditions**
  - Between 2003 and 2012, the most prevalent presenting medical condition for which claims were filed against **Family and General Practitioners** was obesity. Claims involving obesity resulted in an indemnity payment only 4% of the time with an average indemnity payment of $136,017.

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Major Causes of Claims

Patient Conditions (by frequency)	Average Indemnity Payment
Obesity	$136,017
Diabetes	$221,918
Back disorders, incl. lumbago & sciatica	$366,578
Symptoms involving abdomen and pelvis	$224,851
Disorder of lipoid metabolism	$366,250
Chest pain, not further defined	$386,775
Decubitus ulcer	$104,301
Disorder of joint, not incl. arthritis	$174,312
Myocardial infarction, acute	$262,959
Malignant neoplasms of the bronchus and lung	$333,783

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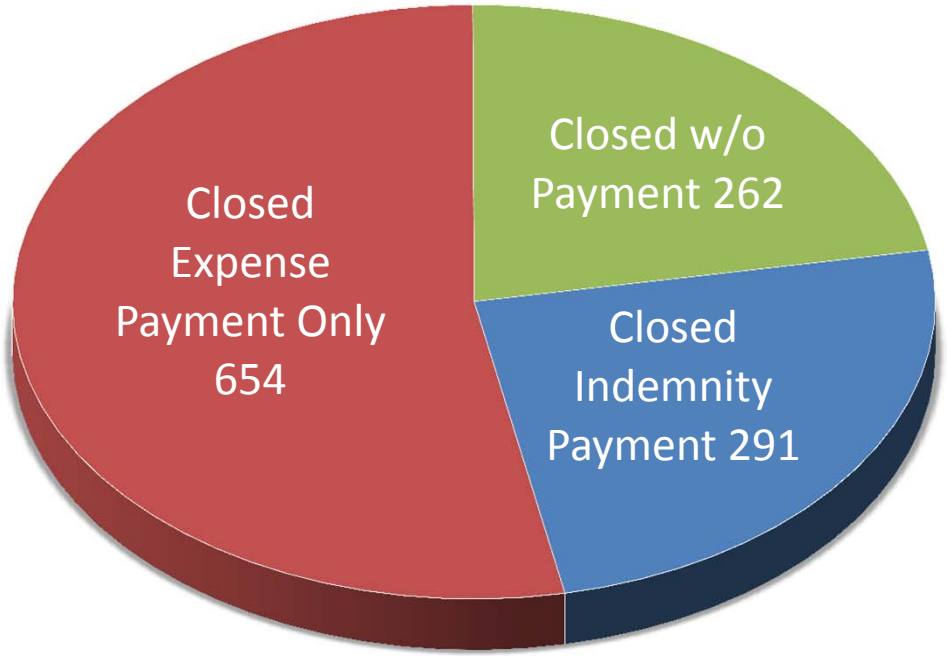
Claim Activity for Family Practitioners

30 year period
All Closed Claims (1,145)

75.9% Closed with No Indemnity Payment (Settlement to Plaintiff)



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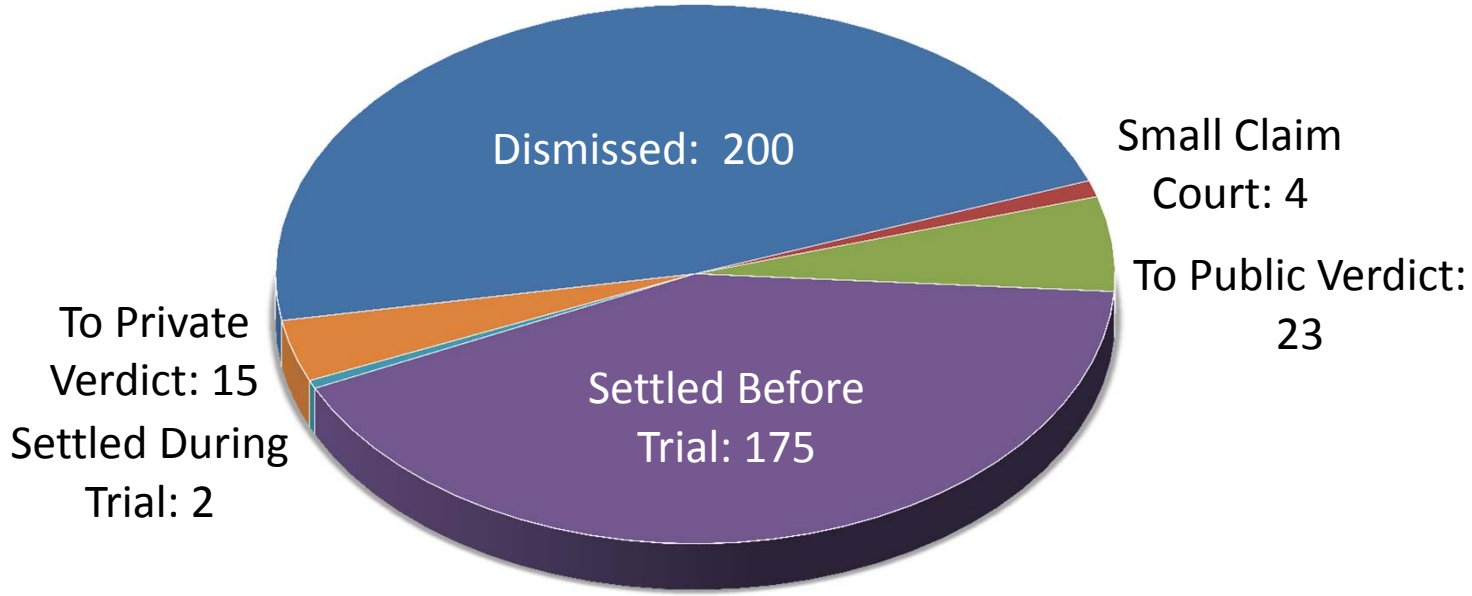
Suit Activity for Family Practitioners

30 year period
Total Suits Closed (419)



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Claims Frequency by Specialty

Family Practice ranks 17th of all specialties covered by Physicians Insurance – with claims turning into suits 29% of the time. Overall range is 18-41%.

It's just a numbers game; there isn't anything I can do to reduce my exposure to a claim.

- Untrue. A key ingredient to reducing exposure is relating well to patients. Honesty, empathy, and compassion promote trust and caring by the patient.
- What you may have heard is true…patients are extremely reluctant to sue a physician that they like.

Specialty	% Claims into Suits[1]
Plastic Surgery	41%
Neurological Surgery	39%
Urgent Care	38%
Neurology	36%
Pathology	33%
Urological Surgery	32%
Otolaryngology	32%
Cardiovascular Surgery	32%
Orthopedic Surgery	32%
General Surgery	31%
Radiology	30%
Emergency Medicine	30%
Anesthesiology *	30%
Cardiovascular Diseases	30%
Colon and Rectal Surgery	30%
Allergy	30%
Family Practice	29%
Obstetrics and Gynecology	29%
Ophthalmology	28%
Hospitalist	27%
Internal Medicine	27%
General Practice	26%
Pulmonary Diseases	26%
Gynecology	24%
Pediatrics	24%
Thoracic Surgery	22%
Dermatology	22%
Gastroenterology	21%
Psychiatry	20%
Physical Medicine & Rehab.	18%

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The Facts About Claims

- Do not practice in fear of getting a claim.
  - About 5% of physicians with a claim in a year
  - Changing public perception of patient responsibility
  - New ways to engage with patients before/after adverse events
- The majority of medical liability claims resolve in favor of the physician.
- 10 year public trial defense verdict at 91%.
  - Since 2009, 67 public trials with 65 defense verdicts.

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The Facts About Claims

- It's all about the money.
  - This may be true for the personal injury lawyer but the patient's motivation is often far different.
- Frivolous lawsuits are the problem.
  - This is not the case. Frivolous suits involving minor or non-injury events are infrequent
- A large percentage of cases are won or lost on the basis (quality) of the medical record
  - Document patient instructions and patient noncompliance
  - Alteration of the medical record WILL be discovered and is ALWAYS fatal to your defense

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The Facts About Claims

- Document patient refusal of recommended care (informed refusal).
- Labs, consults, X-rays and other studies must be reviewed and marked…have a system in place and consistently use it.
- Document provider/patient notification of study results and recommended follow-up.

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A Patient's Story…

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Reduce Risk. Raise Standards.

- The medical record is often the most important evidence allowing successful defense of a malpractice claim or lawsuit.
- Poor records are the most-cited reason for settlement.
- 35 to 40% of lawsuits are compromised by the medical record.

#1 Rule for Charting

If it isn't in the chart, it didn't happen

Reduce Risk. Raise Standards.

- Informed consent is obtained and charted
  - Approximately 40% of medical malpractice lawsuits contain an allegation of “inadequate consent”
- Patient education, instructions and recommendations for treatment, consultations, referrals, and follow-up care are documented
- Return dates are included
- Patient noncompliance is charted
- Information is factual

Reduce Risk. Raise Standards.

- Informed consent is obtained and charted
  - **P**rocedure-**A**lternatives-**B**enefits-**R**isks-**C**omplications
  - Extent in direct correlation to potential risks and complications
  - Signed consent for significant procedures
    - Signed refusal forms are equally important
  - Discussion mandatory even when written consent obtained
    - Consider a memo summarizing what was discussed and decided upon as another layer of communication

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Key Take-Aways

- Know your policy type, language, and coverage options. If you don't know, call your insurer.
- Claims are a matter of when, not if. But they can be reduced if you have strong communication, patient engagement/understanding, and stellar documentation – which all produces better care.
- Don't worry alone. Physicians Insurance is there to help – we have the same goal.

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Thank you!

Phone: (206) 343-7300 or (800) 962-1398
Visit us: www.phyins.com

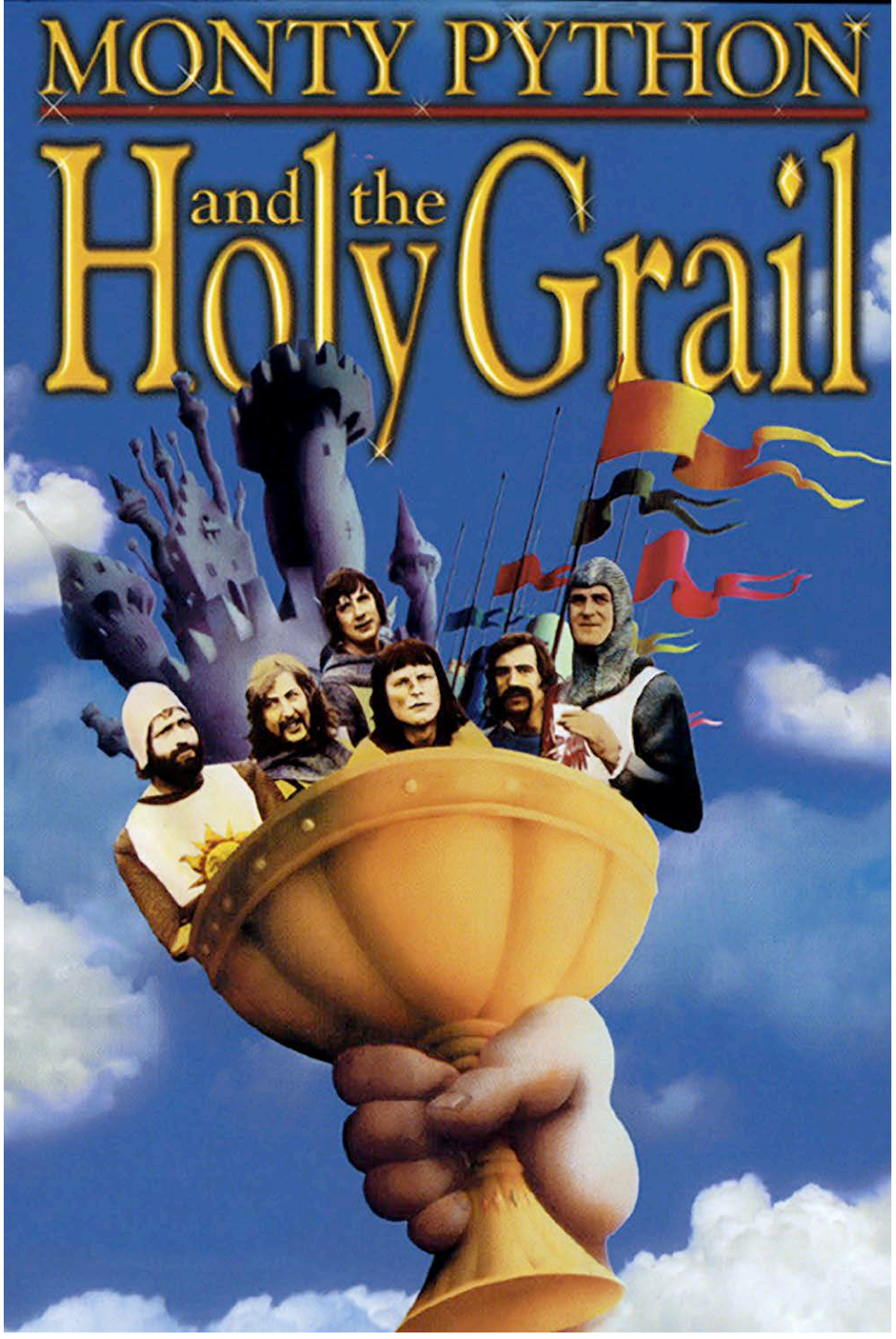
OUR VALUES: PROTECTION | TRUST | INTEGRITY | SERVICE

Get Ready!
Preparing Your CV, Cover Letter and Interview

Jeanne Cawse-Lucas, MD

October 20, 2017

Before you start…




WHAT
YOU LOVE
HAPPY BUT
POOR
JUST A
DREAM
#WIN
WHAT
YOU'RE
GOOD AT
RICH BUT
BORED
WHAT
PAYS
WELL
@eskimon


HELLO
i'm
Awesome

"Yes, I received your resume. In fact, I'm getting ready to send it around the office right now."

Presentation Matters

- Simple formatting
- White paper
- Large font that copies/scans/faxes well
- Online CV

Your Complete Name, MD

Accurate, current address

Phone

Pager

Email

Education

- Reverse chronological order – most recent first
- School name, month, and year of graduation, and degree earned
- List honors associated with your degree
- Don’t mention high school

Post Graduate Education (Residency and Fellowship)

- This can be a separate heading or part of the general education section
- Month and Year of Graduation
- State affiliation “University of Washington School of Medicine, Family Practice Residency Network.”

Honors and Awards

- List relevant honors and awards that are not previously mentioned

Professional Service

- List all memberships and year joined
- Include any offices or committees in which you participate

Employment Experience

"The years 1966 through 1995 are blank because I was on tour with the Grateful Dead."

Employment Experience

- Most recent listed first. Place, position, and time employed.
- Residents should only list those that are meaningful to your employer, and that inform your medical practice.
- For future CVs, leave no time holes: account for years since residency

License and Certificates

License and Certificates

- Very important: and some authors recommend it after the address section.
- Medical license number for each state and the date of expiration
- AAFP Board Certification date. “Board Eligible” fine until exam results are available
- DEA number and date of expiration
- ACLS, PALS, NRP and expiration dates

Publications

- Less important to positions in clinical practice: Make it brief
- For faculty and academic posts, this should be fully fleshed out
- May include relevant publications in the lay press

Languages

- List languages and degree of fluency
- Be accurate
- Citizenship if other than US

Other Skills and Qualifications

- Medical
  - Procedures
  - EMR
  - Clinical leadership
- Include pertinent non-medical qualifications

Community Service

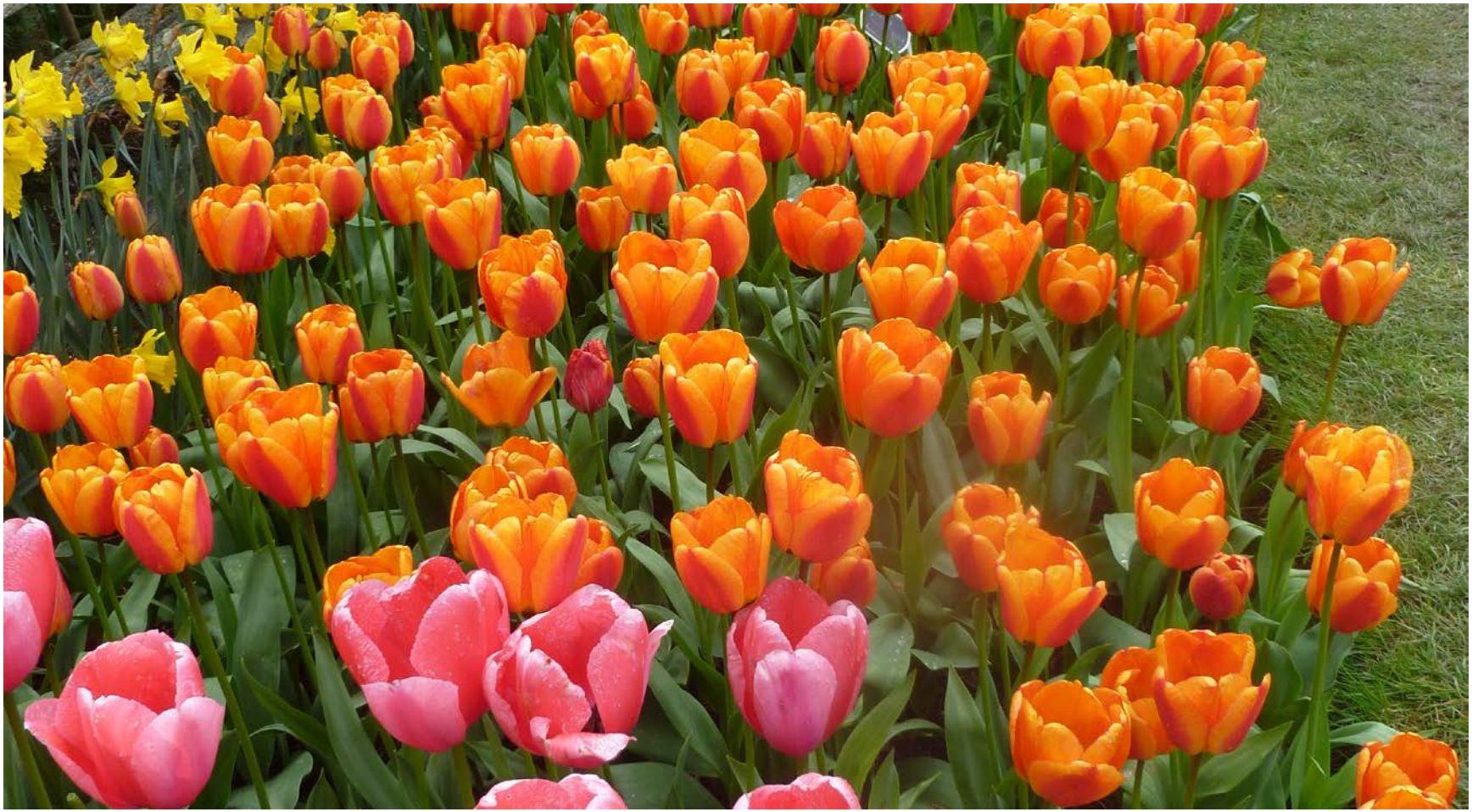
- Non-medical community activities, such as charitable organizations
- Some advocacy groups

References

- Have two STRONG references
  - Let them know that you are using their names
- List their names and contact info
  - Minimum, email and phone number

Things to leave out

Personal information: marital status, number of children, sports, hobbies… save it for the interview or after you have an offer!



COVER LETTER

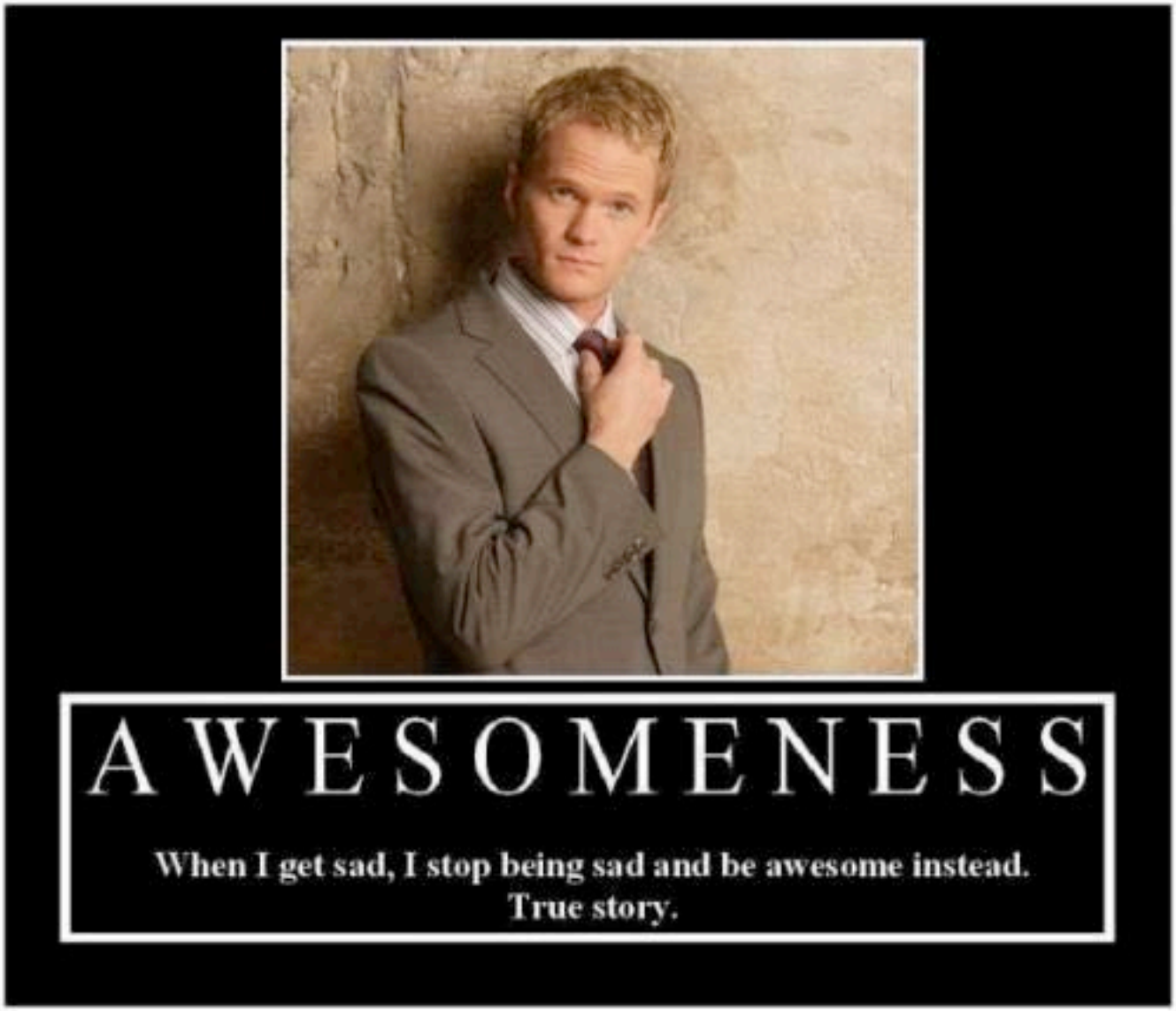
- Write a specific cover letter for EVERY JOB
- It may be the ONLY THING your interviewer will read
- Short and sweet! (1 page)
- It should be SPECIFIC to the particular director, to that particular position

COVER LETTER

TELL THEM WHY YOU ARE PERFECT FOR THE JOB

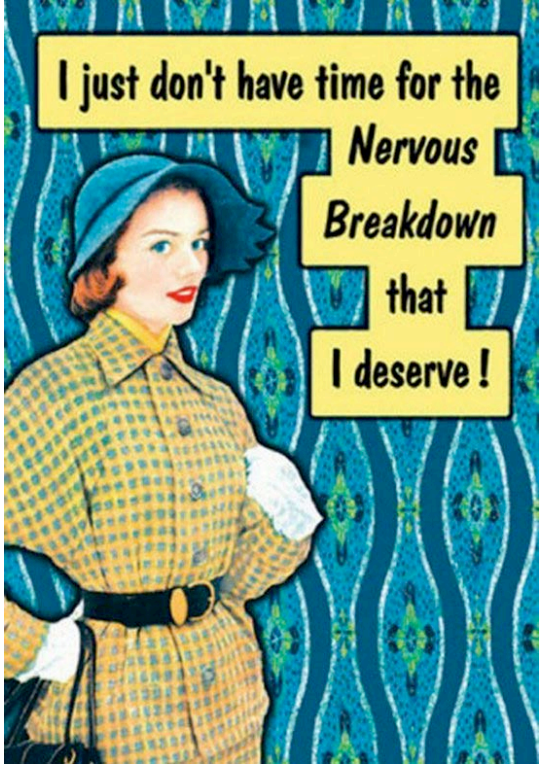
- Special skills
- Interest in particular demographics/communities

INTERVIEWING: CALM DOWN



Getting Ready

Traditional	Business Casual	Business Casual/Casual
		



You only get one chance to make a first impression

Questions

- Standard
  - Targets education, work experiences, and goals
- Behavioral
  - Focus on actions and behaviors in other settings
    - TIP: think of a couple of good patient stories and have them ready to use as examples for behavioral questions
- Inappropriate/unethical
  - Private life or personal background

When to disclose?

You get to ask questions, too!

General Interviewing Strategies

- Be ready to talk about yourself.
- Tell a story!
- Breathe! Think before speaking.
- If you don't understand the question, it's okay to ask for clarification.
- Stay calm. Be yourself! You are awesome!

Follow Up

Practice!

Write down a list of possible questions and think about your answers

Stand in front of a mirror and rehearse your answers

Do a mock interview with your advisor.

Final Thoughts

BE YOURSELF.

You offer valuable skills and services.

Hold out for something that is right for YOU.

Your time is valuable. Don’t let anyone sell you short.

IDENTIFYING YOUR KEY JOB ISSUES

The following three exercises will help you identify the key issues that can help guide your job search.

1. Your perfect job.

List all the things you are really good at doing (e.g., working with children, performing procedures, teaching or managing staff).

_____

_____

Which of the things listed above do you really like to do?

_____

_____

What kind of job will let you do most of these things most of the time?

_____

_____

2. Your great day at work.

Imagine that you are relaxing with a friend at the end of a great day at work. Your friend asks what made it so great. Write down three things. (For example, maybe your day was great because you were able to spend extra time helping one of your elderly patients, you delivered a baby or you negotiated a better contract with one of your health plans.)

1. _____
2. _____
3. _____

3. Your values and goals.

Think about your personal and professional values and goals.

What would you like to achieve in different parts of your life? _____

_____

What type of practice would allow you to meet these goals? _____

How much time would you like to spend working? _____

How close would you like to live to your family and friends? _____

What parts of the country and what types of communities appeal to you? _____

_____

Describe the standard of living you would like to achieve or maintain. _____

How much job security do you need? _____

Do you prefer treating certain types of patients or performing certain types of procedures? Are there certain things you would rather not do? _____

What types of non-clinical activities interest you? _____

Do your religious beliefs guide your practice? _____

What do you like to do when you are not working? _____

Family Practice Management®

 Valancy J. Finding the perfect job. *Fam Pract Manag.* July/August 2006:37-43; http://www.aafp.org/fpm/20060700/37find.html.

Interviewing 101

An on-site interview is your opportunity to assess how well your values and those of a potential employer align.

Rebecca Ann Beach, MD

Dr. Beach is a family physician at the Union Hospital Health Group in Terre Haute, Ind., and the Union Hospital Family Practice Residency. She is also medical director of the Clay City (Ind.) Center for Family Medicine.

CME
covered in *FPM* Quiz

Finding a job that provides long-term satisfaction takes more than the right connections or good luck. For me, it has required a strategy that takes into account my personal and professional needs and values. In a previous article I shared the framework I've used to identify my values and determine what I can and can't live without in a new position (see "How to Find the Job That's Right for You," November/December 2000, page 30). Knowing exactly what I want enables me to focus my efforts on only those opportunities that best suit me. Plus, it saves me time and stress. I approach a job interview the same way.

KEY POINTS:

- Think of the job interview as an opportunity to determine how well a potential employer can meet *your* needs.
- Interviewing support staff can provide you with valuable insight into an organization.
- Touring the physical space where you might work can tell you a lot about the values and priorities of a practice.

Relax

Most of us treat a job interview as a form of mild interrogation: the employer asks the questions, and we provide the answers. Instead, I would encourage you to consider a job interview another opportunity to see how well the organization fits *your* needs. The truth is, by the time you and a potential employer actually meet for an interview, your motives are well aligned. You want a position at a place where you fit in and can stay a while and where you can see a lot of satisfied patients. That's exactly what employers want. They want the best person for the job, and they're hoping that person is you so they can get back to work. Some will even use the on-site interview to try to "sell" you on their organization. Don't be led astray. Stay focused and ask questions that will help you determine whether your values and expectations align with theirs.

Don't pass up the opportunity to talk to nurses and the front-office staff.

Use lists

It's likely you won't be conducting a job search too many times in your career, so don't invest time and effort memorizing your interview questions. Instead, write them down. This recommendation may go against the grain, particularly for physicians who are trained to memorize questions and take minimal notes during a patient interview, but my personal experience has been that everyone reacts positively to my lists. Most administrators are relieved that I am interested and educated enough to bring a list. Many physicians are unsure about what to ask me and seem quite relieved that I have a list of things to talk about. Nurses and support staff seem ecstatic that I cared enough to prepare questions for them.

I tailor each list of questions to each person who interviews me (see page 39), but as you'll see, there are some questions I ask everyone. Their responses – particularly the inconsistencies in their responses – speak volumes. And, while it's likely you're going to interview with the administration and some potential

BOB SCOTT

What questions should you ask?

The following are examples of questions I have asked during job interviews. Consider them a bank to draw from. Your questions may differ depending on your personal and professional needs and values and on the practice setting you're considering. [A longer version of this list is available at www.aafp.org/fpm/20010100/38inte.html.]

Ask a physician

What's the call schedule?

How many calls and admissions do you handle on a typical call night or weekend?

Does the practice use a nurse triage system?

Do you have evening or weekend office hours?

What hospital(s) are you affiliated with?

What is the business plan for the next five to 10 years?

What is the policy regarding prescribing narcotics and antibiotics over the telephone?

Are patient charts well organized? Are they dictated or handwritten?

What are the weaknesses of your current charting system?

Is the practice computerized? What are the future computerization plans?

How would you describe your level of autonomy?

How many patients do you see per day?

Who decides how much time you spend with each patient?

Do you receive appropriate feedback about performance quality?

Do you receive feedback or education on billing and coding?

How would you describe your relationship with the staff?

What are the staff's foremost concerns?

Are you satisfied with the current compensation package?

How is productivity measured?

How would you characterize the pressure to produce?

How would you describe the organization's overall financial health? How is this clinic doing financially?

Is any expansion, integration or corporate rearrangement currently being considered?

Is the administration responsive to your concerns?

Ask an administrator

How would you describe the organization's overall financial health? How is this clinic doing financially?

What is the business plan for the next five to 10 years?

What is the overhead?

Is any expansion, integration or corporate rearrangement currently being considered?

Are you aware of any specific plans for capital improvements?

How would you describe the practice's relationship with third-party payers?

Is the practice computerized? What are the future computerization plans?

What's the payer mix?

How much autonomy do physicians have in this organization?

Do physicians determine how much time they spend with each patient?

Do physicians work any evening or weekend office hours?

Do physicians receive feedback or education regarding performance quality, billing and coding?

Do physicians receive feedback regarding patient satisfaction?

Do physicians hire and fire their own staff? Do physicians have the authority to hire more staff, if needed?

What is the compensation plan (i.e., salary, benefits, vacation, time off for CME, maternity leave)?

Is compensation tied to productivity?

Are bonuses given?

Ask a nurse

Are patient charts well organized?

What are the weaknesses of your current charting system?

Is the practice computerized?

Is it difficult to get equipment replaced or to get new equipment when needed?

What is the practice's policy for prescribing narcotics and antibiotics over the telephone? How closely do providers adhere to this policy?

How much responsibility do nurses have for telephone triage and patient education?

Do you feel that physicians can effectively address your concerns?

Is the office manager responsive when you have concerns?

Do you have any issues or concerns regarding compensation?

How does the overall organization seem to be doing financially? What about this clinic?

Are you aware of the organization's future plans?

Ask support staff

How manageable is the volume of telephone calls the practice receives?

What are the weaknesses of your current charting system?

How would you describe your organization's relationship with third-party payers?

Is the practice computerized?

Is the computer system easy to learn and to use?

Is it difficult to get equipment replaced or to get new equipment when needed?

How would you describe your level of autonomy?

Do you feel the physicians can effectively address your concerns?

Is the office manager responsive when you have concerns?

Do you have any issues or concerns regarding compensation?

How does the overall organization seem to be doing financially? What about this clinic?

Ask everyone

How long have you worked here?

What do you like best about the organization?

What would you change if you could?

How much turnover has occurred during the past 12 months?

Why have people left?

Have you ever considered leaving?

SPEEDBAR®

➤ **To prepare for the interview, write down questions, tailoring them to each person you interview with.**

➤ **Ask about the financial health of the organization and the clinic with which you may be affiliated. Also ask about strategic planning.**

➤ **Allow yourself time to reflect following an interview and don't hesitate to call a potential employer for more information or clarification.**

➤ **Never accept the first job you're offered and don't accept a job if you're hesitant or still have questions.**

colleagues, don't pass up the opportunity to talk to nurses and the front-office staff. They can also provide you with valuable insight about your potential employer. If the opportunity isn't offered, ask.

I highly recommend asking about the financial health of the organization and the specific clinic with which you may be affiliated. It's a vital question considering the amount of change that's occurred in health care in recent years. Also ask about strategic planning: What is in store for the next year, and the next five or 10 years? While an administrator is the logical source for this information, I also like to ask physicians and support staff. If the administration is planning sweeping changes and your future colleagues are unaware, the work environment might become quite uncomfortable.

Evaluate the facility

The interview process should also include visually inspecting the practice. Again, if no one offers to show you around, ask. What you see will shed light on how the organization views its doctors, staff and patients and is another indicator of whether your values align with theirs. For example, are exam rooms a comfortable temperature? Are they well lit and private? If so, it's likely that patient well-being is a high priority. What about the waiting room? Is it clean, comfortable and stocked with up-to-date reading material? Are check-in and check-out areas well marked and easily accessible? Using the same mind-set, walk by the nurses' stations and peek into physicians' personal offices. I also recommend reviewing a few patient charts. Charts that are disorganized and illegible may be a sign of unhappy times to come.

The interview process should also include visually inspecting the practice.

Interview follow-up

After each interview allow yourself some time to review and reflect. You may want to type up your notes and summarize the information you've received. Review your list of questions to make sure you've filled in all the blanks, and call back for more information or clarification if needed. Then write down pros and cons of the position and talk them over with someone who knows you well to help stratify what's most important you.

Job offers

There are plenty of job opportunities for family physicians, so don't feel pressured to accept the first job you're offered. And don't accept a job without a second interview. You'll be cheating yourself out of another chance to evaluate the organization. Why take chances, especially if it means uprooting your family?

Even when you're really sure this is the right job opportunity for you, don't accept an offer immediately. Give yourself and your prospective employers and co-workers some time for "courtship." You'll learn a lot about them by the way they treat you and, to get you on board, they may grant you a few favors not offered to established employees. Perhaps you've identified a few key issues that would make your workday more productive and enjoyable. For example, the office may need another part-time receptionist or medical records clerk, or a better transcription service. Be selective and polite. If you ask for the right things, even the administrators will be glad you asked.

Whatever you do, don't accept a job if you're hesitant or have any questions. The rationalization that "maybe this one issue won't be problem" will inevitably backfire. Instead, ask the employer to address it. If they know an issue is really important to you, they may be willing to make some accommodations.

Get any verbal clarifications or commitments in writing. Perhaps you've been told that you can select your own nurse or that the organization offers six months of maternity leave. Make sure there are no qualifiers attached. The six months of maternity leave may only apply to people who've been employed for three years. Or you may get one opportunity to choose a nurse. What happens if he or she isn't working out? Ask for details, and you may also want to have a lawyer review the contract.

Assuming the job market is a place you'd rather not be, I'd advise you to do everything you can to get exactly what you want. Be choosy and ask questions that will help you determine which job opportunity is the right one for you. FPM

Editor's note: In an upcoming issue, James Giovino, MD, will explore alternative practice styles available to family physicians looking for a change of pace, whether it's working in the emergency department, in a resort community or on Capitol Hill.

Loan repayment

aka: Doing good can do you good

Renee Fullerton | **Washington State Department of Health**

Presented to KCAFP, Oct. 21, 2017

Today’s agenda

noun : a list of items to be discussed at a formal meeting


Government Loan Repayment
Employer Loan Repayment
Public Service Loan Forgiveness

My agenda

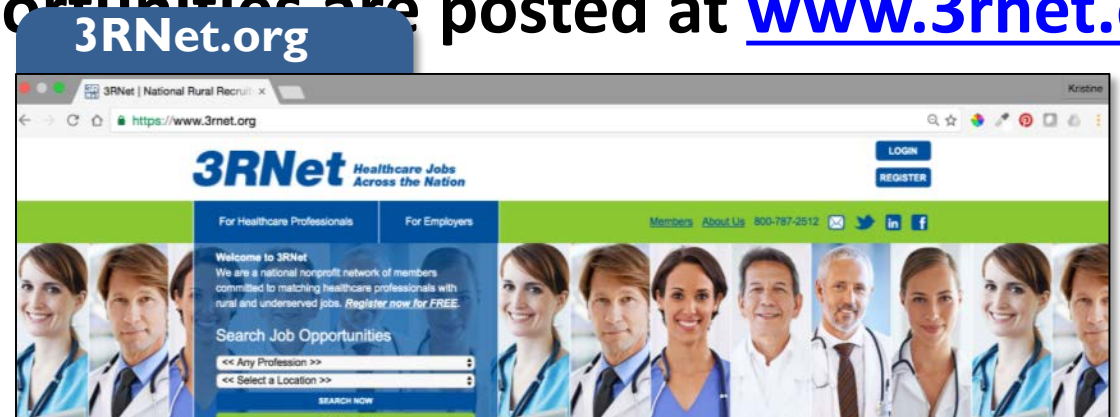
> *noun* : the underlying intentions or motives of a particular person or group

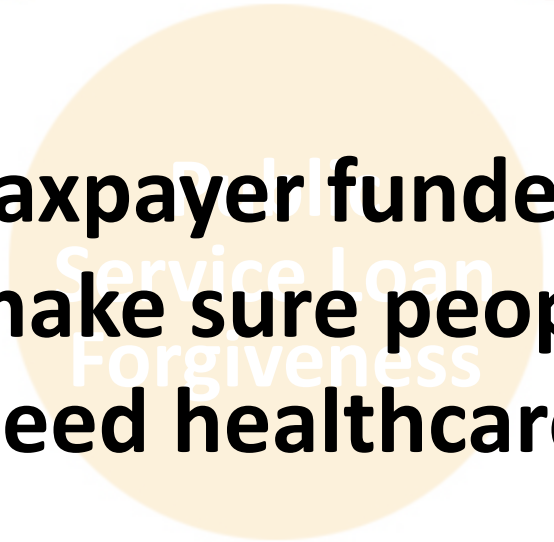

Connect communities with physicians
Reduce health disparities
Support rural Washington

Step 1: Find the right position for you AND your family

The Department of Health has resources to help if you're interested in rural or underserved practice www.doh.wa.gov/ruralhealth

Our opportunities are posted at www.3rnet.org





Taxpayer funded, goal is to make sure people who really need healthcare can get it

It’s all about where you work

Community/Migrant Health Centers

Provide medical, dental and mental health services

Located in both rural and urban areas

Can have focus on special populations (migrants, tribal members)

A snapshot of Washington’s CHCs in 2016:

- 28 Centers, 267 service sites
- 1,035,629 patients
- 60% of patients were Medicaid beneficiaries
- 19% of patients were uninsured
- Majority of loan repayment awards in WA go to clinicians at community health centers

It’s all about where you work

Critical Access Hospitals

- Max 25 acute beds and 96-hour patient stay
- Located in rural areas at least 35 miles from another hospital or 15 miles in mountains
- Vary a lot in size and services offered

Department of Corrections

- Provide medical, dental and mental health services
- Most facilities located in rural areas
- Two facilities for women, the other 10 are men only

Rural Health Clinics

- Provide primary care services and basic lab services
- Located in rural shortage areas
- Can be hospital affiliated or free standing

Tribal Health Sites Run by tribes or Indian Health Service, locations both on tribal lands and urban areas

In Washington, several programs provide loan repayment

State programs

HPLRP

Washington State Health Professional Loan Repayment Program

FSLRP

Federal-State Loan Repayment Program

Federal program

NHSC

National Health Service Corps Loan Repayment Program

Note

You can apply to all the programs, but you can receive funds from only one program at a time

State programs

HPLRP Eligible Professions

- Physicians (MD, DO)
- Nurse Practitioners
- Midwives (CNM, LM)
- Physician Assistants
- Dentists and Dental Hygienists
- Pharmacists
- RNs and LPNs
- Naturopathic physicians
- Variety of mental health professions (new in 2017)

FSLRP Eligible Professions

- Physicians (MD, DO)
- Nurse Practitioners
- Certified Nurse Midwives
- Physician Assistants
- Dentists and Dental Hygienists
- Pharmacists
- RNs

Note

Physicians, NPs and PAs must work in family or internal medicine, OB/Gyn, Pediatrics or Psychiatry

State programs

HPLRP Terms and Awards	FSLRP Terms and Awards
• Full and part time, minimum of 24 hrs work/week	• Full time only, minimum of 40 hrs work/week
• Up to $75,000 ($25,000/yr)	• Up to $70,000 ($35,000/yr)
• Three-year initial contract	• Two-year initial contract
• Extension amounts TBD, based on funds and remaining debt; max of two additional years	• Extension amounts TBD, based on funds available and remaining eligible debt
• Payment made quarterly	• Payment made quarterly

State programs

STEP 1: Site applies

- Practice sites must focus on rural and/or underserved populations, FSLRP sites must have a HPSA score, implemented sliding fee schedule and be not-for-profit or public
- Sites apply in the fall approved sites posted on the state website in January

THEN

STEP 2: Provider applies

- Single application for both programs, open Jan-April 2018
- Must be employed or have a signed contract to begin seeing patients at an approved site by July 1, 2018
- Contract begins July 1 (or Oct 1 if graduating residency off-cycle – after July 1)

Note

Once awarded you stay approved even if the site **doesn't maintain approved** status

NHSC

Eligible professions

- Physicians
- Nurse Practitioners
- Certified Nurse Midwives
- Physician Assistant
- Dentists and Dental Hygienists
- Variety of mental health professions

Terms and Awards

- Fulltime: minimum of 40 hrs/ week, up to $50,000 award
- Part time: 20-39 hours/week, award up to $25,000 award
- Two-year initial contract
- Continuation awards
- Payment is made annually

Note

Physicians, PAs and NPs must work in family or internal medicine, OB/Gyn, Pediatrics or Psychiatry

Note

Award dollars are not taxed as income

NHSC

STEP 1: Site applies

- Facility applies to be NHSC approved site
- Some certain types of sites are automatically approved (Community Health Centers, Tribal Clinics)

THEN

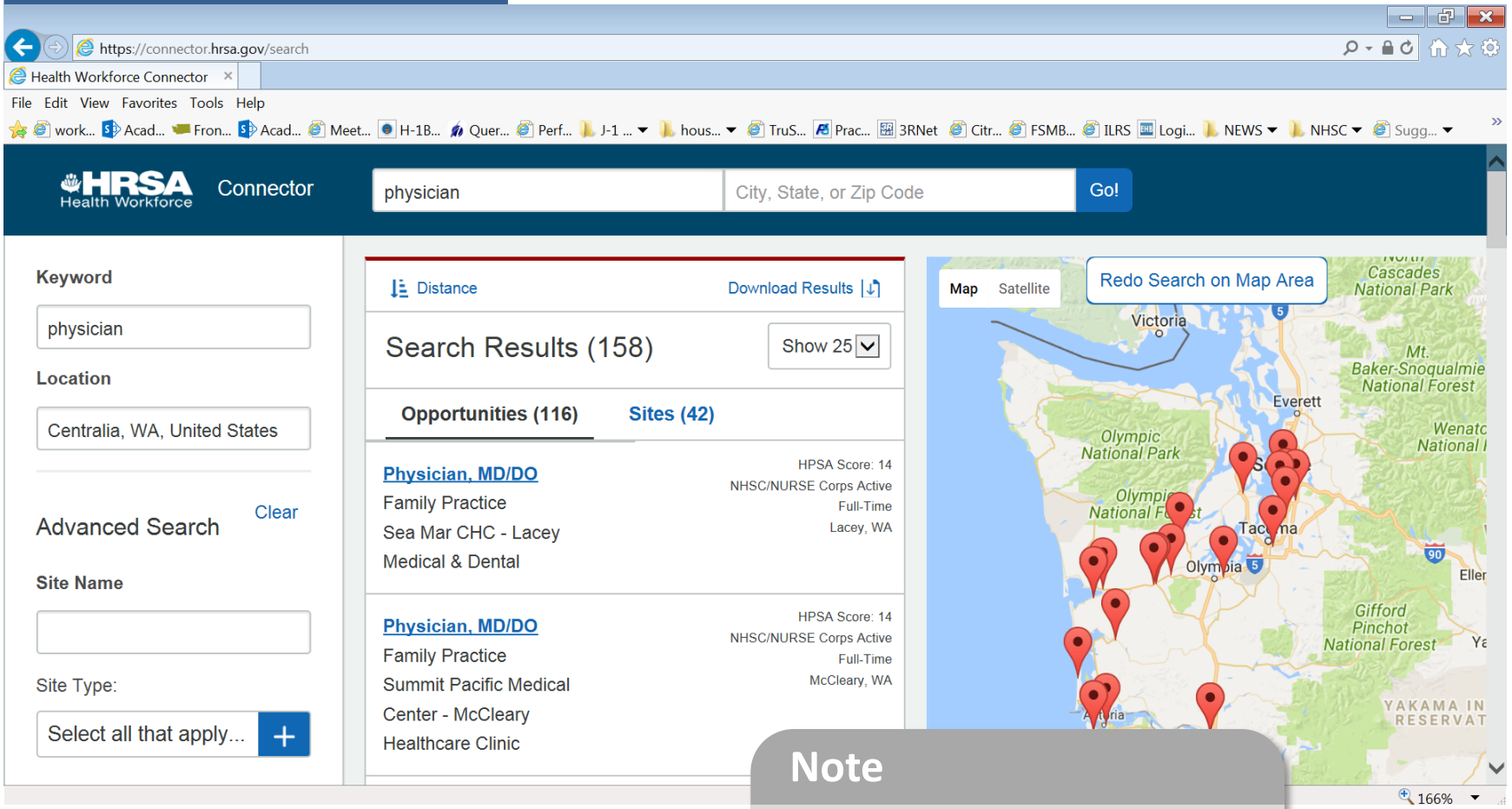
STEP 2: Provider applies

- Provider application is available each winter
- Must be employed or have a signed contract to begin work at an approved site by date in July (it moves a bit each year)
- Awards are made by September 30

Note

Site approval is good for three years

NHSC



Note

Look for approved sites and positions on the Workforce Connector **connector.hrsa.gov/**

Likelihood of receiving an award

State programs

Same scoring method for HPLRP and FSLRP

Provider Application score

+

Site Application score

= Total Score used to rank applicants for awards

Federal program

NHSC

Tiered based on HPSA Score of your site

Date when you applied also matters if you're at a site with a lower HPSA (16 last year)

Note

DSHS psychiatrists, and psychiatric NPs receive priority

Common pitfalls to avoid

- Site not applying to be part of programs
- Paperwork mistakes
- Consolidating eligible educational loans with ineligible debt
- Primary Care Loans/other ineligible loans
- Signing bonuses with payback clauses
- Not applying funds to loans

Other government options:

Indian Health Service Loan Repayment Program

- Sites can be run by IHS, tribal organization or urban Indian program
- 2 year initial contract, up to $40,000
- Continuation awards available
- Taxable as income, program pays 20% of federal taxes you are responsible for the rest
- www.ihs.gov/loanrepayment/

Employer funded, goal is to entice you to choose/stay at a healthcare facility

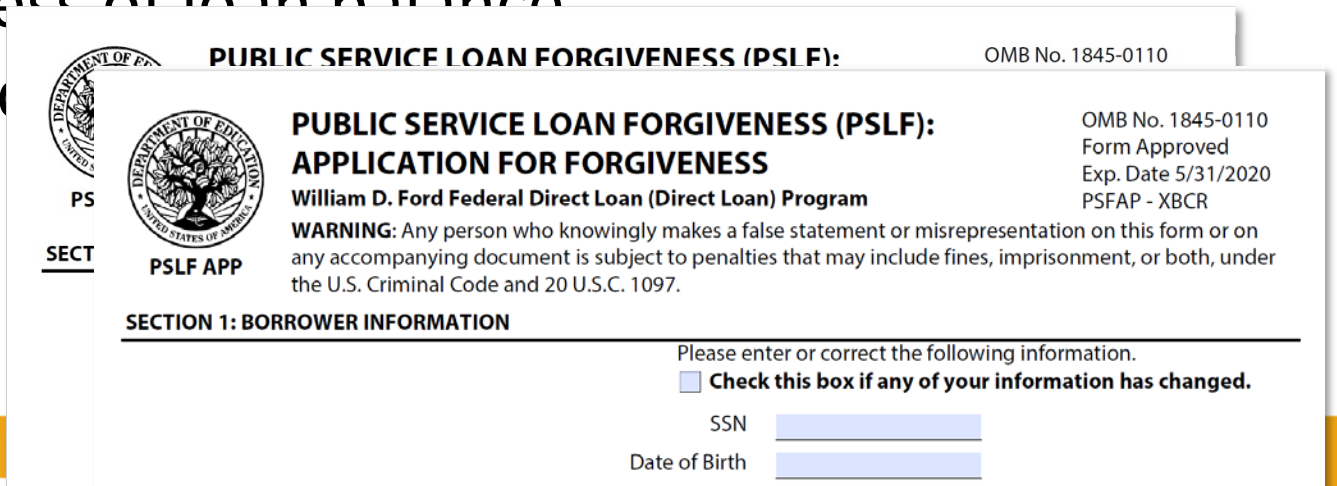
Again, it's all about where you work

- Many more employers now offering this benefit
- Employers offering as a bridge to the government programs
- Can be guaranteed via contract
- Variable length of service
- Sometimes money on the front end, sometimes not paid until the end of a length of service
- Taxable as income (unlike government programs)

Funding unknown, goal is to encourage people to go into public/non-profit careers (and deal with student debt crisis)

The wildcard

- Make 120 payments on your Federal Direct Loans
- Work fulltime at an eligible public/nonprofit employer during payments, at time you apply and at time loans are forgiven
- Track all of it and apply to Department of Education for forgiveness of loan balance (tracking and


PUBLIC SERVICE LOAN FORGIVENESS (PSLF): OMB No. 1845-0110

PS

SECT

PSLF APP

PUBLIC SERVICE LOAN FORGIVENESS (PSLF):
APPLICATION FOR FORGIVENESS
William D. Ford Federal Direct Loan (Direct Loan) Program

OMB No. 1845-0110
Form Approved
Exp. Date 5/31/2020
PSFAP - XBCR

WARNING: Any person who knowingly makes a false statement or misrepresentation on this form or on any accompanying document is subject to penalties that may include fines, imprisonment, or both, under the U.S. Criminal Code and 20 U.S.C. 1097.

SECTION 1: BORROWER INFORMATION

Please enter or correct the following information.

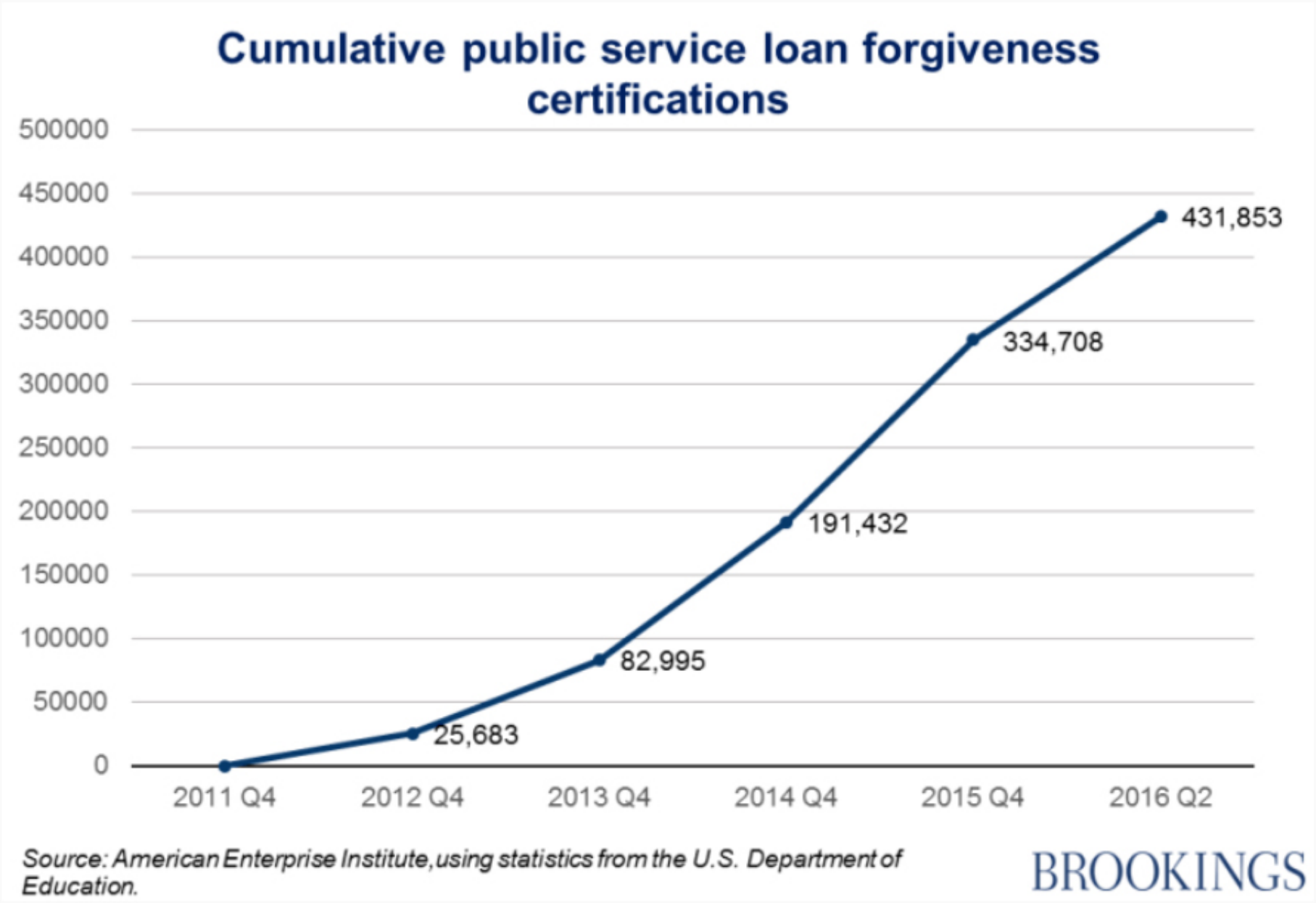
☐ **Check this box if any of your information has changed.**

SSN

Date of Birth

Things to keep in mind

- Only Direct Loans are eligible, other federal loans must be consolidated into this category, private aren't eligible
- Need to be on an income-based repayment plan, that means a longer repayment period with more interest accruing
- Must work fulltime during the time of the 120 payments

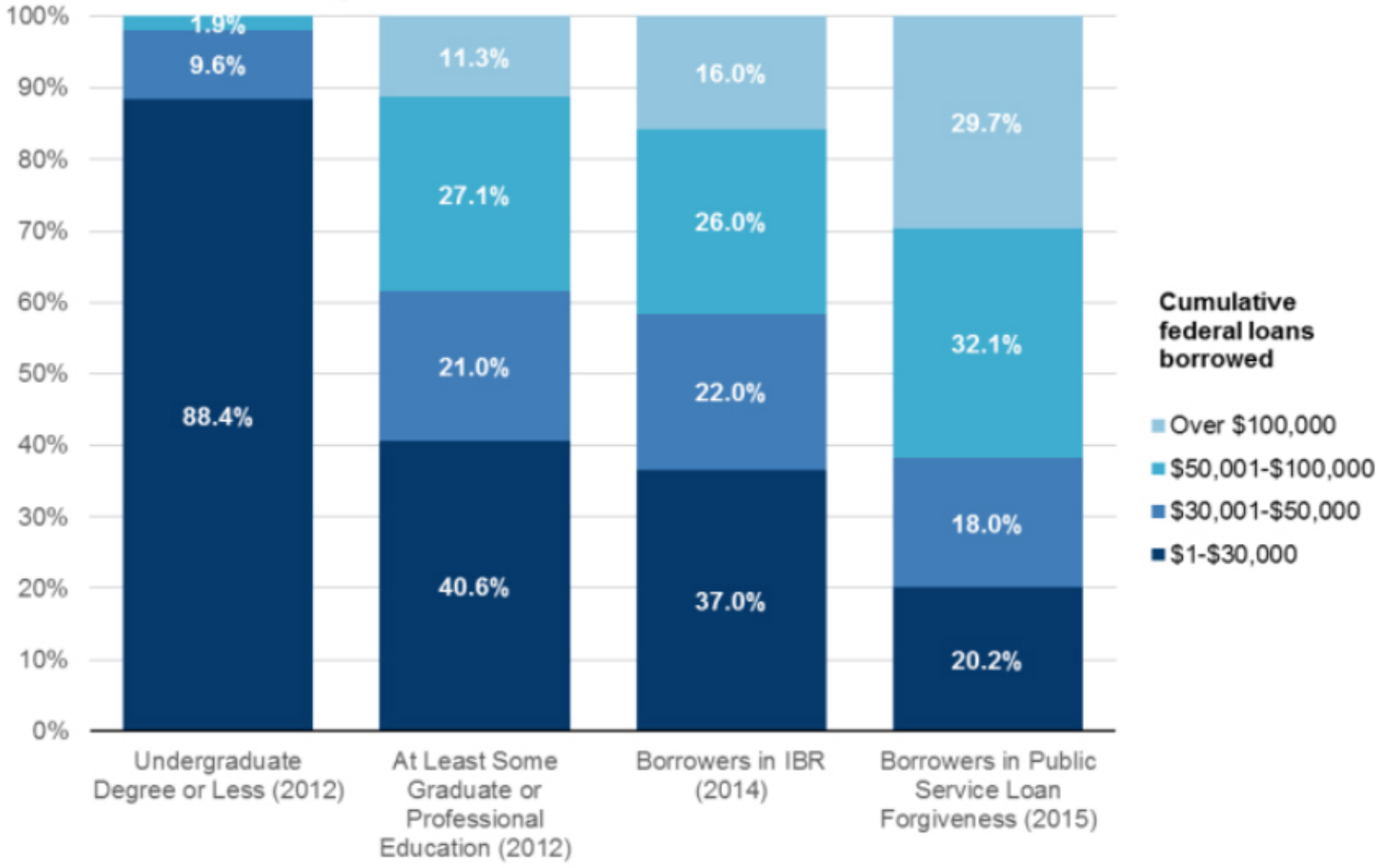


PUBLIC SERVICE LOAN FORGIVENESS

Questions without answers

- Government be willing to honor?
- Will the loan forgiveness amount be capped?
- Current participants/future participants issue
- Letters from loan servicer verifying participation may not be reliable
- Benefits accruing to those who attended graduate/professional school with the highest debt rather than bachelors graduates

Thirty percent of people registered for Public Service Loan Forgiveness borrowed more than $100,000



Sources: National Postsecondary Student Aid Study statistics on graduate and undgraduate borrowing; Government Accountability Office for borrowers in IBR; Department of Education Office of Federal Student Aid for PSLF balances.

BROOKINGS

PUBLIC SERVICE LOAN FORGIVENESS

It’s a lot to take in, feel free to check in with us later

- Renee Fullerton: federal loan repayment, J-1 visa waivers, renee.fullerton@doh.wa.gov
- Jawana Cain: rural/underserved recruitment assistance, jawana.cain@doh.wa.gov
- Chris Wilkins: state loan repayment program, chrisw@wsac.wa.gov

Department of Health placement assistance and 3RNet.org

The Washington State Department of Health helps to connect interested physicians with opportunities in rural and underserved areas. If you'd like to talk with us about your specific interests contact:

Jawana Cain, workforce advisor,
Jawana.Cain@doh.wa.gov, 360-236-2815

We partner with other state health departments to post rural/underserved opportunities to the National Rural Recruitment and Retention Network, **www.3rnet.org.**

Visiting 3RNet is a good way to connect with government/non-profit workforce specialists who know their states and aren't paid based on where you go to work. Jobs are available in every part of the country.

The National Health Service Corps also maintains a jobs website at https://nhscjobs.hrsa.gov. It's a good place to look up whether a practice is qualified as an NHSC site; however the job listings aren't always current or may not be posted when there is an opening.

National Health Service Corps in Washington State

The National Health Service Corps has a strong presence in Washington through its loan repayment and scholarship programs. As of Sept. 29, 2016, there are 381 clinicians working across the state with an NHSC obligation. These individuals work at 196 different NHSC approved sites. The bulk of those clinicians (355) are taking part in the NHSC Loan Repayment Program. The Loan Repayment Program involves an initial two-year commitment with the option to continue on with one year extensions until all eligible debt is repaid. Some clinicians in the summary below have been participating in the NHSC Loan Repayment Program for seven years. The other 26 NHSC-obligated clinicians are NHSC Scholarship recipients who had all or part of their training paid and now have an obligation to work in an area of greatest need.

The NHSC uses Health Professional Shortage Area (HPSA) scores to prioritize which areas receive first consideration for federal resources available through NHSC programs. HPSAs change as new designations are approved and scores changed on the HRSA Data Warehouse website (https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx). The NHSC pulls HPSA scores for approved NHSC service sites from the Data Warehouse each January. These are the scores in the NHSC Jobs Center (https://nhscjobs.hrsa.gov).

All current NHSC program participants by discipline and credential

Primary care	**118**
Physician (DO or MD):	47
Nurse practitioner:	26
Nurse midwife:	3
Physician assistant:	42
Dental	**93**
Dentist:	82
Dental Hygienist:	11
Mental health	**170**
Psychiatrist (DO or MD):	2
Clinical psychologist:	27
Licensed independent clinical social worker:	24
Licensed mental health counselor:	88
Marriage and family therapist:	12
Psychiatric nurse practitioner:	17

NHSC physicians by practice site

The 49 NHSC physicians (MD/DO) work in the following site types

Tribal health clinic:	3
Rural health clinic:	5
State prisons:	1
Federally Qualified Health Center:	40

NHSC physicians by county

The 49 NHSC physicians work in the following counties. This isn't a perfect representation of where clinicians are working as a few are assigned to multiple sites in different counties but are only counted in a single county.

Asotin:	1	Klickitat:	1
Chelan:	4	Okanogan:	4
Clallam:	1	Pierce:	2
Clark:	1	Snohomish:	1
Franklin:	1	Spokane:	1
Grant:	2	Whatcom:	3
King:	12	Yakima:	15

Prepared by Renee Fullerton, Washington State Department of Health, renee.fullerton@doh.wa.gov, October 2016

Health Professional Shortage Area Designations

Who: The U.S. Department of Health and Human Services (HHS) is charged by the Public Health Service Act to determine which parts of the United States don't have enough health professionals. Within HHS, the Health Resources and Services Administration (HRSA) works with State Primary Care Offices (PCOs) to designate Health Professional Shortage Areas. In Washington State the PCO is part of the Department of Health.

Federal regulations determines the type of information used in making a HPSA designation and the formula for calculating a HPSA score.

What: There are three types of HPSAs, Primary Care, Dental and Mental Health. Each HPSA is assigned a score ranging from 1-25 (or 1-26 for dental HPSAs.) A higher score means greater need for clinicians in the area or facility. HPSAs can be for everyone in a geographic area, certain vulnerable populations or specific healthcare facilities granted the right to a designation by legislation.

Main determining factors:

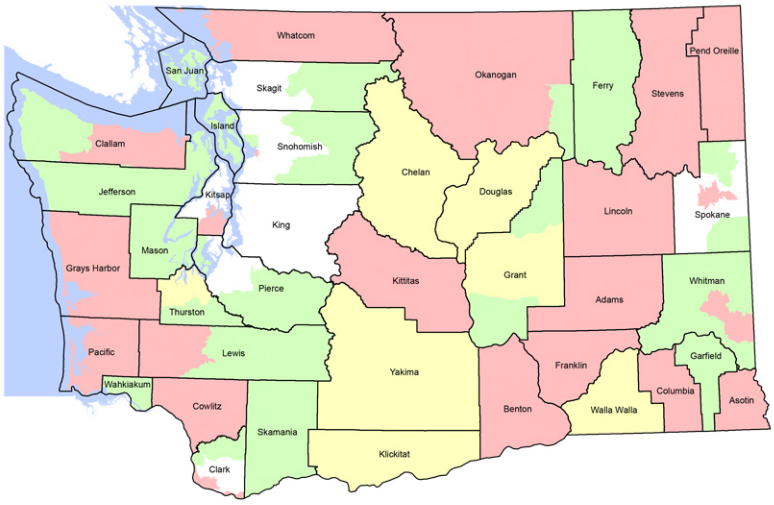
- Population to provider ratio
- Percent of population below poverty level
- Travel time/distance to next nearest source of care
- Depending on the type of HPSA, other considered factors include infant mortality, access to fluoridated water, drug/alcohol abuse and population age

Where: HPSAs cover geographic areas comprising logical healthcare use travel patterns. They can be multi-county, single county or census tracts.

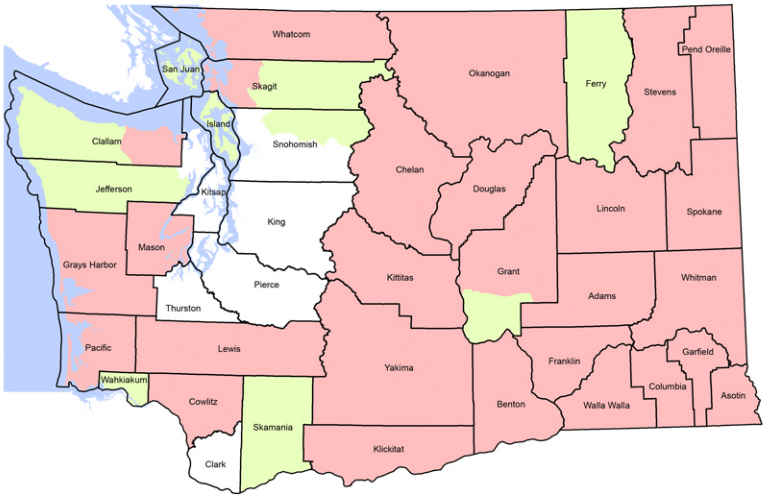
When: HPSAs are reassessed every three years to determine if the area still fits the criteria.

Why: The federal government requires participation in this designation process so they can compare healthcare access nationally. HPSAs are used by the National Health Service Corps in determining eligibility for loan repayment awards and placement of NHSC Scholars and S2S participants. Many other federal programs, ranging from enhanced Medicare payments to telehealth reimbursement, use the HPSA designations also.

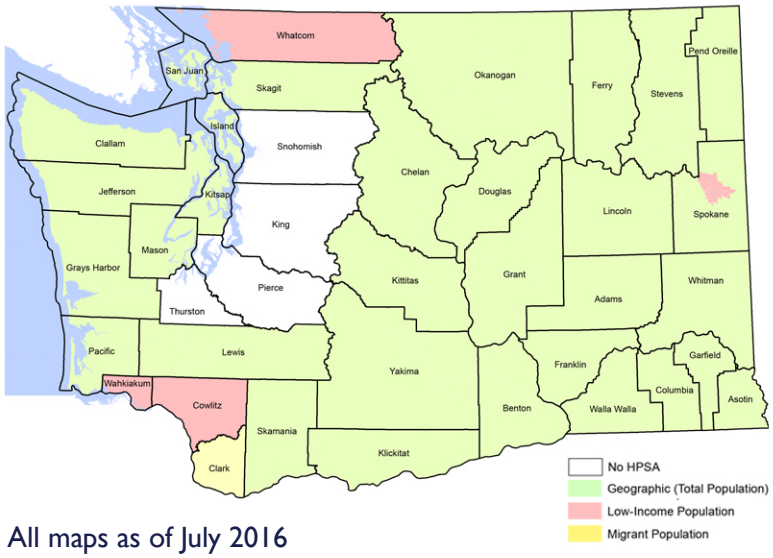
Washington Primary Care HPSAs



Washington Dental HPSAs



Washington Mental Health HPSAs



All maps as of July 2016

WASHINGTON STUDENT ACHIEVEMENT COUNCIL
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Washington State Health Professional Loan Repayment Program

2017-18

About the Program

The Health Loan Repayment Program helps the state attract and retain licensed health professionals to serve in critical shortage areas in Washington State by providing educational loan repayment assistance.

Two programs—with different requirements—provide educational loan repayment assistance.

Requirements	Health Professional Loan Repayment Program (HPLRP)	Federal-State Loan Repayment Program (FSLRP)
Funding source	State funds only	Federal funds matched with state dollars
Maximum award	$75,000	$70,000
Minimum service obligation	3 years	2 years
Minimum work week	24-hour work week, service obligation is prorated	40-hour work week
Default penalty	(2 x funds disbursed) + interest	(months NOT served x $7,500) + interest *Minimum $31,000 payback*
Annual leave away from clinic Includes holidays, sick, vacation, continuing education, etc.	40 days	Approximately 35 days
Eligible sites See provider reference guide for full details.	Optional: • Health Professional Shortage Area (HPSA) designation. • Nonprofit. • Posted sliding fee schedule.	Required: • Have a federal Health Professional Shortage Area (HPSA) designation. • Be a nonprofit. • Have an implemented and posted sliding fee schedule.
Eligible providers As of Sept. 2016	MD, DO, ND, Physician Assistant, Nurse Practitioner, Psychiatric Advanced Practice Clinician (PA or NP), Mental Health Nurse, Registered Nurse, Licensed Practical Nurse, Pharmacist, Registered Dental Hygienist, Certified Nurse Midwife, Licensed Midwife, DDS, or DMD. **Newly eligible:** Clinical Psychologist, Licensed Independent Clinical Social Worker, Marriage and Family Therapist, Mental Health Counselor. • Master's or doctoral degree required. Must be working in an integrated care system.	MD, DO, Physician Assistant, Nurse Practitioner, Registered Nurse, Pharmacist, Registered Dental Hygienist, Certified Nurse Midwife, DDS, or DMD.

Two-Step Process

1. Sites must apply each year during the site application cycle.
2. Providers must have an employment contract at an approved site to apply during the provider application cycle.

2017 APPLICATION TIMELINE

Fall 2016	Nov. 16, 2016	Dec. 2016	Jan. 2017	Apr. 14, 2017	June 2017	July 2017
Site application opens.	Site application closes.	Sites notified of approval.	Provider application opens.	Provider application closes.	Applicants receive notification.	New provider contracts begin.

National Health Service Corps Loan Repayment Program

Program Description	The National Health Service Corps (NHSC) Loan Repayment Program (LRP) offers primary care medical, dental, and mental and behavioral health care providers the opportunity to have their student loans repaid, while earning a competitive salary, in exchange for providing health care in urban, rural, or frontier communities with limited access to care.		
Financial Benefits	The NHSC Loan Repayment Program offers two levels of funding, based upon the need of the community in which a provider works, as defined by a HPSA score.		
Initial Award Amounts		**2 Years Full-time**	**2 Years Half-time**
	Sites with HPSA Score of 14-26	Up to $50,000	Up to $25,000
	Sites with HPSA Score of 0–13	Up to $30,000	Up to $15,000
	With continued service, NHSC providers may be able to pay off all of their student loans.		

Service Commitment

Full-Time Option:

2 years of *full-time* service (minimum 40 hours/week, 45 weeks/year) at an NHSC-approved service site.

- For all health professionals, except as noted below: 32 hours/week providing patient care at an NHSC-approved service site.
- For OB/GYNs, Certified Nurse-Midwives, Pediatric Dentists and Geriatric Service providers: 21 hours/week providing care at an NHSC-approved service site; 19 hours/week providing patient care at an alternate service site.
- No more than 8 hours/week may be spent on practice-related duties.
- Up to 8 hours/week may be spent teaching in a clinical setting.

Half-Time Options:

2 years of *half-time* service (minimum 20 hours/week, 45 weeks/year) at an NHSC-approved service site.

- For all health professionals, except as noted below: 16 hours/week providing patient care at an NHSC-approved service site.
- For OB/GYNs, Certified Nurse-Midwives, Pediatric Dentists and Geriatric Service providers: 11 hours/week providing patient care at an NHSC-approved site; 9 hours providing patient care at an alternate site.
- No more than 4 hours/week may be spent on practice-related duties or teaching.

Continued

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

January 2016

National Health Service Corps Loan Repayment Program *(continued)*

Eligible Disciplines	• **Physician (MD/DO)** — Family Medicine — Obstetrics/Gynecology — General Internal Medicine — Geriatrics — General Pediatrics — General Psychiatry • **Physician Assistant (primary care)**	• **Nurse Practitioner** — Nurse Practitioner (adult, family, pediatric) — Psychiatric/ mental health — Geriatrics — Women's Health — Certified Nurse-Midwife — Psychiatric Nurse Specialist	• **Dentistry (DDS, DMD)** • **Dental Hygienist** • **Mental and Behavioral Health** — Health Service Psychologist — Licensed Clinical Social Worker — Licensed Professional Counselor — Marriage and Family Therapist — Physician Assistant
Where Members Serve	• NHSC clinicians must work at an NHSC-approved service site in a Health Professional Shortage Area (HPSA). • HPSAs are located around the country in rural, urban and frontier communities. • NHSC-approved service sites are generally outpatient facilities providing primary medical, dental, and/or mental and behavioral health services. These facilities may be a: — Federally Qualified Health Center (FQHC) — FQHC Look-Alike — Rural Health Clinic — Hospital-affiliated Primary Care Outpatient Clinic — Indian Health Service, Tribal, and Urban Indian Health Clinic (ITU) — Private Practice (Solo/Group) — State or Federal Correctional Facility — Other Health Facilities: ▫ Community Mental Health Facility ▫ Community Outpatient Facility ▫ Critical Access Hospital ▫ Free Clinic ▫ Immigration and Customs Enforcement (ICE) Health Service Corps ▫ Mobile Unit ▫ School-based Health Program ▫ State and County Department of Health Clinic		
Application Requirements	U.S. citizen (U.S. born or naturalized) or U.S. national		
Tax Liability	Not taxable		
Web Site	NHSC.hrsa.gov/loanrepayment		

NHSC's mission is to build healthy communities by supporting qualified medical, dental, mental and behavioral health care providers working in areas of the United States with limited access to care.

HRSA
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

January 2016

LOAN REPAYMENT and SCHOLARSHIP PROGRAMS

Loan Repayment Programs	Oregon Partnership State Loan Repayment Program (SLRP)	Medicaid Primary Care Loan Repayment Program (MPCLRP)	National Health Service Corps (NHSC)	Indian Health Services Loan Repayment Program (LRP)
Who Can Apply?	Primary Care MDs & DOs, NPs, PAs, DDS, dental hygienists, Social Workers, Counselors & Psychologists	Primary Care MDs & DOs, NPs, PAs, DDS, expanded practice dental hygienists, and behavior health clinicians	Primary care physicians (MD or DO), NPs, PAs, DDS, certified nurse midwives, dental hygienists and behavioral health clinicians	US Citizens with a degree in a priority health profession, currently in post-graduate training or in their final year of a health profession school.
Payoff Commitment	1:1 – one year of loan repayment for one year of clinical service	1:1 – one year of loan repayment for one year of clinical service	1:1 – one year of loan repayment for one year of clinical service	1:1 – one year of loan repayment for one year of clinical service
Minimum Participation Commitment	2 years	3 years	2 years	2 years
Maximum Participation Commitment	Up to three additional years	Not yet determined	Eligible for a continuation award as long as clinician has eligible loan debt	N/A
Obligated service start date	N/A	No later than 4 months from notification of award	Must be employed by a NHSC approved site at the time of application	Must begin service obligation no later than September 30 of fiscal year in which they receive an HIS LRP Award.
Minimum Clinical Practice	Full & part-time options available	Full & part-time options available	Full & part-time options available	Full-Time
Location of Practice Site	Non-profit and Federally designated HPSA	Federally designated HPSA, although other sites not located in a designated HPSA may be eligible, subject to approval	Federally designated HPSA	Indian Health Service clinics and hospitals, and approved Tribal clinics nationwide.
Type of Practice eligible	Unrestricted	Rural Hospital, FQHC, RHC, sites providing primary care services in a HPSA area, other sites providing primary care services to an underserved population as determined by the Authority	FQHC, FQHC Look-Alikes, Indian Health Facilities, Correctional or Detention Facilities, Rural Health Clinics, CAHs, State or County Health Departments, Private Practices, School Based Clinics, Mobile Health Clinics, Free Clinics	Indian Health Service clinics and Tribal facilities.
Patient Criteria	Must see all patients regardless of ability to pay	At least 15% Medicaid patients	Must see all patients regardless of ability to pay	Must see all patients regardless of ability to pay
Maximum	$35,000/year	$35,000/year	Up to $50,000 total for a two year commitment if	$20,000/year
			practicing in a HPSA area of 14 or greater	
Site Contribution	50% of award +10% admin fee	None	None	None
Funding Source	Federal Grant + match	State of OR	Federal funding	Federal funding through Indian Health Service
Tax Liability	Award is tax free	Award is tax free	Award is tax free	LRP pays 20% of the federal tax liability. Recipients are responsible for paying the balance of their federal tax liability and any state and local taxes.

FINANCIAL PLANNING

For the “Doctor Doctor” World

Introduction

- Univ. of Washington – MHA 2015, MBA 2014
- Univ. of Virginia – BA 2005

- Finance Manager – Providence St. Joseph Health
- Financial Advisor – 2010 – 2013

Disclaimer: I am no longer a practicing financial advisor. My intent is to give you the tools and theories necessary to approach your own financial choices. When in doubt contact a professional.

Session Overview

- Guiding Principles
  - How to prioritize
  - What to do with student loans
- Retirement Savings
  - How much
  - Which investments to use
- Insurance
  - Is it necessary (Yes)
  - Where to get it
- Questions/Extras

Guiding Principles

- Spend less than you make
- You will make more money than you need to be happy
- There are many solutions to financial wellbeing, pick the one that works for you
- A good way to prioritize:
  - Future You
  - Current You
  - Everything Else

Guiding Principles

- Average annual starting salary: $170,000
- Average loan debt post residency: $200,000

	10 Year Repayment	30 Year Repayment
Loan Balance	$200,000	$200,000
Interest Rate	6.8%	6.8%
Monthly Payment	$2,301	$1,303
Percent of Gross Inc.	19.7%	11.1%
Total Interest Paid	$76,192	$269,386

Guiding Principles

Non-Negotiable

- Retirement Savings
- Short-term Savings
- Insurance

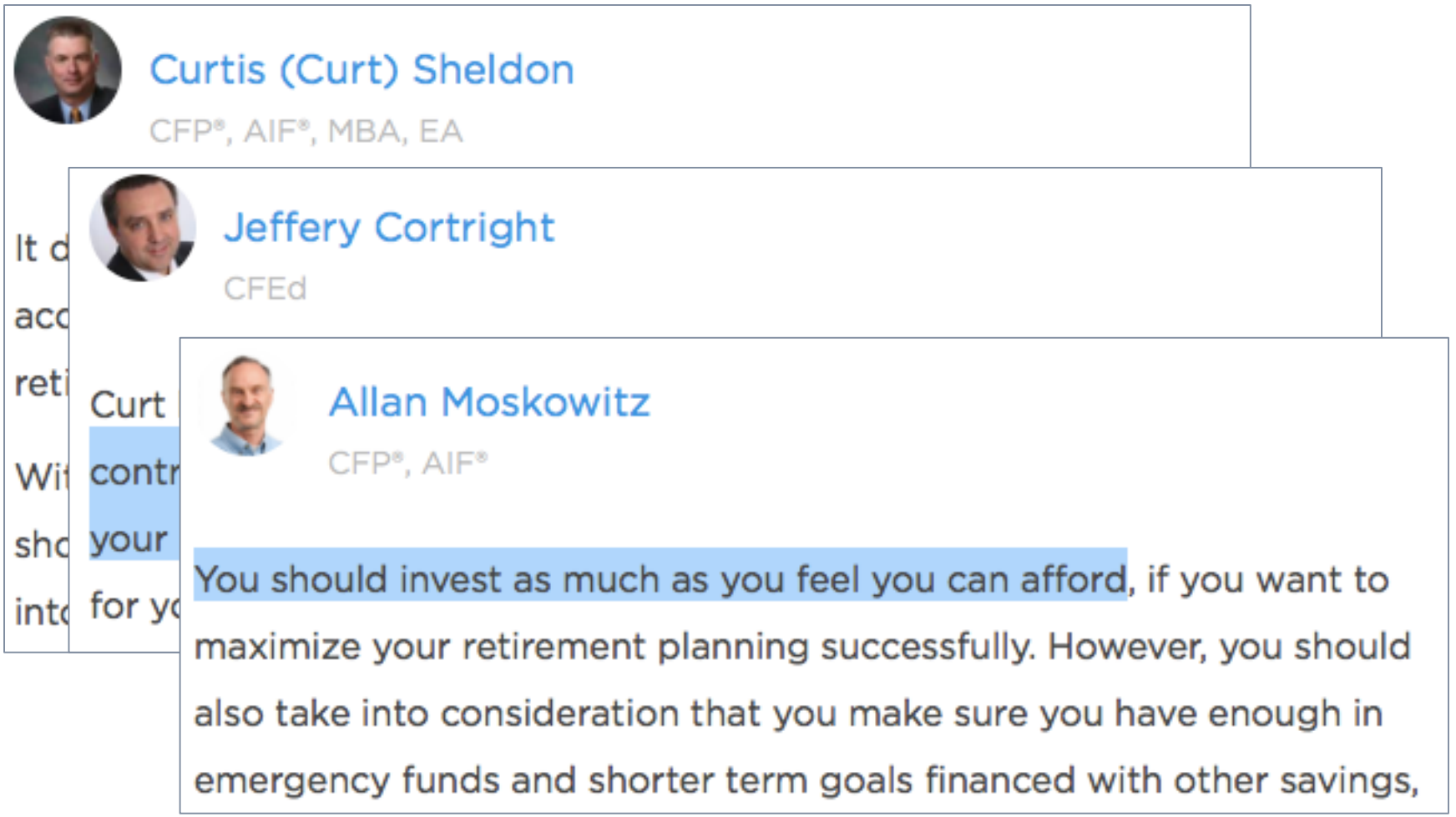
Negotiable

- Housing
- Consumer Debt
- Daily Expenses

RETIREMENT

15% in a Roth* 401(k), in a target date, index fund

15% of Income in a Roth* 401(k)…



Source: Nerdwallet.com

15% of Income in a Roth* 401(k)…

- This is a safe guess. Everybody's rate is different
- Some factors affecting the savings rate are:
  - Retirement age and lifestyle
  - Current money saved
  - External factors
- Three ways to get to 15%
  - Right now
  - With a pay raise
  - Over time

15% of Income in a Roth* 401(k)…

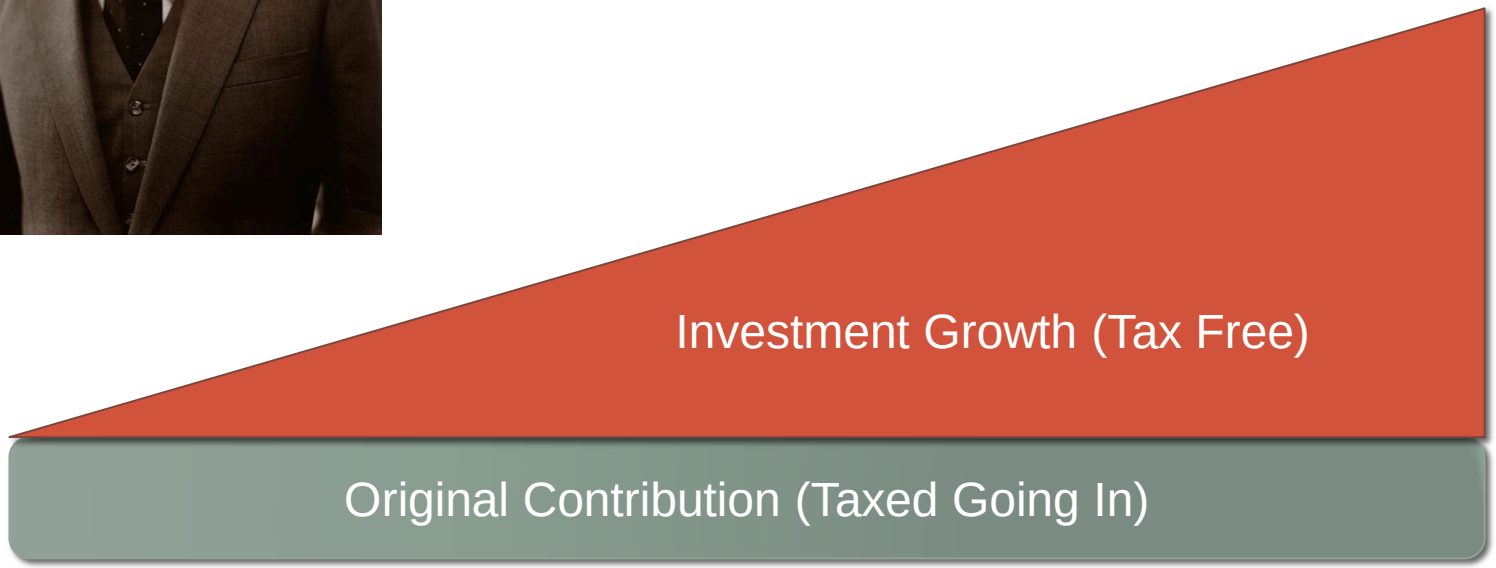
	Traditional	Roth
Work	401(k)/403(b): $18,000 annual employee limit $24,000 annual total limit Pre-tax contributions No income limits	Roth 401(k)/403(b): $18,000 annual employee limit $24,000 annual total limit Post-tax contributions No income limits
Home	IRA: Individual Retirement Acct $5,500 annual limit Pre-tax contributions No income limits	RIRA: Roth Individual Retirement Acct $5,500 annual limit Post-tax contributions Income limitations

15% of Income in a Roth* 401(k)…

- *Traditional* retirement accounts do not tax the money when it goes into the account. But everything is taxed when it is taken out

15% of Income in a Roth* 401(k)…

- *Roth* accounts require income tax to be paid on the money going in, but the money coming out is income tax free



15% of Income in a Roth* 401(k)…

- Roth accounts are good when
  - You do not intend to withdraw the money for at least 10 years
  - You are in a low tax bracket, or expect to be in a higher tax bracket in the future
- Traditional accounts are good when
  - You expect to withdraw the money in less than 10 years (approx.)
  - You are in a high income tax bracket
- Roth accounts also tend to have more flexibility for withdrawals

in Target Date, Index Funds

- Target Date Funds – An investment that adjusts the level of risk with the expectation of using the funds at a predetermined time

- Good for people who:
  - Don’t want to rebalance their accounts regularly
  - Those who are prone to making emotional investment choices

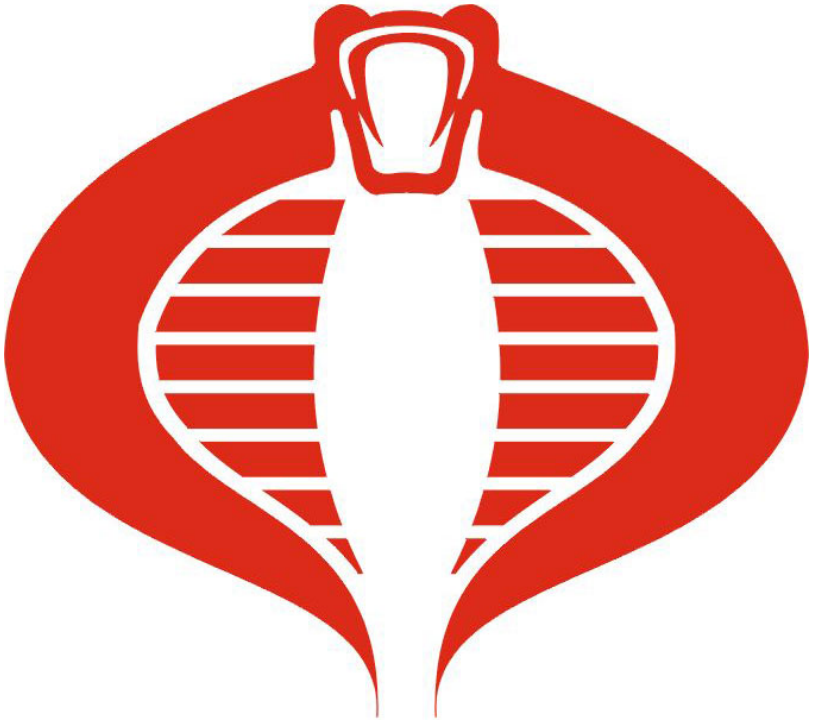
in Target Date, Index Funds

- Index Funds – Mutual funds that attempt to track a broad market index, such at the S&P 500. In other words it tries to be average
- Index funds tend to have lower fees which usually makes them a better investment than similar, **actively managed** funds
- Charles Schwab, Fidelity, and Vanguard are good organizations

INSURANCE

Life & Disability

Health Insurance



- Keep your employer insurance for up to 18 months after leaving
- You pay the entire premium
- 60 Days to enroll

Life Insurance… Just Get It

- You will rarely spend that extra dollar on something more worthwhile
- Purchase only what you need
- Some life insurance should be temporary (term), some should be permanent (universal, whole life)
- Insurance can be a useful investment tool (used to mitigate taxes), but you probably aren’t rich enough to worry about that… yet

Disability Insurance

- Disability is not as uncommon as you think. Chances of a disability occurring:
  - 3 months or more – 1 out of 3
  - 1 year or more – 1 out of 5
  - 5 years or more – 1 out of 7[1]

- Disability is more than just on-the-job injuries:
  - 90% due to illness, 10% due to injury[2]

1. Burke, J. Christopher. “What Every Physician Should Know About Disability Insurance.” *AMA Insurance Agency*. January, 2011. http://www.amainsure.com/static/cms_workspace/AM213-WhitePaper-v2.pdf
2. 2. “What You Need to Know About Disability Insurance.” *The Life and Health Insurance Foundation for Education*. 2011. http://www.lifehappens.org/pdf/printable-consumer-guide/disability-pcg.pdf

Disability Insurance

- Covers 40 – 60% of pre-disability income
- Most employers provide some coverage
  - Short-term: first 2 weeks
  - Long-term: weeks 2 – 12
- Three sources of additional coverage
  - Employer plans
  - Professional organizations
  - Private insurance

Disability Insurance

What to look for in a plan:

- Elimination Period: 90 days
- “Own occupation” coverage
- Inflation protection
- Portable
- Renewable

QUESTIONS?

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APPENDIX

Financial Advisors

- Useful if…
  - You don’t want to do your own research
  - You want to combat your own bad financial behavior
  - Couples want to mediate their differences of opinion
- Good sources for financial planning:
  - Your work
  - NAPFA – fee only planners
  - Garrett Planning Network
- It is never too early to start

Financial Advisors

- To find an advisor I recommend looking on the NAPFA website. From the profiles I've seen, I would suggest these:
  - 2020 Financial Planning – Stacy comes highly recommended and has experience with the medical world
  - Columbia Financial Planning
  - Michael Pace
  - IJD Evergreen

Note: I have no relationship with these advisors, and have never worked with them. This is just my suggestion for a starting point in your search for a good match.

Short-term Savings

- Cash on hand – money to handle normal expenses (car repairs, weekend getaways, etc.) $2,000 - $5,000
- Emergency savings – this is your rainy day fund, to be used for job transitions and major emergencies
  - Should equal 3 – 6 months of expenses (not income)
  - The riskier the job, the more months this fund should cover
- A signing bonus is a great way to achieve this quickly
- Going forward, put half of all bonuses and raises towards your financial plan. Or try to put away 5% of your monthly income

Housing

- Typically you should spend no more than 25% of take-home pay (18% of gross) on housing
- Homes are a poor investment
  - Overtime they keep pace with inflation. Think of it as forced savings
  - Purchase a home because you want to live there for several years
- If you can’t afford a fixed rate mortgage you probably should not buy the home
- Think of renting out your home like running a small business with thin margins… because it is

Consumer Debt

- Ideally no more than 5% of gross pay (excludes housing)
- Paying down debt vs. investing
  - 7% rule – if the debt interest rate is more than 7%, it is better to pay off the debt
  - It's a matter of personal preference
- Mathematically, it is best to pay off debt with the highest interest rate first. But do whatever works best for you
- In most cases you should start some cash savings *while* paying off debt

College Savings

- Saving for your child's college comes after saving for your retirement
- Your children would rather have student loans than have you living in their basement
- Typically 529 plans are the best way to save for college (use target date funds…always)
- For a newborn $500/mo will be enough to put them on track for the best in-state, public school
- Savingforcollege.com is a great resource

Parents

- You need to know if your parents are planning on you supporting them
- Spouses should be on the same page about how their parents are going to be supported
- Long Term Care Insurance is a great, but an expensive option